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Exploring the Cost of the Pregnancy Pathway

NHS Greater Glasgow and Clyde and NHS Ayrshire & Arran

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The Exploring the Cost of the Pregnancy research was funded by NHS Health Scotland¹ and the fieldwork was carried out by Scott Porter Research & Marketing Company Ltd. Queries about the report should be sent to Dr Regina McDevitt, Public Health Specialist, NHS Ayrshire & Arran (Regina.McDevitt@aapct.scot.nhs.uk).

Please note that the Exploring the Cost of the Pregnancy Pathway research was carried out prior to the coronavirus pandemic – however, the issues raised in the research remain pertinent, particularly as many families with young children face a reduction in their income increasing the likelihood of children living in poverty.

¹ *NHS Health Scotland was dissolved 31/3/20 and replaced by Public Health Scotland from 1/4/20.

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Abbreviations

NHSA&A: NHS Ayrshire and Arran NHS Board area

NHSGGC: NHS Greater Glasgow and Clyde NHS Board area

GCPH: Glasgow Centre for Population Health

NHSHS: NHS Health Scotland

Acknowledgements

This research was jointly commissioned by NHS Ayrshire & Arran, NHS Greater Glasgow and Clyde and NHS Health Scotland. The commissioned agency, Scott Porter Research & Marketing Ltd, conducted the fieldwork and reporting. Grateful thanks are due to the midwives, family nurses and health visitors, and most of all, the families who generously gave of their time to talk about their experiences. Thanks also to the Advisory Group for their helpful and timely support and advice.

Executive summary

Background

The relationship between lack of material resources and poor health, including during pregnancy, is well established, and the birth of a new baby can result in those close to the poverty line falling below it.

The Scottish Government published '*Every Child, Every Chance*', its first child poverty delivery plan, in March 2018 as part of its duties under the Child Poverty (Scotland) Act 2017. The plan outlined proposed actions for helping families in receipt of low income, including new actions on the cost of living and social security, and support for income maximisation services in health settings. In addition, the NHS in Scotland has a new statutory duty under the Act to work with local authority partners to maximise the incomes of pregnant women and families.

Evidence shows that there can be cost-related barriers to accessing universally provided, and free at the point of access services. NHS Health Scotland (NHSHS), Glasgow Centre for Population Health (GCPH), NHS Greater Glasgow and Clyde (NHSGGC) and NHS Ayrshire & Arran (NHSA&A) therefore wished to commission a qualitative study to explore the financial impact of pregnancy on low-income families in the two respective NHS Board areas with a view to establishing any cost-related barriers to these audiences accessing antenatal healthcare and exploring what health services can do to support the financial wellbeing of expectant parents and their families.

The findings will be used to inform the development of strategies to better support low-income families during pregnancy and into the early stage of family life.

Aims

The two overall aims of the study were to:

- explore the financial impacts of pregnancy for expectant and new families living in the NHS Greater Glasgow and Clyde and NHS Ayrshire & Arran areas, particularly those in receipt of a low income
- explore feasible actions, including income maximisation, which NHS Greater Glasgow and Clyde and NHS Ayrshire & Arran, with their national and

community planning partners, can take to reduce any observed cost-related barriers to accessing care and mitigate financial pressure on expectant parents and their families.

Methods

A qualitative approach was adopted, using mixed methods comprising in-depth interviews and focus groups. A total of 25 in-depth interviews (five of them paired with an expectant or new mother and their partner) and four focus groups were undertaken with pregnant women and new mothers, alongside two focus groups with frontline staff. Key inclusion criteria were as follows:

- Location: interviews were conducted in the NHS Greater Glasgow and Clyde and NHS Ayrshire & Arran areas, with the latter providing the opportunity for interviewing those living in rural communities
- Mothers and mothers-to-be: women in late pregnancy (post 28 weeks) or with a new baby (under one year old)
- Families at risk of poverty: both in-work and unemployed, including some who were in receipt of Universal Credit.

The two staff groups comprised midwives, family nurses and health visitors working in each of the NHS Board areas.

Findings

The financial pressures of pregnancy for expectant and new families set the context for the specific cost-related barriers that families in receipt of a low income experienced in accessing antenatal and postnatal care.

The impact of less money coming into the household was evident across both those who were in regular paid employment and those who were out of work.

Many relied on family support and the welfare system. Establishing entitlement, applying for and managing welfare payments was a key concern. The way in which Universal Credit operates created additional pressure, income ‘gaps’ and uncertainty for families. Limited awareness of entitlement and a lack of confidence in seeking information and applying had led to delays in accessing the welfare system, for some.

With no right to work or to access the wider welfare system in the UK, the asylum-seeking families interviewed found their support payments were

insufficient to enable them to cope financially during pregnancy and the early postnatal period. They spoke of relying on charity, and of negative impacts on their mental health.

It was evident that pregnancy brought a period of sudden increased financial pressure associated with the purchase of items felt to be essential for a baby and for some, new living expenses (for example furniture for a new social-rented tenancy). Sustained money worries were reported following the birth of a baby, with key factors in this context being:

- additional heating costs
- buying formula and food, with increasing costs as baby grows; this can lead to a poor diet or missed meals for other family members, and for mothers in particular
- buying baby clothes as the child grows
- buying nappies
- adequately providing for the needs of older children (food, clothes, activities etc.).

Cost-related barriers to accessing antenatal and postnatal care related to both current maternity service characteristics and to logistic and personal circumstances:

- The centralisation of services which can be at a significant distance (especially in rural A&A) increased both the cost involved in travel (and in some cases, parking) and the time and effort required in negotiating the transport solutions available.
- The limited length of time spent with the health professional at some appointments can feel too cursory to be of real value, leading some women to question the value of regular attendance, particularly if financial or practical difficulties were experienced in attending.
- Appointment-related issues included:
 - the limited co-ordination of appointments across different departments can lead to repeated trips in a short period and push women into having to prioritise those they felt were more important

- the lack of flexibility to schedule appointments to fit around shifts, childcare patterns or travel restrictions can place additional financial pressure on low-income families
 - long delays with appointments was not only a source of frustration and stress, but resulted in additional costs linked to childcare, loss of income and the need to purchase food and drink on site.
- Organising childcare for other children presented a significant problem for families unable to access funded early learning and childcare. Mothers felt they had no option but to take children with them to hospital appointments, something perceived to be discouraged by the staff.
- Managing time off work to attend appointments was more of an issue for dads, with the potential to result in loss of earnings for those wishing to accompany their partners on more than the two occasions that statutory provision allows.

The logistical and financial pressures that low-income families experienced in attempting to regularly attend their antenatal appointments were felt by many to negatively impact their mental health: high levels of stress were induced, particularly with the perceived threat of social work involvement if they did not attend.

Health professionals' experience of the kinds of financial pressure that pregnancy and a new baby can place on low-income families reflected similar issues, but also stressed the impacts on the wider family who might also be struggling financially to support young families.

It was believed that the current design of financial support services could pose an additional barrier for those pregnant mothers with poor literacy skills or experiencing anxiety, limiting their ability to advocate for themselves. Additionally, poor mental health acted as a stress multiplier and a further barrier for some.

The health professionals in the study unanimously viewed addressing the financial health needs of their clients as an integral part of their role but noted that it was not always easy to identify individuals experiencing money worries.

The research found a strong belief among health professionals that a person-centred approach that enables relationship building and open conversations is key to facilitating a real understanding of individual financial pressures and needs.

The ability to signpost or refer to specialist financial inclusion services was seen to be a vital part of the health professional's role as opposed to being experts in providing advice on financial issues. Encouraging client engagement with such services was perceived to be greatly facilitated when the service is available on-site and working in partnership with the healthcare team.

Health professionals valued the availability of local resources that can help with money-related needs but felt that most of these are currently very dependent on individuals building their own contacts rather than being able to access such resources uniformly.

A number of barriers were highlighted in relation to being able to further support families around their financial needs:

- Lack of time to be able to sensitively probe personal circumstances and provide personalised guidance to all clients.
- Constant changes to the services available (for example, as a result of inconsistent funding of individual third sector organisations) make it hard to keep track.
- Lack of a centralised resource listing local sources of support for families, resulting in reliance on the personal contacts of individual staff members and therefore inconsistency in signposting and support access.

Conclusions

A range of factors contributed to the financial pressures experienced by expectant and new families in receipt of low income, the most significant of which were:

- an increased burden on overall household income levels, particularly for asylum seekers, single parent families, and those in receipt of Universal Credit
- additional costs associated with preparing for the arrival of a new baby and ensuring the child's wellbeing once born
- the social pressure to 'buy the best' for the baby.

While families experienced a sudden and intense financial pressure during pregnancy, varying degrees of financial support were accessed for 'baby-focused' spending such as clothes and equipment. This support was provided

primarily by close family, and (for those eligible) by the availability of the Scottish Government Baby Box and the Best Start Grant.

Money worries were felt to intensify in the early postnatal period, when the effect of the ongoing costs of caring for a baby were strongly felt, with the pressure on family finances being significantly higher where there were older children to be cared for as well.

Antenatal (and to a lesser extent postnatal) healthcare needs added a further layer of financial pressure on the income of these families, particularly those living in rural locations. The key impacts of accessing this care related to:

- travel costs for attendance at centralised venue appointments, whether for antenatal clinics or for scans/specific monitoring – again a particular issue for those in rural areas
- cost, or lack of availability of free, childcare to address the restrictions on having children present at assessment centres or to facilitate travel to appointments
- additional costs incurred as a result of the ineffective or uncoordinated scheduling and running of appointments (parking, travel costs, food)
- loss of earnings due to partners attending antenatal appointments

Recommendations

The following actions by the NHS boards and their national and community partners are required to support reducing cost-related barriers to accessing care and mitigating financial pressure on expectant parents and their families:

- Greater opportunities for meaningful engagement with midwives at the antenatal stage will provide for continuity of care and time to build relationships of trust (for example, as with the Family Nurse model). This will afford better opportunities to identify and support women with anxiety and offer more person-centred guidance to financial and budgeting advice.
- The provision of clearer awareness-raising and signposting of specialist money advice/welfare rights services is needed. Training of staff to raise and discuss financial inclusion issues in a sensitive and probing way, and facilitate initial engagement with the service, ideally through the on-site presence of service partners, is key. It will be important to raise awareness of the service

offered and breadth of engagement to remove any sense of stigma in accessing it.

- Proactive discussion of the financial support that is available must take place early in the antenatal care process to guard against unnecessary expenditure. Verbal communication, rather than relying on written material alone, will be more effective.
- The cost of travel to access antenatal care is a barrier that must be addressed, particularly in rural areas. The provision of vouchers or passes will be more helpful than retrospective reimbursement of expenses. Access to hospital transport from a central point for those in dispersed rural locations would go some way to reducing both logistical and cost barriers. Consideration needs to be given to alleviating excessive parking costs, particularly for those who are required to access the service more frequently.
- Greater ease of accessibility to welfare foods (Healthy Start vitamins and Best Start Foods) is needed. Increasing the range of foods covered and eligibility to cover asylum seekers, and removing the perceived stigma associated with them by limiting overt signs of welfare e.g. on vouchers, welfare parcels will be supportive. Logistical and cost barriers related to redeeming such payments must also be considered: e.g. travel to and from food banks with a young baby/child, and the local availability of shops providing Healthy Start voucher/Best Start Foods redemption options. Emergency cash payments would be more helpful for some.
- Local second-hand buying options, third sector services, and online platforms which provide equipment for new parents should be promoted. Digital / social media platforms are familiar and easily accessible for families with internet access. A centralised database for health professional use would provide the opportunity for more equitable sharing of resource and support sources.

A number of wider-reaching service considerations would have a significant impact on reducing cost-related barriers to accessing antenatal and postnatal care:

- Access to childcare facilities, specifically for those attending more frequently for additional care appointments.
- Greater flexibility to accommodate individual circumstances when arranging appointments.

- A more decentralised service delivery model, for example, a hub-and-spoke model, particularly in rural areas.

Introduction

The relationship between lack of material resources and poor health, including during pregnancy, is well established. Furthermore, the birth of a new baby can result in those close to the poverty line falling below it², and it is predicted family poverty will increase substantially over the next few years.

The Scottish Government published '*Every Child, Every Chance*', its first child poverty delivery plan, in March 2018 as part of its duties under the Child Poverty (Scotland) Act 2017. The plan outlines proposed actions for helping families in receipt of low income, including new actions on the cost of living and social security, and support for income maximisation services in health settings. In addition, the NHS in Scotland has a new statutory duty under the Act to work with local authority partners to maximise the incomes of pregnant women and families.

Evidence shows that there can be cost-related barriers to accessing universally provided, and free at the point of access services. Glasgow Centre for Population Health, NHS Greater Glasgow and Clyde and NHS Ayrshire & Arran sought to commission a qualitative study to explore the financial impact of pregnancy on low-income families in the two respective NHS Board areas with a view to establishing any cost-related barriers accessing antenatal healthcare, and exploring what health services can do to support the financial wellbeing of expectant parents and their families.

The findings will be used to inform the development of strategies to better support low-income families during pregnancy and into the early stages of family life.

² Poverty and Inequality Commission, *Advice on the Scottish Government's Child Poverty Delivery Plan 2018* (Poverty and Inequality Commission, 2018) available at <https://povertyinequality.scot/wp-content/uploads/2018/02/Child-Poverty-Delivery-Plan-advice-Final-Version-23-February-2018.pdf>

The two overall aims of the study were to:

- investigate the financial impacts of pregnancy for expectant and new families living in the NHS Greater Glasgow and Clyde and NHS Ayrshire & Arran areas, particularly those in receipt of a low income
- explore feasible actions, including income maximisation, which NHS Greater Glasgow and Clyde and NHS Ayrshire & Arran, with their national and community planning partners, can take to reduce any observed cost-related barriers to accessing care and mitigate financial pressure on expectant parents and their families

The study had a number of specific objectives.

Pregnant women/mothers with new babies and partners

- To explore the extent to which low-income families living in the target areas experience cost-related barriers to accessing antenatal and postnatal care.
- To identify the broader financial pressures related to pregnancy and the early postnatal period which are being experienced by low-income families living in the target areas.
- To explore what low-income families feel could be put in place by services to reduce any barriers to accessing care and/or financial pressures associated with pregnancy.

Frontline staff

- To explore the understandings, beliefs and experiences of frontline staff (including midwives, family nurses and health visitors) in relation to supporting pregnant and early postnatal families experiencing money worries.

Overall

- To identify any further learnings which may assist NHS Greater Glasgow and Clyde and NHS Ayrshire & Arran, with their national and community planning partners, to take action to reduce any observed cost-related barriers to accessing care and mitigate financial pressure on expectant parents and their families.

This report describes the methodology and sampling strategy adopted for the research, details key findings together with a discussion of these findings, before going on to provide study conclusions and recommendations.

The Appendices detail the research materials used (discussion guides, recruitment questionnaire, participant information sheet and consent form) and characteristics of the study population.

Methodology

In designing the research approach, a number of factors relating to the target audience and subject of the study were taken into consideration.

Sensitivity of approach

It was recognised that sensitivity of approach would be required when interviewing the target audience of pregnant women, given both the emotional and physical impacts of pregnancy, and the added financial pressures arising from being in receipt of a low income. It was also acknowledged that speaking openly about personal finances, particularly with unknown individuals in a focus group setting, may be uncomfortable. Willingness to openly share thoughts and experiences on the subject, and fear of ‘reporting’ to authorities, were potential barriers.

The approaches adopted needed to mitigate as far as possible against any unnecessary upset or anxiety that may be caused through the discussions of money worries at this time. In doing so, procedural criteria were implemented:

- Provision of assurance to respondents of impartiality and confidentiality.
- Ensuring full and complete transparency with regards the issues to be discussed and what will be required of participants at the time of recruitment to the study.
- Allowing for additional time at the beginning of the research sessions to establish rapport with the respondent prior to embarking on direct discussion of the key issues, and facilitating a relaxed, semi-structured interview, with additional time permitted if required.
- Adopting an interview approach which enabled respondents to engage with researchers in an open manner, allowing them to feel that they can respond at the level with which they feel comfortable. An individual face-to-face interview approach was adopted for the majority of the participants, providing a more private and comfortable context for the exploration of experiences and sharing of personal financial information.

Consideration of equality issues

Issues of equality and diversity were considered when designing the inclusion criteria and recruitment strategy to ensure that the research would capture experiences and perspectives of different equality groups. No respondent was excluded from taking part and provision was made to accommodate childcare, travel and access to the research sessions (primarily held in respondent homes) as necessary.

A qualitative approach was adopted, using mixed methods comprising a series of in-depth interviews and focus groups. A total of 25 in-depth interviews (five of them paired with new mothers and their partners) and four focus groups were undertaken with pregnant women and new mothers, alongside two focus groups with frontline staff (see Appendix 5).

Key inclusion criteria were as follows:

- Location: interviews were conducted in the NHS Greater Glasgow and Clyde and NHS Ayrshire & Arran areas, with the latter providing the opportunity for interviewing those living in rural communities.
- Mothers and mothers-to-be: women in late pregnancy (post 28 weeks) or with a new baby (under one year old).
- Families at risk of poverty: both in-work and unemployed, including some who were in receipt of Universal Credit (screened as having money worries – see recruitment questionnaire in Appendix 1).

Other variables of interest were:

- Age: a spread across three age bands: 16-25 years; 26-35 years; and 36-45 years.
- First time and experienced parents.
- Household composition: including lone parents and those with a partner.
- Minority groups: Black and minority ethnic, refugees and asylum seekers.

The recruitment of the pregnant women and new mothers was undertaken using a mix of free-find methods (via Scott Porter research consultancy's network of freelance recruiters) alongside assistance from the teams in NHS Greater

Glasgow and Clyde and NHS Ayrshire & Arran to identify appropriate respondents from their caseloads who may be willing to participate.

For the free-find approach, experienced recruiters from the specific research locations sourced local respondents who fitted the desired sampling criteria. The process for the recruitment was as follows:

- At project set-up, the ‘invite to research’ material was designed and approved, considering potential literacy issues.
- Recruiters were sent the appropriate documentation and then received a full telephone briefing on the project requirements.
- All screening of potential respondents was carried out via a recruitment questionnaire devised by Scott Porter and signed off by the research team prior to recruitment starting. This document included all the inclusion criteria needed to reach the specified quotas (see Appendix 1).
- If potential participants qualified for inclusion and were willing to participate in principle they were given a ‘participant information sheet’ showing full details of the project, a note of the proposed date, time and location of the interview, and who to contact for further information (see Appendix 2).
- All those willing to participate received a phone call or text message one to two days before the interview to be sure of their willingness to take part.
- Finally, prior to commencing the interview, respondents were reminded of the process, including audio recording, confidentiality and data protection, and signed a form to confirm they had been informed about the study and were happy to take part by providing their written consent (see Appendix 3).

Given the specific profile of the respondents whose views were sought, it was decided that support from frontline staff in antenatal clinics would aid recruitment. Also, as the number of women attending each clinic on any one day in Ayrshire & Arran was small, the knowledge of the local midwifery and health visitor teams in three of the clinics was utilised to identify and recruit suitable respondents. These health professionals asked women in their caseload whether they would be interested in participating. Those who said they were willing to take part in the research and who provided consent for their details to be passed on, were subsequently contacted by one of the recruiters working on the project. They were then taken through the recruitment questionnaire to verify that they fitted

the respondent specification, with the procedure described above for free-find respondents subsequently followed.

In Greater Glasgow and Clyde, recruiters were given permission to approach women directly in five of the clinics. They were positioned either outside or within the clinics, approaching women and screening them as per the free find procedure.

As is customary with qualitative research, all participants were offered an incentive to thank them for their time and received £30 in cash at the end of their participation.

The two staff groups comprised midwives, family nurses and health visitors working in each of the study NHS Board areas. They were recruited with the assistance of members of the project working group in each of the appropriate NHS Board areas. Health professionals with experience of working with the target audiences in the locations were approached, informed of the purpose of the research and their participation requested.

Data collection

All data collection sessions were facilitated by senior Scott Porter researchers. Discussion guides (one for each audience) were developed and used to provide a consistent discussion format for each of the research sessions (see Appendix 4).

All interviews and focus groups were audio recorded with the respondent's informed consent.

In-depth interviews with families were conducted in the respondent's home, with the focus groups being held in local community venues. The staff focus groups were held on NHSGGC and NHSA&A premises.

With permission from each of the qualitative respondents having been granted, each interview was audio recorded and then transcribed or notes taken from the recording. An informal framework was designed around these and used to facilitate thematic and explanatory analysis. All members of the research team then met to discuss the outcomes of their respective sessions. The final analysis, conducted by the Lead Researcher, used all the available data.

Review of NHS assessment criteria for research ethics suggested that the study did not require NHS research ethics committee approval. Reassurance was

sought from the West of Scotland Research Ethics Service and confirmation was received that the work fitted the ‘service evaluation’ category and thus formal ethical approval was not required.

This piece of work was a qualitative study. It provides helpful information from people with lived experience of the research question. Although steps were taken to include a broad range of perspectives, the findings may not represent the views of the wider populations. The research is intended to be useful in guiding the services concerned in consideration of how best to reduce the cost-related barriers to women participating in antenatal and postnatal appointments.

Results

The following sections of the report detail the findings from the qualitative depth interviews and focus groups with pregnant women, parents and NHS frontline staff. The results section starts by describing the broad financial pressures reported by the low-income families in the study, and then details findings with respect to cost-related impacts on access to antenatal and postnatal care as described by both the target audience and health professionals working in this area. The final section reports on the actions that these audiences felt could be taken by the NHS Boards and their national and community planning partners to help reduce barriers to access to antenatal and postnatal healthcare services.

The financial impacts of pregnancy for expectant and new families set the context for the specific cost-related barriers that low-income families experienced in accessing antenatal and postnatal care. They were consistently identified as stemming from the following key factors:

- Overall household income levels, including access to benefits.
- The cost of additional purchases and household expenses.
- Socially induced pressures.

Household income levels

The impact of less money coming into the household was evident for both those who were in regular paid employment and those who were out of work. In terms of the former, entitlement to maternity pay enabled some degree of financial forward planning during pregnancy, with some managing to save a little towards the additional costs they anticipated would arise. However, most found that after the initial six weeks, the statutory maternity payment at 90% of average weekly earnings was insufficient to cover existing financial commitments (e.g. car loan and bills). Those with partners who were in work, often found that this resulted in being ineligible for Universal Credit both on the basis of the partner's income and the mother's own maternity payments.

As a consequence, most had been forced to borrow money from family or take out a loan in order to manage regular expenses alongside the additional costs of the (expected) baby. Postnatally, those who could access childcare had found

themselves having to return to work early (often on reduced working hours) in order to augment the income coming into the household. From being in a position of managing the household budget, these families often found themselves pushed into hardship.

Those who were out of work (especially single parents, teens, those attending college, and those on zero hours contracts) most strongly experienced the financial impact of pregnancy and early parenthood. They reported being obliged to stop work/college early due to (employers') health and safety concerns, an inability to accommodate available shift patterns, difficulty accessing convenient and/or affordable childcare, or because of complications during their pregnancy.

The need to maximise income became a priority, often forcing changes in living circumstances, particularly for young/teen mothers who had to move back in with their parents or live apart from their partners.

"It'd be impossible us living together! He struggles himself with the rent and stuff so he wouldn't be able to support me and the baby too if we moved in and my benefits stopped. He's on minimum wage ...it's a nightmare!"

New mum, first time, GGC

Many became reliant on family support where this was available, and on benefit payments. Those who were not already in the benefits system (or not switched over to Universal Credit) experienced high levels of stress and financial hardship while benefit (re)assessments were undertaken.

Establishing entitlement and applying for and managing benefit payments were key concerns for both working and non-working families. The way in which Universal Credit operates created a lot of pressure and uncertainty for families: payment in arrears meant that families had to cope for 5-6 weeks without income (on initial application), with the option to take an advance creating its own problems as this became a further monthly expense deducted from income once the benefit payments started. Additionally, many found that the varying levels of benefit payment received each month (as work income altered) made it difficult to budget for regular outgoings.

“They give you transitional money that’s supposed to last you five weeks, but it doesnae last you that long, and then they take the money back off you. But the money is never consistent – you get one amount one month and it can be a totally different amount the next month. You get statements but you just get them a few days before so it’s difficult to plan.”

New mum, experienced, GGC

Delays to accessing benefits also stemmed from a lack of awareness of entitlement and a lack of confidence in finding out more and applying. Some had not known where and how to source the information, while others had been reticent about asking for advice due to feeling embarrassed about not being able to organise it themselves. Some of the women stated that they had felt too pressured trying to cope with the pregnancy itself and had sought to avoid the further anxiety of dealing with ‘officialdom’. Many had applied for Universal Credit in the expectation that, having stopped work, they would be entitled, but had found that they were ineligible. Having already made baby purchases in anticipation of receipt of this benefit, some had subsequently found themselves financially unprepared and left trying to recover or having to borrowing money.

“H- was working at the time and I was pregnant, but we found out we weren’t entitled to anything until she was here. So that was like a kick to the teeth actually. We were kind of struggling then to make ends meet, just with bills and things... Getting everything ready for her coming was a problem – we had to borrow money off H-’s cousin because we were in dire straits really.”

New mum, first time, A&A

With no right to work or benefits in the UK, the female asylum seekers in the study found their asylum support payments insufficient to enable them to cope financially during pregnancy and the early postnatal period. They reported that the additional payments for pregnancy (£3 per week) and babies under one year old (£5 per week) did not cover their basic needs, resulting in high levels of hardship, especially if they had other children or were single parents. They found themselves becoming reliant on charity, and with negative impacts on their mental health.

"I was depressed. I had anxiety... The Home Office is giving me an extra £3 because I was pregnant but £3 is really not enough... you have to take buses, you have to feed yourself on that little money and you have to dress yourself – it really is too much (stress)..."

New mum, asylum seeker, experienced, GGC

Cost of additional purchase and household expenses

It was evident that pregnancy brought a period of sudden increased financial pressure stemming from a strong sense of wanting, as well as needing, to prepare for the new baby. For many (especially younger and first-time parents), early purchase of equipment such as cots, prams, sterilisers, as well as baby clothes was viewed as essential preparation for the arrival of the baby. This sometimes resulted in the purchase of items that may be of limited use later (e.g. car seat to take the baby home from hospital when the parents did not own a car themselves) which added unduly to the burden, particularly where second-hand options were deemed to be unsafe.

Financial pressures could be further increased by new living arrangements, for example the need to purchase furniture, carpets, washing machine and so on and decorate when moving into new housing. This was noted to have a particularly negative impact on those who found themselves with sole responsibility for the household expenses if they were a single parent.

The greatest level of sustained money worries was reported as being experienced once the baby is born. Having to manage ongoing day-to-day costs on very tight budgets resulted in high levels of stress, particularly among first-time parents for whom the extent of these was often not anticipated or 'visible'.

Once the excitement of a new baby had died down, many parents found themselves having to cope alone, with less financial and emotional support forthcoming from friends and family, and a partner's income insufficient to cover their needs, especially if they were not eligible to claim Universal Credit. The uncertainty of monthly income, and the gaps in payment experienced by many, made it hard for families to budget properly and to feel financially secure.

"It felt like it was never ending – all our money was going on what we needed for this wee baby... everyone suffered."

New mum, experienced, GGC

"It's not the cost of nappies or her food that's the issue...it's 'cos we're living off one wage to feed us, to pay the bills. A few people have told us we'd be better off if we lived apart, but we just couldn't do that."

New mum, first time, GGC

"This morning we were low on milk. I forgot how much milk costs. I sent him to the shops but he had to come back 'cos I didn't give him enough."

New mum, experienced, GGC

"Cos for five weeks you don't really get benefit so you kind of struggle past... 'cos you have to apply for the child benefit, you have to apply for everything! So it was an extra struggle when she was born – extra mouth, extra clothes, and everything we had to buy... it put a big pressure on us."

New mum, experienced, GGC

"My husband's not well and he's not able to work. Suddenly we had zero income (just applied for Universal Credit). All we had were a couple of beds and someone had given us a sofa. We literally had to rely on the kindness of other people to get us through that – it restores your faith in humanity!"

New mum, experienced, A&A

"I remember my kids, for that couple of months saying 'Mum are we poor?'... and I just had to tell them that it wasn't always going to be like that."

New mum, experienced, GGC

"It causes a lot of stress and anxiety. I can't get a peaceful sleep like I used to 'cos I've always got that financial headache. You don't get much on benefits now and whatever you get, you scrape by. And you don't get that much (wellbeing) support outside, so it's difficult."

Pregnant, BME, Experienced, GGC

The main money worries in this context related to:

- additional heating costs, especially for winter babies
- buying formula and food, increasingly as the baby grows; this can lead to poor diets or skipped meals for mothers especially as they prioritise their baby/other children (a key issue for refugees and asylum seekers)
- buying clothes as the baby grows and no more gifts are forthcoming
- buying nappies

Families with more than one child reported increased levels of financial pressure at the time of any subsequent pregnancy and in the early years of the new child. A particular impact related to access to, and affordability of, childcare for those returning or wanting to return to work. This was particularly noted where the older children were not yet eligible for funded early learning and childcare, and where there was no family support network close by. Additionally, families stated that their ability to adequately provide for their other children was compromised, particularly with respect to ensuring sufficient food and regular snacks, new clothes and toys, and to covering travel and activity costs.

Socially induced pressures

All of the study participants said they had been careful with their spending on equipment (and especially prams) prior to the birth of their babies. A few had bought second-hand items, and others bought items at what they perceived to be the lower end of the price range, around £300-£400 (although they made reference to friends who said they had spent £800-£1,000 on a pram). Many expressed a desire to buy the best that they could afford for their baby but acknowledged that they had not considered buying second hand, preferring something new. The norming of this expectation, and the pressure to 'look good' on social media, added to existing financial stresses and, for some, to the prioritisation of such visible displays of preparation for the arrival of the baby.

Health professionals' experiences further highlighted the impact that social media/peer pressure could have on financial priorities, describing young families paying for additional scans, photographers or 'gender reveal' parties.

Financial priorities

The majority of respondents interviewed reported that they had had to prioritise their spending in order to cover the additional costs arising from their pregnancy/baby. Although a degree of variance was evident (these being dependent on individual circumstances), financial priorities were largely as shown in Figure 1.

Figure 1: Financial priorities of parents (-to-be).

Baby	Food & shelter	Other children	Travel	Self
<input type="checkbox"/> equipment	<input type="checkbox"/> food for family	<input type="checkbox"/> clothing	<input type="checkbox"/> car expenses	<input type="checkbox"/> clothes
<input type="checkbox"/> milk	<input type="checkbox"/> rent	<input type="checkbox"/> snacks	<input type="checkbox"/> bus fares	<input type="checkbox"/> food
<input type="checkbox"/> nappies	<input type="checkbox"/> heating	<input type="checkbox"/> toys		<input type="checkbox"/> mobile phone
<input type="checkbox"/> clothes		<input type="checkbox"/> activities		

Some, especially more experienced parents, felt they had been better able to adapt their expenditure to what they perceived to be 'real' priorities by limiting their spending during pregnancy. This included: being cautious with non-essential purchases; budgeting to ensure their income covered all essential expenditure; buying less-expensive prams, clothing and buying strategically (e.g. stocking up on nappies when on offer); and shopping in discount stores, 'Jack & Jill' markets, charity shops and via Facebook. Despite this, however, many had a strong sense of just 'getting by', with no buffer for any unforeseen needs.

"I buy for the baby when I have money... when I got the Baby Start Grant I just went out and got loads – I buy when I see them on offer. Some things are hard to buy on a budget... Mum's buying the pram for me – £100 off Amazon – but you see people spending like £800 – it's mad!"

Pregnant, first time, A&A

For all interviewees, the focus was on the newborn, but those with other children expressed concern about not being able to meet the needs of the older ones, especially with regards to new clothes/school clothes for growing children, and sufficient food and snacks (for teens in particular).

Family support was vital for most in managing additional costs, and particularly for pregnancy stage purchases and the costs of setting up home. Parents (and grandparents) often helped with the purchase of bigger items such as washing machines, and provided short-term borrowing to assist with daily living expenses.

Many expectant families had had to take out one or more loans (Credit Union or payday loans) to facilitate pregnancy-related purchases, or else buy on credit. A minority of working families had savings on which they were able to draw.

Some (mainly asylum seekers and refugees) had used food banks. Others (largely native Scots) were reluctant to acknowledge regular use of this provision, mentioning that they did not like the overt sign of poverty which they felt was associated with it. For example, some mentioned that it was not easy to disguise that they had visited a food bank as they carried the goods home.

Government funded support was highly valued by all of those who had received it. The majority of respondents were aware of the Best Start Grant (via their midwife, advertising, Money Matters, or their own online research) and had applied for it. All those who had received the Grant spoke very positively about its impact, having used it to buy equipment, clothes, nappies or formula for their baby: *"It takes time to come through... but it's a godsend!"*. However, there was evidence that poor or incomplete understanding of eligibility and/or timing of receipt of the Grant meant that purchases were sometimes made in anticipation of receipt, with some subsequently finding that they did not qualify.

The Scottish Government Baby Box was similarly valued by all, with mothers-to-be amazed at the range and quality of the contents. Again however, lack of early awareness of the box itself and of its specific contents (and also impatience due to the timing of its delivery) can reduce its positive financial impact, with items such as thermometers, clothes or changing mats having already been purchased.

Those families in receipt of the Healthy Start food vouchers felt these also made a huge difference, both to the mother's own diet while pregnant and to the baby's nutrition. All of the mothers in the study were using the vouchers for milk, and many for fruit too. In the rural areas of Ayrshire & Arran, issues relating to access were raised, in particular the inability to source the appropriate formula brand or fresh fruit and vegetable options in the local stores, requiring travel (and cost) in order to be able to redeem them. Nonetheless, it was acknowledged that these vouchers provided a financial safety net and a source of essential nutrition for the lowest income families.

Cost-related impacts on access to antenatal and postnatal care

Families' perspective

All study participants spoke of the importance of attending antenatal appointments; first-time mothers and those with (prior) complications in pregnancy/in consultant-led care were particularly emphatic. Those appointments which provided the opportunity to monitor their baby's growth and gave peace of mind with respect to both the baby and their own health were most valued. In this context, scans and non-routine appointments tended to be treated as a priority, being perceived to offer a 'tangible' assessment of the health of the pregnancy.

Postnatally, any appointments relating to the baby's health were treated as important. However, those associated with the health of the mother (e.g. diabetes, physiotherapy, mental health-related appointments) were sometimes sacrificed if families were experiencing access problems for financial or logistical reasons. There were no such barriers reported with health visitor and Family Nurse appointments as these are home-based.

A significant number of the cost-related barriers described by families related to current maternity service characteristics, including the following:

- The location of services which can be at a significant distance (especially in rural Ayrshire & Arran). The centralisation of maternity services had the potential to greatly increase the difficulties that low-income families experienced in accessing healthcare on a regular basis. This stemmed from both the cost involved in travel and the time and effort required to get to the hospital (discussed in detail below).
- The length of time spent with the health professional which can feel too cursory to be of real value. Midwifery appointments assumed lower importance for some (especially experienced mothers and those with straightforward pregnancies) who stated that they did not "*see the point of them all*". This view was driven by a perception that these appointments were very short, consisting of the midwife simply asking "*a tick-list of questions*" and providing a quick check-over. The women felt that they had no time for discussion, and therefore questioned the value of regular attendance, particularly if they were experiencing financial or practical difficulties in attending. Such perceptions were further reinforced where no personal relationship could be established due to a lack of continuity of care from a single midwife.

"I've seen three different ones (midwives) so you can't build a bond. I don't feel I can ask questions in case they think I'm stupid... if you keep getting new ones, they don't want to know you."

Pregnant, first time, GGC

- Limited co-ordination of appointments across different departments. Women with more complex care needs found themselves with a range of appointments designed to meet all of their healthcare needs, but which could result in the need for multiple visits to clinic and/or hospital. The added pressure resulting from inefficient scheduling of multiple appointments, requiring repeated trips in a short period, sometimes pushed women into having to prioritise what they could manage, based on what they perceived to be the most important appointments.

"Sometimes the midwife would book appointments, the health visitor would book appointments, the GP would also. Sometimes it would be four appointments per week – that's a lot of money! Nobody gives you the money."

New mum, experienced, asylum seeker, GGC

- Inflexible or inconvenient appointment times.

The lack of flexibility to schedule (some) appointments to fit around shift patterns, childcare or travel restrictions placed additional financial pressure on low-income families. Many spoke of difficulties in co-ordinating these elements, particularly if they had no family support nearby. The additional costs incurred through loss of earnings (for example if their partner had to take time off work to attend appointments), childcare adjustments, and taxi costs could present a significant barrier.

"Financially, we couldn't afford to go to them all. We had to go to Glasgow for them and they wanted us to be there early. They were so inflexible – the receptionist was so snotty when I explained we were coming in from rural Girvan. She wouldn't swap the times."

New mum, experienced, A&A

- Extended periods of time spent waiting for (delayed) appointments.

This was often a source of frustration and stress, especially for those who were expected back at work by a certain time or had to pick up children from childcare, and those conscious of parking restrictions. The resulting additional costs were likely to be further augmented by the need to purchase food and drinks on site.

Given the unpredictable nature of many of these factors, families in the study found it difficult to budget for such additional, unexpected costs.

The other reported barriers were logistical and personal in nature, with indirect cost implications:

- The availability and/or convenience of transport solutions.

The distances to be travelled, the time taken, and practicality were key issues, especially for those living in rural locations in Ayrshire & Arran where respondents reported several hours travel time each way on public transport to Crosshouse Hospital. The logistical complexity of accessing services was greatest for those families without a car as they had to negotiate timetable limitations (especially in rural areas), experienced difficulties getting on and off (several) buses with a pram (whether physical struggles, or because of the limited space available for storing the pram on the bus), and the stress of managing their other young children during the long journey.

The associated cost of travel to centralised maternity services can be significant, whether this be for bus fares or fuel, and a lack of available funds on the day can impact on ability to attend appointments. These costs were likely to be higher in rural areas, if the partner wanted to accompany the mother, and for those with pregnancy complications and associated additional appointments. Parking was also highlighted as a significant cost for those with cars attending the Princes Royal Maternity Hospital (and the Queen Elizabeth University Hospital if the appointment went over the maximum four hours parking permitted).

“It’s three buses to get to Crosshouse... Nine pounds eighty single all the way. So nearly £20 return – £40 for us both – just to get a scan!”

Pregnant, experienced, A&A

"I had an extra check every two weeks at the Princess Royal. It's a half hour bus and 15 minutes' walk. If M- was off he'd drive me up, but he very seldom could get the time off work. Taxis are like £15 one way – I had to get taxis a few times as well just because of the times of the appointments."

New mum, experienced,
GGC

- Organising childcare for other children

The majority of families were unable to access childcare for older children unless they had funded early learning and childcare entitlement. The cost of privately paid-for childcare was prohibitive for those on benefits or statutory maternity pay with no local support systems. This limited their employment options and levels of personal flexibility in respect of hospital appointment attendance. Even those parents with existing childcare arrangements occasionally experienced difficulties as a result of their antenatal care needs, for example where appointments were scheduled outwith existing childcare/school times (or when run-over is anticipated). It was often not possible for partners to alter their shifts in order to provide childcare cover without incurring loss of earnings or loss of goodwill.

Consequently, mothers felt they had no option but to take children with them to hospital appointments. This was perceived to be discouraged by the staff as toddlers were generally not permitted in the room while a scan was taking place and there was no-one to look after them/no children's area outside. With so many barriers to overcome, mothers sometimes found themselves having to weigh up the 'value' of attendance at every appointment.

- Managing time off work to attend appointments

Given that it is a statutory requirement, few study participants had experienced problems taking time off work to attend antenatal appointments. However, some felt that it can be grudgingly given to shift workers as it created problems re-scheduling shifts, or because they could not be sure of getting back to work in time as a result of delayed appointments.

More restrictions had been experienced by partners wanting time off (outwith the statutory two occasions) to accompany or drive their partners to appointments. The only option they felt was open to them was to take unpaid

leave (if permitted to do so), leading some to have concerns about possible negative impacts on their working relationships, and fear of loss of their job or a reduction in their working hours.

"He works set hours so trying to get a babysitter was difficult... for scans you're allowed to go to two but his boss didn't allow him more time off... so I had to take her (toddler) too."

New mum, experienced, A&A

The logistical and financial pressures that low-income families experienced in attempting to regularly attend their antenatal appointments were felt by many to negatively impact their mental health: high levels of stress were induced, particularly with the threat of the involvement of social services if they did not attend.

"No one asks you if you can get to appointments – they just send out details and expect you to work it out! It's not good... it's not easy."

Pregnant, experienced, A&A

"Cos I'm a single mother, attending these appointments is very, very difficult. And I don't drive. It's a lot (of bus travel) and a lot of travel costs. Then carrying another baby... and the pram. You have to take food – it's just so much pressure. Then you try to phone them to say I'm going to be two minutes late and they're not having it!"

Pregnant, experienced, BME, GGC

The main factors that facilitated attendance at antenatal appointments were:

- Easily accessible antenatal care

Local clinics where the mother/ mother to be was able to walk to her appointment, strongly facilitated regular attendance at antenatal appointments. This was not only from the perspective of removing the cost of transport, but also in alleviating issues relating to the length of time required and the organisation of childcare. Home visits such as those by Health Visitors and Family Nurses removed many of the logistical and cost-related barriers to engagement with maternity services.

- Family support

This was key in terms of providing practical assistance, for example lifts to hospital appointments, childcare, cash (petrol, parking, food) or simply short-term loans.

- Reimbursement of travel expenses

A minority of the study participants were reclaiming travel costs. While this was acknowledged to provide some financial assistance, it did not address the immediate lack of cash on the day of the appointment.

Health professionals' perspective

Health professionals' experience of the kinds of financial pressure pregnancy and a new baby can place on low-income families reflected the problems highlighted by the families themselves. Additionally, they noted a number of wider impacts:

- Family support

Grandparents (both of the baby and of the mother) were recognised as providing an important lifeline for many, particularly teen mothers. While very positive for the new parents (-to-be) themselves, health professionals noted the potential for negative financial impacts for family members trying to support the new parents. They observed that some were struggling financially in an effort to help their children, often going without themselves in order to ensure there was food in the house for the young family. It was felt that pride could prevent these older generations from seeking help directly, but that home visits provided the opportunity for health professionals to evaluate the situation and probe to establish the extent of need.

Some frontline staff also felt that family involvement with a pregnancy was not always positive, citing examples of pregnant mothers (especially teens) who did not have a bank account having to rely on their finances (including the Best Start Grant) being managed by a family member, creating a greater sense of dependency.

The difficulties created by the absence of local family support was highlighted in Ayrshire & Arran where the large number of young girls moving into the area away from their families was noted. Health professionals' views reflected those noted above, namely that a lack of this support network impacted on women's ability to access antenatal care. The resulting non-attendance therefore stemmed more from financial pressures than an unwillingness to engage with maternity services.

- Anxiety

The role of anxiety in limiting a pregnant mum's ability to advocate for herself was believed to pose a significant barrier for some in accessing financial support. Health professionals spoke of their experience of engaging with women who lacked the confidence to make phone calls to inquire about their entitlements, be this benefit payments or vouchers. Additionally, it was

believed that such anxiety also stopped them from seeking advice on money matters.

Poor literacy skills posed an additional barrier in this context, impacting on the ability (or willingness) of some low-income families to fill out forms in connection with claiming benefits, and on their engagement with written information such as leaflets and websites. This can result in a lack of awareness of wider entitlements such as grants unless they were told about them verbally (and subsequently helped to access). This can induce additional anxiety and delays in accessing financial support.

- Lines of communication

Money pressures sometimes meant that women were unable to maintain the credit on their mobile phones which restricted their ability to communicate both with health professionals, and with organisations dealing with their Universal Credit assessments.

The absence of a stable address (particularly in the case of asylum-seeking families) had implications for the safe delivery of Baby Boxes for example.

- Health issues

A new mother's mental health as she struggles to adjust to the demands of a new baby while trying to cope with money worries, was a real concern for health professionals. They noted that this could become a further barrier to sourcing financial support, with mothers sometimes feeling unable to pick up the phone or attend appointments with money advice services.

There was also awareness of occasions where the lack of sufficient money for food meant that family members had to miss meals. This was often the mother but could also be the other children. This was noted for both the asylum-seeking community and Scottish families.

It was believed that the prioritising of the baby's appointments over her own for affordability reasons could also have implications for maternal health.

- Working conditions

Health professionals noted that they were aware of discriminatory treatment by some employers towards those in low-paid jobs. This was seen to manifest itself in, for example, questioning around the amount of time needed away from work to attend appointments (particularly those with complications

during pregnancy), and hours being cut when told of the pregnancy. This impacted on partners too, with lack of employer flexibility in allowing time off to accompany their partner, and the resultant loss of income if unpaid leave had to be taken.

- Social pressures

It was observed that financial difficulties could be augmented by social pressure to appear to be ‘managing’ through pregnancy and the early postnatal period. This can become a question of self-esteem for some, leading to a prioritisation of visible items (e.g. pram) while sacrificing money for rent, heating or food, and a refusal to consider second-hand items or help from food banks. Others were believed to adopt a *head in the sand* attitude, embarrassed to acknowledge their need for help with budgeting and other financial matters. This was felt to impact on families’ preparedness to discuss money worries with their midwives and health visitors, particularly where a good relationship had not been established.

Health professionals’ perceptions of their role in addressing the financial health needs of their patients

Being very conscious of the impact of financial pressures on the health and wellbeing of both children and parents, the health professionals in the study all viewed addressing the financial health needs of their clients as an integral part of their role. They noted however, that it was not always easy to identify individuals experiencing money worries as it was not necessarily the most ‘obvious’ families who were affected (for example, working families can be impacted as much as those out of work). Given that some families were not willing to openly discuss their financial needs, they felt that identification of those households experiencing money pressures could be easier in the context of home visits where there may be more visible signs of need.

“Sometimes they’ll tell, but mostly they’re really embarrassed to admit it. But you get to know your families and you get to know things are a wee bit different in the house... and I don’t have a problem asking do they need a bit extra.”

There was evidence of differing approaches to raising the issue of money worries, with some frontline staff initiating discussion around the benefits to which they may be entitled, or asking directly whether they would like a referral to someone who can help maximise their income. Others felt it could be more

productive to simply thread such probing into natural conversation, rather than making it a set piece which might not engender an open response.

Many of these health professionals, particularly those engaging with families antenatally, reported personally taking steps to ensure those with strong financial pressures had immediate access to essentials. This included a range of actions to help minimise the immediate impact of their limited income, for example picking up and delivering food from the food bank, sourcing and delivering equipment for the baby from charities, Facebook and so on, doing some food shopping for the family and organising lifts to hospital when they were not able to take the mother themselves.

Facilitators and barriers

There was a strong belief among health professionals that a person-centred approach that facilitates relationship building and open conversations is key to facilitating a real understanding of individual financial pressures and needs. The Family Nurse and Special Needs in Pregnancy Services (SNIPS), together with Health Visitors, were seen to be well placed to provide this type of engagement for the most vulnerable families, given the opportunity for longer term interactions. However, heavy caseloads and clinic-based engagement for the majority of women antenatally were perceived to severely limit the time available for personalised conversations around the financial and home situation, particularly where there was no continuity of carer for routine antenatal appointments.

There was an acknowledgement of not being experts in providing advice on financial issues, and as such, the ability to signpost or refer to specialist financial inclusion services was seen to be a vital part of the health professional's role. Encouraging client engagement with such services was perceived to be greatly facilitated when the service is available on-site and working in partnership with the healthcare team (an embedded model of delivery as for example with Money Matters and SNIPS) as this was felt to provide a human face to the service, making it less intimidating.

Health professionals greatly valued the availability of local resources that could help with money-related needs (for example East Ayrshire Money, local charities, contacts through the British Red Cross, and their own local networks), but felt that most of these are currently very dependent on individuals building their own contacts rather than being able to access such resources uniformly.

A number of barriers were also highlighted in relation to being able to further support families around their financial needs. These included:

- a lack of time to be able to sensitively probe personal circumstances and provide personalised guidance to all clients
- constant changes to the services available (for example, as a result of inconsistent funding of individual third sector organisations) making it hard to keep track
- a lack of a centralised resource listing local sources of support for families, resulting in reliance on the personal contacts of individual staff and therefore inconsistency in signposting and support access.

Reducing barriers

The final part of the research discussions focused on exploring the views of both low-income families and frontline staff on what they felt could be put in place by services to reduce the financial pressures associated with pregnancy and any cost-related barriers to accessing care. The key areas mentioned are detailed below, from the perspective of both audiences.

- Time for personal advice from health professionals

Many of the families sought the opportunity for a stronger relationship with the primary health professional looking after their antenatal care. They thought that this would help to build a relationship of trust which could facilitate discussion of wider issues associated with the pregnancy. They also felt that discussion of any money worries in this context would feel less stigmatising than being referred to a money advice service. Furthermore, families anticipated that it would be less daunting to speak initially with a known and friendly individual, and that this would provide the encouragement and reassurance needed to engage subsequently with specialist service partners. There was also a perception that this approach would provide women with a greater sense of control, providing them with advice on essentials or priorities for spending during pregnancy.

Health professionals also sought more time with patients to facilitate better relationship building to enable discussions of wider financial needs to be instigated in the context of sensitive yet focused conversations. They felt that this would also better equip them to identify those families who needed more hand-holding, to provide broad advice on money management and planning,

and to provide personalised guidance to appropriate service partners or local resources.

"I think it's OK to be asked about finances by the midwife – it's a confidential appointment. Then they can refer you on. It's better if they do it 'cos folks might not want to do it themselves."

Pregnant, first time, A&A

"Just talk to you and get to know your circumstances... I wouldn't bring it up, but if they asked me I'd be honest with them."

New mum, experienced, GGC

- Access to specialist financial advice services

Families pointed to the fact that they had little detailed awareness of such services and the type of engagement contacting them would entail. As such, proactive awareness-raising of the availability of such services and the breadth of their offering is key, discussing this as part of a wider conversation rather than it being a 'fact-finding' aspect at the booking appointment. Equally, it was noted that active referral or signposting is likely to have greater impact than relying on raising awareness via leaflets or other printed materials.

Having the specialist advice service on-site and as a familiar part of the maternity service context would also offer great advantages in terms of overcoming any intrinsic suspicions about the service.

Health professionals also sought stronger personal links with the professionals providing the financial advice service, considering access to personal specialist contacts in this area to be more important than training to handle clients' money worries themselves. It was believed that close partnership working (on-site where possible) would help to foster such personal relationships and move access to the service away from being just a functional referral. The ideal was felt to be a single point of access service, positioned as a source of support in working out entitlements, helping with applications, providing advice on budgeting and so on, with the service provider having time to follow up with the client where relevant.

"It'd be amazing to have somebody to sit with you, talk you through things, and then help fill out the forms together so you can get them off."

New mum, experienced GGC

"It's different if you go in and it's all explained to you rather than you having to go in asking for help."

New mum, experienced, GGC

"The best thing was having the Money Matters woman in the waiting room. If the midwife had offered it to me I might not have taken it up. They're pushing too much onto you, so probably I wouldn't have felt comfortable saying 'yes, put me forward'."

Pregnant, first time, GGC

- Travel costs

Addressing the issues raised by travel to appointments was viewed as a key need by families, particularly those in rural areas. They suggested providing vouchers or bus passes to women – and ideally their partners too – over the period of the pregnancy (or longer if they had complications), thereby removing the reliance on reclaiming expenses.

Those living in urban areas requested free parking for antenatal appointments, and especially for those requiring multiple appointments due to complications. A hospital bus service picking up from a central point, or hospital transport service for those in rural areas with limited transport links, was suggested.

Health professionals also recognised the value of providing assistance with transport and sought the discretion to assess need and allocate this directly to their clients.

"If there was a system that would help with transport to appointments, even if it was the bus fares... or if it was a bus that'd pick you up from certain points around Glasgow and drop you off at hospital."

New mum, experienced, GGC

"I don't mind the food and drink I have to pay for those days but help with transport would be good."

New mum, experienced, GGC

- Access to second-hand equipment

Many families felt it would be useful for all women to be given, in early pregnancy, a resource list detailing local venues or organisations where they could access good quality second-hand items. The inclusion of online sources and delivery information would also be useful. It was felt that this might go some way to normalising the use of previously used equipment.

(Local area list) *“Definitely put them all together so you can see where you can get stuff cheaper... like local charities, shops, Facebook.”*

Pregnant, first time, GGC

Health professionals sought access to a shared, regularly updated, local contacts list in a central database in order to reduce reliance on individual personal knowledge and contacts and ensure greater efficiency in accessing specific requirements. They felt that it was important to build strong relationships with local providers, resources and statutory partners in this context, but were wary of over-reliance on the third sector due to their unstable funding.

- Access to welfare foods

It was believed that easier and more sensitive access to food, formula, or food banks would reduce barriers for families. While the support offered currently via the Healthy Start vouchers was recognised, reducing overt signals of welfare food (i.e. the vouchers³) and providing the potential to use these more widely (e.g. for tinned fruit and veg, milk for toddlers) and in small local stores, would help to increase uptake and value. A further consideration would be in addressing the needs of rural communities where sourcing of foods that can be purchased via such welfare food payments can be difficult. Health professionals felt that early highlighting of entitlement and help with application was essential for some families.

³ Potentially addressed by the new Best Start Foods card (a pre-loaded payment card) which replaced the Healthy Start vouchers in Scotland in August 2019.

They also sought a streamlined application process, minimising the need for several independent applications for grants/vouchers⁴. Speeding up the assessment process to avoid gaps without access to foods was believed to be key.

- Childcare facilities

Providing access to childcare facilities at antenatal clinics/assessment units was a priority for families, to alleviate both the pressure of finding childcare at home and the stress of caring for young children while attending appointments at clinic/hospital. A watched area with a toy box would be sufficient for routine appointments, with provision for short-term access to more formal childcare for those with complex pregnancies needing frequent attendance at hospital.

Health professionals recognised the difficulty associated with the provision of childcare facilities at clinic or in hospitals and sought greater opportunity to assess and refer families to nursery places thereby reducing some of the barriers perceived to be currently in place. This was felt to be predicated on the availability of more childcare places, particularly in rural areas.

- Support tools and resources.

Families felt that they were more likely to engage with online tools than leaflets or booklets as this was a familiar channel when it comes to seeking information. In addition to listing local resources such as ‘Jack and Jill’ markets, charities and money advice services, a forum for the sharing of tips with other local women had appeal: a Facebook group perhaps, or a community-based social support group such as that provided by Baby Chat in East Ayrshire.

Proactive awareness-raising and sharing of information about the types of local social support and services available (e.g. Warm Home Discount, nappy collection service, nappy library) was seen as important.

- More localised services

⁴ A single application has now been introduced for the Best Start Grant and new Best Start Foods card

Health professionals believed that the key to reducing many of the biggest barriers to access (pressures related to travel and childcare) was to provide more services rooted in the community. It was felt that co-ordinating services in health centres (a hub-and-spoke model) to provide easier access, but also to enable building of better local relationships with local support services would have many advantages.

“Getting appointments closer. I think for anybody in Girvan who would be travelling to Crosshouse it’s a nightmare.”

New mum, Experienced, A&A

- Greater flexibility

Health professionals also believed that greater flexibility was required within the system to better accommodate the needs of low-income families, for example through better co-ordination of multiple appointments, consciousness of travel distance when allocating appointment times, and providing health professionals with the scope for flexibility in assisting families e.g. families using their own car to get to the hospital.

Discussion

Many of the key cost-related impacts of pregnancy and the early postnatal period arising in this study closely reflect the priority action areas outlined in the Scottish Government's first child poverty delivery plan, '*Every Child, Every Chance*'. This research highlights the fact that such factors can have a clear impact on health outcomes, particularly where financial pressures place barriers in the way of low-income households accessing antenatal and postnatal care, despite the services being free at the point of use.

The move towards centralisation of services presents well documented challenges, particularly for families in rural communities, in terms of the physical distance and the consequent time and logistical difficulties of travelling to the hospital or clinic. In terms of maternity care, it is also the source of additional cost for the patient and a key factor in driving consideration of non-attendance at antenatal appointments. While the cost of travel is certainly a factor, the financial burden of attending an appointment is magnified by the knock-on effects of the time taken, the need to purchase food and source childcare, as well as the need for extended periods of time away from work.

Limited continuity of care and time to have personalised conversations over and above the required health checks that are undertaken can also have a negative impact on the strength of the relationship developed with midwives. This, in turn, may limit open discussions about money worries and receptiveness to referral to money advice services.

The opportunity to maximise income is strongly linked to raising awareness of the entitlement to benefits and to facilitating access to support in making the appropriate claims. Many of the study participants were either unaware of, or unable to navigate, the various benefits open to them, with some expressing a lack of confidence and/or the literacy skills to investigate. This study found that the introduction of Universal Credit has created an additional layer of complexity and hardship for expectant and new families, in terms of both increased financial pressure and anxiety. While the implementation of Universal Credit is beyond the scope of this study, providing easily accessible and unintimidating sources of advice and assistance in terms of claiming entitlements and managing the payment gaps is associated with maximising income.

In this context, it should be noted that there can be a suspicion/distrust, or even fear, of ‘officialdom’ in relation to claiming benefits, which suggests that the positioning of any advice service offering should be carefully considered. Approaches are likely to have greater success when presenting the information in an open form, such as '*there's a really good service that can tell you all about/help you to claim...*', rather than '*would you like me to refer you to...*'. The independence and approachability of services such as Money Matters can be highlighted in these conversations, with every effort being made to normalise use of the service.

In terms of immediate actions to mitigate against the financial costs of pregnancy, the areas creating the greatest concern included costs associated with travel to appointments, and equipment, formula and the purchase of nappies. The introduction of the Best Start Grant in the winter of 2018 has made a significant difference to the income of the study families who received it. However, providing information on the Grant and the Baby Box early in pregnancy would facilitate better planning of expenditure during pregnancy and help to address some of the financial anxiety experienced.

Participants reported that the money from the Best Start Grant had been used to purchase bigger items for babies, rather than for household expenses. Further financial support is needed to target those cost-related barriers specifically impacting on access to antenatal care, including travel passes/vouchers, parking permits/bays designated for antenatal appointments in hospitals where parking is not free, and access to childcare. The scheduling of appointments has an indirect impact which can be mitigated by better co-ordination to minimise the number of trips required, and wherever possible, flexibility offered to better accommodate work and childcare schedules.

However, pregnancy also brings wider household financial challenges such as managing the costs of rent and heating, of clothing, food, childcare and activities for other children, and of borrowing. These can have indirect impacts on accessing antenatal care when prioritised over what are perceived to be the ‘less important’ appointments. While food bank vouchers may provide a short-term solution, it should be recognised that access can itself be a problem where travel (and carrying items received from the food bank) is involved, and the perceived stigma associated with them can prevent use in all but the most severe circumstances. More direct ways of providing access to essential foods at this time of increased financial pressure, such as broadening the range of foods that can be purchased through the Best Start Foods card would be beneficial.

Extending this to cover other essentials such as nappies or upfront costs associated with using nappy libraries⁵ should also be considered.

Health professionals can play a more consistent role in raising awareness of sources of good quality second-hand items or existing assistance or grants, for example, the Warm Home discount scheme and signposting to organisations that can help with the application. However, more informal conversations and guidance are very important, particularly in supporting those families who lack confidence in making appointments to see third parties. Facilitating initial contact with the external party either via telephone or in the home could provide a more comfortable way of initiating access to advice in such cases (e.g. Money Worries, Home-Start).

⁵ Nappy libraries are groups where parents can obtain information, support and resources to help them use re-usable cloth nappies.

Conclusions and recommendations

Conclusions

This study found that a range of factors contributed to the financial pressures experienced by expectant and new families in receipt of a low income, the most significant of which were:

- an increased burden on overall household income levels, particularly for asylum seekers, single parent families, and those in receipt of Universal Credit
- additional costs associated with preparing for the arrival of a new baby and ensuring the wellbeing of the newborn
- the social pressure to 'buy the best' for the baby

While families reported experiencing a sudden and intense financial pressure during pregnancy, varying degrees of financial support were accessed for 'baby focused' spending such as clothes and equipment. This support was provided primarily by close family, and for those eligible, by the availability of the Baby Box and the Best Start Grant.

Money worries were felt to intensify in the early postnatal period, when the effect of the ongoing costs of caring for a baby were strongly felt, and especially with the pressure on family finances being significantly higher where there were older children to be cared for as well.

Antenatal, and to a lesser extent postnatal, care needs added a further layer of financial pressure on the income of the families, particularly those living in rural locations. The key impacts of accessing this care related to:

- travel costs for attendance at hospital-based appointments, whether antenatal clinics or for scans/specific monitoring – again a particular issue for those in rural areas
- the cost, or the lack of availability, of affordable childcare to address the restrictions of having children present at assessment centres or to facilitate travel to appointments
- additional costs incurred as a result of the ineffective or uncoordinated scheduling and running of appointments (parking, travel costs, food)

- loss of earnings for a partner to attend antenatal appointments

Recommendations

The following actions by the NHS boards and their national and community partners are required to support the reduction of cost-related barriers to accessing care and mitigating financial pressure on expectant parents and their families:

- Greater opportunities for meaningful engagement with midwives at the antenatal stage will provide for continuity of care and time to build relationships of trust (for example, as with the Family Nurse model). This will afford better opportunities to identify and support women with anxiety and offer more person-centred guidance to financial and budgeting advice.
- The provision of clearer awareness-raising and signposting of specialist money advice/welfare rights services is needed. Training of staff to raise and discuss financial inclusion issues in a sensitive and probing way, and facilitate initial engagement with the service, ideally through the on-site presence of service partners, is key. It will be important to raise awareness of the service offered and breadth of engagement to remove any sense of stigma in accessing it.
- Proactive discussion of the financial support that is available must take place early in the antenatal care process to guard against unnecessary expenditure. Verbal communication, rather than relying on written material alone, will be more effective.
- The cost of travel to access antenatal care is a barrier that must be addressed, particularly in rural areas. The provision of vouchers or passes will be more helpful than retrospective reimbursement of expenses. Access to hospital transport from a central point for those in dispersed rural locations would go some way to reducing both logistical and cost barriers. Consideration needs to be given to alleviating excessive parking costs, particularly for those who are required to access the service more frequently.
- Greater ease of accessibility to welfare foods (Healthy Start vitamins and Best Start Foods) is needed. Increasing the range of foods covered and eligibility to cover asylum seekers, and removing the perceived stigma associated with them by limiting overt signs of welfare e.g. on vouchers, welfare parcels will be supportive. Logistical and cost barriers related to redeeming such

payments must also be considered: e.g. travel to and from food banks with a young baby/child, and the local availability of shops providing Healthy Start voucher/Best Start Foods redemption options. Emergency cash payments would be more helpful for some.

- Local second-hand buying options, third sector services, and online platforms which provide equipment for new parents should be promoted. Digital / social media platforms are familiar and easily accessible for families with internet access. A centralised database for health professional use would provide the opportunity for more equitable sharing of resources and sources of support.

A number of wider-reaching service considerations would have a significant impact on reducing cost-related barriers to accessing antenatal and postnatal care:

- Access to childcare facilities, specifically for those attending more frequently for additional care appointments.
- Greater flexibility to accommodate individual circumstances when arranging appointments.
- A more decentralised service delivery model, for example, a hub-and-spoke model, particularly in rural areas.

Appendices

Appendix 1. Recruitment questionnaire.

Scott Porter Research & Marketing Ltd
31 Bernard Street
EH6 6SH
Tel: 0131-553 1927

Job No: 1589
June 2019
Participant ID no: _____

**Exploring the cost of the pregnancy pathway
Recruitment questionnaire
V3 final – 26th June 2019**

INTRODUCTION

NOTE: use name of appropriate Health Board throughout

Good morning/afternoon, my name is..... from Scott Porter Research. We are an independent market research agency conducting a study on behalf of the NHS. We would like to speak to pregnant families and those with a baby across NHS Greater Glasgow & Clyde/NHS Ayrshire & Arran to discuss their thoughts on and experiences of the impact of pregnancy and having a new baby on household finances. The findings from this study will help in the development of better support for families during pregnancy and the first years of a child's life.

Would you be interested in learning more about the study? **IF YES, PROCEED:**
Do you have a couple of minutes to run through what's involved now?
IF YES, CONTINUE – IF NO, ASK WHEN/HOW WOULD BE CONVENIENT

If you are eligible and wish to take part, you will be invited to either a group discussion with up to 5 other pregnant women or new mums OR a one-to-one interview with one of our researchers. The group discussion will last 90 minutes and be held in a local venue. The interview will last approximately an hour and can be held at your home or some other convenient location. If you do take part, you/the household will receive a cash gift of £30 at the end of your participation, to thank you for your time.

This research is being conducted on a strictly confidential and anonymous basis in line with the Market Research Society Code of Conduct. This means that anything that you say within the research will be treated confidentially both by Scott Porter Research and by NHS Greater Glasgow and Clyde/NHS Ayrshire and Arran, and that any comments you make will not be linked to your name. Whether you take part or not will not affect any health care you may receive.

As we are looking for people from different backgrounds and experiences, would you be happy for me to ask you a few more questions to see if the study is suitable for you? This will take 2 or 3 minutes to complete.

Yes 1 THANK AND CONTINUE TO INITIAL SCREENING
No 2 THANK AND CLOSE INTERVIEW

CLASSIFICATION	INITIAL SCREENING
RESPONDENT AGE (Q1):	
16-25.....1	QA. Have you ever attended a market research focus group or an interview for research purposes?
26-35.....2	Yes.....1 GO TO QB
36-45.....3	No.....2 → QC
45+4	
MATERNAL EXPERIENCE (Q2):	
First time1	QB. How long ago was this?
Subsequent/experienced2	In the last 6 months.....1 CLOSE
	Over 6 months ago2 → QC
TARGET AUDIENCE (Q3-Q4):	
Pregnant (28+ weeks)1	QC. Do you remember what the discussion was about?
Mum (baby up to 1 year)....2	
Plus partner3	
WORKING STATUS (Q7):	
Working household.....1	CLOSE IF ON SAME OR SIMILAR SUBJECT (ANY PREGNANCY OR EARLY YEARS RESEARCH), OTHERWISE, CONTINUE TO QC
Non-working household.....2	
POSTCODE:	
Write in full	QD. Do you or your family or any close friends work in any of the following occupations or any related industries?
Check instructions for urban/rural definitions	READ OUT:
LOCALITY:	Marketing1 CLOSE
Urban (NHS GGC)1	Advertising2 CLOSE
Rural (NHS AA).....2	Market Research.....3 CLOSE
NHS HEALTH BOARD AREA:	Design4 CLOSE
Greater Glasgow & Clyde1	Journalism5 CLOSE
Ayrshire & Arran2	Scottish Government.....6 CLOSE
METHOD OF INTERVIEW:	NHS/nursing7 CLOSE
One-to-one depth.....1	Financial/banking.....8 CLOSE
Paired depth.....2	Money advice companies....9 CLOSE
Focus group3	None of these.....10 → Q1

MAIN QUESTIONNAIRE

Q1. Can I just double check your age group first of all? Are you...:

- | | |
|------------------------------|-----------------|
| Under 16 | 1 THANK & CLOSE |
| 16-25..... | 2 |
| 26-35..... | 3 |
| 36-45..... | 4 |
| Over 45 | 5 |
| I'd rather not comment | 6 THANK & CLOSE |

ENSURE GOOD MIX OF AGES ACROSS SAMPLE

Q2. Which of these best describe your current family situation? **SHOWCARD A**

- | | |
|--|--------------------|
| I am pregnant with my first child | 1 FIRST TIME → Q3 |
| I am pregnant and also have other children | 2 EXPERIENCED → Q3 |
| I'm not pregnant but have one child | 3 FIRST TIME → Q4 |
| I'm not pregnant but have children..... | 4 EXPERIENCED → Q4 |
| I have no children..... | 5 THANK & CLOSE |
| None of these | 6 THANK & CLOSE |
| I'd rather not comment..... | 7 THANK & CLOSE |

*ENSURE MIX OF FIRST (CODE 1 OR 3)
& EXPERIENCED (CODE 2 OR 4)*

ASK PREGNANT WOMEN ONLY:

Q3. May I ask how many weeks pregnant are you at the moment?

- | | |
|-------------------------------|-----------------|
| Under 28 weeks | 1 THANK & CLOSE |
| 28 weeks or more | 2 → Q5 |
| I'd rather not comment..... | 3 THANK & CLOSE |

*ALL PREGNANT WOMEN MUST BE
AT LEAST 28 WEEKS AT INTERVIEW*

ASK NON-PREGNANT WOMEN, i.e. MUMS ONLY:

Q4. May I ask the age of your youngest child?

- | | |
|---|-----------------|
| Under 12 months/1 year old | 1 → Q5 |
| Older than 12 months/1 year old..... | 2 THANK & CLOSE |
| I'd rather not comment..... | 3 THANK & CLOSE |

*ALL MUMS MUST HAVE A
BABY UNDER 12 MONTHS AT INTERVIEW*

Q5. Which of the following would best describe your household? **SHOWCARD B**

<i>I live with:</i>		
Adults	No other adults	1
	My spouse/partner	2
	Other adult family members	3
Children under 18	No children yet, pregnant with first	4
	1 child under 18	5
	2 children under 18	6
	3 or more children under 18	7
	No children	8 CLOSE
	I'd rather not say	9 CLOSE

ENSURE MIX ACROSS SAMPLE OF:

- **LONE PARENT (code 1); WITH PARTNER (code 2)**
- **1st PREGNANCY (code 4); 1-2 KIDS (code 5, 6); 3+ KIDS (code 7)**

Q6. Are you involved in the decisions made about the finances in your household?

- Yes, I am the main or only decision maker.....1
- Yes, but I make decisions jointly with my partner2
- No, I leave it all to someone else.....3 CLOSE
- Don't know who is responsible4 CLOSE

ALL MUST BE A FINANCIAL DECISION MAKER

Q7. Thinking of those who contribute to the household income, which of the following applies? **SHOWCARD C**

WORKING HOUSEHOLD – at least 1 person working

- I work full time.....1
- I work part time2
- My partner/another adult works full time3
- My partner/another adult works part time.....4

NON-WORKING HOUSEHOLD – no one working

- I don't work/am unemployed (for any reason).....5
- My partner/another adult doesn't work/is unemployed.....6
- Don't want to say7 CLOSE

CHECK QUOTA: WORKING (codes 1-4) OR NON-WORKING (codes 5, 6)

Q8. What does the person in the household earning the highest income do for a living?

Write in: _____

- Don't want to say1 CLOSE

Q9. Think about your household finances and tell me which of the following statements applies to your household at this moment in time? Please just read out the number that applies to you. **SHOWCARD D**

- I/We manage quite well and have no major worries 1 CLOSE
I/We find it a struggle to make ends meet, but manage 2
I/We are starting to fall behind on some bills at the moment .. 3
I/We are struggling with money and can't pay all the bills 4
None of these 5 CLOSE

ENSURE A MIX OF THOSE ALMOST MANAGING AND THOSE NOT MANAGING WELL WITH THEIR FINANCES CURRENTLY

Q10. Imagine you had an emergency at home one day (something broke down or stopped working for example) that meant you had to spend £100 to fix it within a day or two. Which of the following statements would best fit your thoughts at that moment? Again, read out the number that applies to you. **SHOWCARD E**

- I/We'd be worried, but could probably find it..... 1
I/We'd be worried as it would depend on work at that time – sometimes we could but sometimes we'd just not have it..... 2
I/We'd be very worried and would struggle to find it all..... 3
I just don't think I/we could manage that at all and would have to borrow it from someone/somewhere..... 4
I/We wouldn't worry because we'd be able to pay it easily..... 5 CLOSE
Don't know 6 CLOSE
None of these 7 CLOSE

ALL MUST FIND IT DIFFICULT, OR AT LEAST VERY WORRISOME, TO GET AN EMERGENCY SUM OF MONEY SUCH AS DESCRIBED TOGETHER

Q11. We would also like to speak to some partners/significant others if they are also involved in decisions made with regards to the household finances, to understand their thoughts as well. They would take part in the interview with you. Do you think they might be interested in taking part?

- Yes – *specify relationship:* 1
Maybe – *specify relationship:* 2
No..... 3



CODE 1 OR 2:

- AS APPLICABLE, TALK THROUGH THE BEST WAY TO CONTACT THE PARTNER – WHERE AND WHEN
- RUN THORUGH FRONT COVER PROJECT INFORMATION WITH PARTNER, CHECK WILLING TO TAKE PART, THEN GO TO INVITE BELOW FOR ONE OR BOTH AND INVITE TO DEPTH INTERVIEW (NOTE: incentive of £30 is for the household overall, i.e. both)

CODE 3:

- INVITE TO DEPTH (GO DIRECT TO INVITE SECTION) OR GROUP (GO TO Q12) AS REQUIRED

ASK Q12 ONLY IF RECRUITING FOR GROUPS:

Q12. If you were invited to give your views on a topic in a group of other pregnant women or mums you perhaps didn't know, how do you think you might feel and behave?

READ OUT AND CODE ONE STATEMENT

I'm quite reserved and probably wouldn't say much 1 THANK & CLOSE
(invite to depth if applicable)

I'm not uncomfortable in those kinds of situations and would make an effort to join in 2 INVITE TO GROUP

I'd enjoy discussing my opinion with other people and would join in quite easily..... 3 INVITE TO GROUP

I'm very outspoken and am always keen to express my opinion 4 THANK & CLOSE
(invite to depth if applicable)

INVITE

If eligible, thank respondent for their time & invite to take part in depth interview, paired depth interview, or group discussion (as appropriate).

Then complete the following steps:

1. *Provide (both) respondents with a Participant Information Sheet to read and point out the key areas of information.*
2. *Continue now to consent page (P7/P8), read out the information and establish answers to the 5 statements, then sign and date where specified.*
3. *Assign respondent (household if partner taking part) a participant information number (as detailed in the recruiter brief), and record this on front cover*
4. *Finally, classify all relevant details on page 2 CLASSIFICATION.*

CONSENT PAGE – PREGNANT WOMEN/NEW MUMS

READ OUT VERBATIM: With your permission, the research team will be passed the details you have given me so that the researcher knows who I have invited to take part in the research, and for the depth interview, so they know where to meet you. Also, with your permission, they will need to recontact some of the people who have taken part in the study so they can check I've recruited the right people for the project in the right way.

I will therefore need to record your name, address and a contact telephone number. The research company will keep these details for up to 1 month after the end of the project before securely destroying them. Your personal identifiable information will not be passed on or used for any other purpose other than to confirm/assist the interview and for quality control. In line with new data protection laws could you tell me:

	Yes	No
Do you consent to taking part in an interview or focus group in line with what's been described to you?	1	2
Do you consent to me passing your personal details to Scott Porter for the reasons described above and the data processing associated with this?	1	2
Can you confirm that you have been given a Participant Information Sheet to provide you with additional information and a consent form?	1	2
Do you consent to Scott Porter contacting you to check that this interview was conducted appropriately at the end of the study?	1	2
Do you consent to me and/or Scott Porter contacting you to reconfirm your consent and attendance to an interview or focus group?	1	2

RESPONDENT DETAILS: If consent given above complete:

Name:

Address:

.....POSTCODE.....

Phone number:

GROUP/INTERVIEW DETAILS:

Date:

Time:

Location:

Interviewer/moderator name:

RECRUITER DECLARATION: MUST BE COMPLETED

I declare this interview has been carried out strictly in accordance with your specification, within the code of conduct, and with a person totally unknown to me. I also confirm that the respondent meets the specified recruitment criteria and was asked, and verbally responded to the consent questions,

Consent: On (date): At (time):

Interviewer name:

Interviewer signature:

Signed on (date):..... At (time):

Scott Porter

7

CONSENT PAGE – PARTNERS

READ OUT VERBATIM: With your permission, the research team will be passed the details you have given me so that the researcher knows who I have invited to take part in the research, and for the depth interview, so they know where to meet you. Also, with your permission, they will need to recontact some of the people who have taken part in the study so they can check I've recruited the right people for the project in the right way.

I will therefore need to record your name, address and a contact telephone number. The research company will keep these details for up to 1 month after the end of the project before securely destroying them. Your personal identifiable information will not be passed on or used for any other purpose other than to confirm/assist the interview and for quality control. In line with new data protection laws could you tell me:

	Yes	No
Do you consent to taking part in an interview in line with what's been described to you?	1	2
Do you consent to me passing your personal details to Scott Porter for the reasons described above and the data processing associated with this?	1	2
Can you confirm that you have been given a Participant Information Sheet to provide you with additional information and a consent form?	1	2
Do you consent to Scott Porter contacting you to check that this interview was conducted appropriately at the end of the study?	1	2
Do you consent to me and/or Scott Porter contacting you to reconfirm your consent and attendance to an interview?	1	2

RESPONDENT DETAILS: If consent given above complete:

Name:

Address:

.....POSTCODE.....

Phone number:

INTERVIEW DETAILS:

Date:

Time:

Location:

Interviewer name:

RECRUITER DECLARATION: MUST BE COMPLETED

I declare this interview has been carried out strictly in accordance with your specification, within the code of conduct, and with a person totally unknown to me. I also confirm that the respondent meets the specified recruitment criteria and was asked, and verbally responded to the consent questions,

Consent: On (date): At (time):

Interviewer name:

Interviewer signature:

Signed on (date):..... At (time):

Appendix 2. Participant information sheet.

SCOTT PORTER
Research & Marketing



Exploring the cost of pregnancy Participant Information Sheet 26/06/19; v3 final

Invitation to take part:

We'd like to invite you to take part in our research study. Deciding to take part is entirely up to you. Before you decide we would like you to understand why the study is being done and what it involves. **Please read this information sheet carefully.** Discuss it with others if you wish. If you have any questions, or if anything is unclear, please ask a member of the research team (details are on page 3).

Location of group/interview:				
Date:	Start time:	Finish time:		
Name of recruiter:	Recruiter's tel:			
Please remember: <i>Please arrive 10 minutes before the start time so we can start the session promptly. If you usually wear reading glasses, please bring them with you.</i>				
We will 'phone you the day before, to check you are still happy and willing to take part.				

What is the study about?

We are doing this study to find out about experiences of how pregnancy and having a new baby affects household finances.

Who is organising and funding this study?

This study is being carried out by Scott Porter Research on behalf of NHS Greater Glasgow and Clyde and NHS Ayrshire and Arran. The study will make recommendations about how families can be better supported during pregnancy and a baby's first years.

Why have I been invited to take part?

You've been asked to take part in the research because you are 28, or more weeks pregnant at the moment, or you have a baby under one year old.

What does taking part involve?

If you agree to take part, you'll be asked to come to a one-to-one interview or a focus group in August 2019. There will be 25 interviews and three focus groups held altogether, with people in NHS Glasgow and Clyde and NHS Ayrshire and Arran. The sessions will be relaxed and informal and led by a researcher. The focus groups will have up to five other people also attending, last approximately 90 minutes and take place near your home (e.g. hotel or community centre). Interviews will last around 60 minutes and take place at your home, or another suitable venue that you are happy with.

During the interview or focus group you'll be asked about the impact being pregnant and having a new baby may have on family finances. Talking about personal finances can be awkward, so if a question makes you uncomfortable you don't have to answer it. You can also leave the focus group or interview at any time without giving us a reason.

With your permission, we'll audio-record the discussion to ensure that we get the information you give us right, and somebody from the research team may get in touch within a couple of weeks after the research to check how the interview or focus group went and make sure that we have conducted it correctly (quality control).

Will my taking part in this study be kept confidential?

Yes. All information collected from and/or about you will be kept confidential. The only exception to this is if the researcher becomes concerned about your health and wellbeing or somebody else's health and wellbeing. In this case they have a duty to tell somebody appropriate so they can help you. If you attend a focus group, the other people in the group will know what you have said but everyone is asked to respect each other's privacy. You will never be identifiable in any report or discussion about the study. We may use some direct quotes from what you said but we'll make sure we don't use identifying information (e.g. your name).

What will happen to the results of this study?

What you tell us will be combined with what the other research participants tell us, and this will be used to produce a presentation and report to be shared with the Health Board.

Do I have to take part?

No, it is entirely up to you. Taking part is voluntary; you do not have to take part if you do not want to. If you do decide to take part, the recruiter will give you this 'Participant Information Sheet' to keep and will check whether you are still happy to take part a day or so beforehand. Then on the day of the focus group/interview the researcher will ask you to sign a 'Participant Consent Form' to confirm that you are happy and willing to take part. A copy of this form is provided for you to keep and read on page 5 of this document.

What will happen if I don't want to carry on in the study?

Even if you tell our recruiter you want to take part, or sign the form, you're still free to leave at any time without giving a reason. Please be assured that deciding to leave will have no effect on any care you receive or any services you use, now or in the future.

If you decide you don't want to take part *before* the date and time of the focus group/interview, please contact the recruiter (details on p1). If you don't want to continue taking part *during the focus group or interview*, simply let the researcher know you'd like to stop. If you decide you want to leave the study *after* the focus group/interview, please contact Rachel Bishop at Scott Porter Research (contact details are on p3). We will not be able to separate the information you provided in a group with those of the other people taking part so we will need to keep the information you provided. Your rights to access, change or remove your information will be limited at that point as we would need to manage your information in specific ways for the study to be reliable and accurate. However, to safeguard your rights, be assured we will use the minimum amount of information we can identify as yours as possible.

What are the possible benefits of taking part?

The information you give us will be used to develop better support for families during pregnancy and a baby's first years. There will be no immediate direct benefit to you if you take part, nor will there be any personal benefit in the level of health or social care you receive now or in the future. However, to thank you for your contribution and time, you will be offered £30

for taking part. You will receive this in cash at the end of the focus group/interview. You will be asked to sign to confirm you have received this money. This form will have your name, address and signature and will be kept secure by Scott Porter for the current required time period of 7 years, then securely destroyed. It will not be shared with any other person or agency.

What are the possible disadvantages of taking part?

We have tried to minimise any possible negative effects of taking part. You may be asked questions that you feel are hard to answer, or that make you uncomfortable. If this happens, the researcher will check whether you wish to continue. They will also have information on organisations who may be able to help you if you would like this.

Data Protection information

Scott Porter Research are responsible for looking after your information and making sure it is used properly, an important part of managing research information. The information will only be used for the purposes of this specific study. During the study your information will be stored securely with access limited to the research team. We will anonymise/pseudonymise any personal data you provide as soon as we can (i.e. remove personal details like name and contact details and assign a number instead). Once quality checks have been completed or one month after project end (whichever is soonest), we will securely destroy any identifying information (e.g. recruitment questionnaires, participant sheets with name and contact details).

Who do I contact if I want more support, or to talk about how I am left feeling having taken part, or if I want more information about sources of potential financial support?
If you wish to seek further support/advice on money worries, please speak with your midwife or health visitor, who will be able to refer you to your local money advice service.

Contact details

If you have any concerns or questions at all about taking part in the research study or have any other research related queries, please contact Rachel Bishop at Scott Porter Research on 0131 553 1927 or email: rachel@scottporter.co.uk

If you are still concerned or are unhappy about any aspect of the study, please contact one of the below for your particular area:

- NHS Ayrshire & Arran: Lynne McNiven, 01292 885 876, lynne.mcniven@aapct.scot.nhs.uk
- NHS Greater Glasgow & Clyde: Jackie Erdman, 0141 201 4560, equality@ggc.scot.nhs.uk

If you wish to raise a complaint on how your personal data has been handled please contact the Data Protection Officer at Scott Porter Research at: menekse@scottporter.co.uk

If you are not satisfied with our response or believe we are processing your personal data in a way that is not lawful you can complain to the Information Commissioner's Office (ICO). For information on how to make a data protection complaint you can visit their website (<https://ico.org.uk/concerns/>) or contact their helpline (telephone: 0303 123 1113).

Thank you for taking the time to read this and considering taking part. Please take this sheet away with you.



The Market Research Society (MRS) is the professional body for market and social researchers.

This project is being conducted by Scott Porter Research & Marketing Limited. You can verify this by calling MRS Freephone 0800 975 9596 or visiting the MRS Freephone website:
<https://www.mrs.org.uk/standards/online-register>

Under the MRS Code of Conduct, you have the right:

- To know the purpose of the interview
- To know who is interviewing you: The Interviewer Identity Card gives the interviewer's name, photograph and organisation
- To end the interview at any point
- To know that any personal information provided will only be used for the purposes about which you have been told

www.mrs.org.uk

PARTICIPANT COPY FOR REFERENCE PURPOSES

Project title: Exploring the cost of pregnancy
Name of researcher:

Please read each of the statements below. If you have any questions, please ask the researcher from Scott Porter. Please initial each box to confirm that you've done this and only sign the form when you are happy with ALL statements.

This consent form is to ensure that you understand the nature of this research and have given your consent to participate. Your participation is entirely voluntary, and you are free to change your mind about taking part at any time. Just contact the researcher (Rachel Bishop) if you wish to do this.

By signing this form, you agree to take part in an audio-recorded interview/group discussion to share your thoughts on dealing with the household finances during pregnancy and with a new baby.

Please initial box

Statement	Initial
1. I confirm that I have read and understand the participant information sheet dated 26/06/19 (v3) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered to my satisfaction.	
2. I understand that my participation is voluntary and that I am free to withdraw from the study at any time, either during the focus group or afterwards without giving a reason and without there being any negative consequences. I understand any care or services I currently receive or use or offered in the future will not be affected.	
3. I understand that I do not need to answer any questions that I do not wish to.	
4. I agree to the focus group being audio recorded and any direct quotes being used as required.	
5. I understand that direct quotations from the focus group may be used for research purposes (e.g. research presentation, publications) but my identity will not be revealed.	
6. I give permission for members of the research team to have access to my anonymised responses.	
7. I give my permission for members of the research team to use my contact details to re-contact me for quality control purposes.	
8. I agree to take part in the above study.	

Name of Participant _____

Date _____

Signature _____

Name of person taking consent _____

Date _____

Signature _____

Appendix 3. Consent sheet.

SCOTT PORTER Research & Marketing 1589	Participant Consent Form 26/06/19; v3	NHS Health Scotland																		
RESEARCHER COPY																				
Project title: Exploring the cost of pregnancy																				
Name of researcher:																				
<p>Please read each of the statements below. If you have any questions, please ask the researcher from Scott Porter. Please initial each box to confirm that you've done this and only sign the form when you are happy with ALL statements.</p>																				
<p>This consent form is to ensure that you understand the nature of this research and have given your consent to participate. Your participation is entirely voluntary, and you are free to change your mind about taking part at any time. Just contact the researcher (Rachel Bishop) if you wish to do this.</p>																				
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Please initial box																				
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Name of Participant	Date	Signature																		
Name of person taking consent	Date	Signature																		
6																				

Appendix 4. Discussion guides.

J/N 1589

SCOTT PORTER
Research & Marketing

Exploring the cost of pregnancy pathway Pregnant women/young families Discussion guide – final 28.06.19

(Please note that the questioning approach used will be adapted to the needs of each respondent, with the moderator simplifying language as appropriate. Timings shown for both depths and groups.)

1. Introduction and respondent background (5/10 mins)

- Self, Scott Porter, MRS Code of Conduct, confidentiality, recording
- Research purpose: *to explore your experience of pregnancy/being a new parent, especially the impact it may have had on your life and any pressures that it had brought, including those linked to your finances.*
- Respondent intro: (name) age, family status
 - pregnant women: first or subsequent pregnancy, term of pregnancy
 - new mothers/parents: first or subsequent child, age of youngest
- Who else is in the household
 - partner or other family
 - any other children, and ages
 - any children not living in the household (e.g. staying with grandparents/partner)
- Living situation
 - is it your own home, or rented/social housing
 - how long lived here
 - do you have friends/family nearby

2. Experience of pregnancy/parenthood (10/15 mins)

- In general, how have you been getting on with this pregnancy/parenthood (spontaneous)
 - how easy/difficult has it been to adjust
 - do you feel it has impacted on your day-to-day life; if so, if what ways
 - what sorts of pressures have you had to deal with
 - how has it affected your life
 - probe in detail the areas of life affected (e.g. finances, time, work, emotional) and extent of impact
 - how have you personally been feeling
- Have you had a fairly straightforward pregnancy/time after the birth of your child, or have there been complications which meant you had to go for daycare or inpatient appointments
- Have you been able to get support from anyone to help with these things
 - if so: who and how has this been of help
 - if not: do you feel you have had to cope alone? How have you found this?

From this point, order of coverage to be determined as most appropriate/natural flow for each respondent based on the preceding discussion

3. Income

(5/10 mins)

- Did you work prior to this pregnancy/birth
 - if so, what did you do
 - what sort of employment was it (e.g. full/part-time, permanent, zero hours)
 - and are you working now/do you intend to go back to work (if so, when?)
 - **if so, have you been able to do this at the time/on the terms you preferred or did you feel pressure to go back to work earlier or work hours that weren't ideal**
 - is there income coming into the household from partner/other family members in employment
 - what do they do, and what sort of employment is it
- Do you receive any kind of benefits at the moment
 - if so, which ones – *spontaneous only* (universal credit, job related maternity pay, any other benefits e.g. Best Start Baby Grant, Healthy Start food vouchers – as appropriate)

4. Access to antenatal/postnatal care

(15/20 mins)

- Have you been able/did you manage to attend your antenatal/postnatal appointments
 - all or some of them?
 - why is that (probe for attitudinal vs practical/cost factors)
 - probe to establish how/when 'decide' which ones are attended vs missed

Explore fully, allowing for spontaneous discussion at first, and then prompt:

Barriers

- what are the things that have made it difficult to attend all of your appointments
 - travel to appointments (time/cost/distance)
 - need time off work (difficult/loss of earnings)
 - **working conditions (ability to take time off work/access to maternity leave)**
 - childcare (difficult/cost)
 - cost (of what?)
 - *self completion sheet: rating of extent to which each factor is felt to impact on access to antenatal/postnatal care*

Facilitators

- and have there been things that have helped you to go to your appointments
 - support from friends/family (emotional/practical/financial)
 - help with transport
 - help with childcare
- Overall, how important do you think it is to access antenatal/postnatal care
 - why/why not
- *If perceived to be important:* what benefits do you think there are; what do you feel you would gain by doing this
- *If not perceive to be important:* explore whether not seen as necessary, or reluctance to engage with health professionals (what drives this)
 - briefly explore social/community norms and any barriers as a result of previous experience

5. Wider pressures**(10/15 mins)**

- Do you have any/more money worries now that you are pregnant/have a young baby
 - what are these due to; *explore spontaneously then prompt*
 - additional purchases, less money coming into household (not working/reduced hours), attendance at clinics
- Do you find you have to prioritise what to spend your money on more now
 - do you feel you have enough money to make ends meet/do everything you need or would like to do
 - are there specific things that you are concerned about or feel you can't really afford at this time
- What sorts of costs have you found you have had to cover because of your pregnancy/having a new baby – *spontaneous, then prompt:*
 - maternity/baby clothes
 - equipment, toys
 - extra heating, lighting, electricity
 - formula, food for baby/self/others in family
 - general travel
 - **childcare (if returning to work)**
- How have you found it managing these extra costs
 - have you looked for/been able to get financial help from anywhere/anyone; *explore in detail*
 - have you heard of/applied for the Best Start Baby Grant, Healthy Start food vouchers – as appropriate
 - if yes, how helpful did you find it

6. Financial assistance

(15/20 mins)

- Do you think there is anything the health service can do to help mothers-to-be/mothers/parents to more easily manage the costs of pregnancy/a new baby
 - what do you think could help at this time; *probe fully, then prompt (showcards if required):*
 - signposting or direct referral to specialist money advice/welfare rights/citizens advice services
 - support tools (online) and resources
 - personal advice from midwife/health visitor (*what more could they do for you?*)
 - travel costs
 - childcare facilities at clinic
 - access to second-hand equipment
 - referral/access to food/formula/**foodbank** vouchers
 - grants for pregnant women/new mothers
- Is there anything else you feel would help you to access antenatal/postnatal care more easily, or would help with the additional financial pressures that come with pregnancy/having a new baby

THANK AND CLOSE

Total time: 60/90 minutes

**Exploring the cost of pregnancy pathway
Staff
Discussion guide – final 28.06.19**

1. Introduction and respondent background (10 mins)

- Self, Scott Porter, MRS Code of Conduct, confidentiality, recording
- Research purpose: *to explore your experience of the needs of pregnant women and early postnatal parents experiencing financial pressures, and your thoughts on the kinds of actions that could be implemented by services to reduce the impact of these pressures.*
- Respondent intro: name, role – what does it involve

2. Experience and understanding of issues (25 mins)

- What is your experience of the kinds of financial pressure or money worries pregnancy/a new baby can place on low income families
 - in what ways can it affect individual's lives; can it affect their accessing of maternity services
 - direct costs related to travel, childcare etc.
 - time required for antenatal/postnatal care
 - loss of income (time off work)
 - limited discretionary income
 - little/no support from family/friends
 - mental health/gender based violence issues
 - reinforcement of attitudes established through the wider experience of living in poverty (lack of engagement with health and services, poor understanding/value associated with antenatal/postnatal care)
- What do you understand to be the key factors at play - spontaneous then prompt:
 - unemployed/type of employment/contract (less money coming into household)
 - working conditions (ability to take time off work/access to maternity leave)
 - access to benefits (unclear of entitlement, delays in receipt)
 - additional household costs (clothes, equipment, food, heating)
 - emotional (family problems, attitude to pregnancy, lone parent)
 - social (social norms, education, support network)

- How easy/difficult is it to identify individuals who may be experiencing financial pressures
 - how willing are individuals to talk about their concerns with you or to ask for support; why do you think that is
 - *if feel are willing to discuss*
 - what sorts of issues are raised
 - at what stage is support sought
 - are certain 'types' of patient more likely to discuss their concerns with you, and others more likely to try to cope alone

3. Views on addressing financial health needs/**money worries** (35 mins)

- What are your views on being involved (in your own role) in addressing the social health needs, in particular the financial health needs, of your patients
 - do you feel this is an important part of your role - why/why not
 - are there areas you feel are more/less appropriate for you to be involved in - what are these
 - why do you feel that (*explore fully*)
 - if not mentioned, probe specifically for financial health needs
 - *if not seen as part of role:* who do you think is better placed to do this – why is that
- What are you currently able to do in your professional role to address the social (and especially, financial) health needs of patients

Explore fully, allowing for spontaneous discussion at first, and then prompt:

Facilitators

- what are the factors that enable you to do this
 - personal-centred approach to care
 - having time to get to know individuals and their home situation/build relationships
 - availability of good resources/materials to use with patients
 - other local factors?

Barriers

- what do you feel are the barriers that need to be overcome to enable you to support pregnant women and families more around their financial needs
 - lack of time to develop relationships of trust
 - lack of experience in dealing with financial issues
 - lack of training/good resources
 - availability of grants etc.
 - other?

4. Service actions (20 mins)

- What more do you think Health services and Children's services could do to help support patients experiencing money worries
 - in relation to reducing barriers to accessing antenatal/postnatal care
 - in relation to wider financial pressures (e.g. equipment, heating)
- What do you think would help you, in your role, to better address the financial wellbeing of pregnant women and new parents (*spontaneous, probe fully*)
 - prompt as required
 - stronger links to specialist financial inclusion services/being able to signpost/refer to specialist money advice/welfare rights/citizens advice services
 - support tools (online) and resources
 - training/development
 - ability/time to provide personalised advice
 - availability of financial support e.g. vouchers for travel costs, food/formula
 - easy access to grants for pregnant women/new mothers
 - childcare facilities at clinic
 - links to organisations providing access to second-hand equipment
- Is there anything else you feel should be taken into account in providing financial support support to pregnant women and parents with new babes

THANK AND CLOSE

Total time: 90 minutes

Appendix 5. Composition of study participants.

Focus groups

Two groups: NHS frontline staff.

Four groups: pregnant women and mothers with babies up to one year old.

	NHSGGC	NHSA&A
Staff (including midwives, family nurses, health visitors)	1 group	1 group
General public	3 groups	1 group
- mix: with babies up to 1 year & pregnant	1 group	1
- with babies up to 1 year	1 group	-
- pregnant women	1 group	-
- working households, non-working households	Mix	Mix
- age 16-34 and 35-45 years	Mix	Mix
- first time and experienced parents	Mix	Mix
- on benefits/Universal Credit, lone parents, BME	Random fall out	

In-depth interviews

Twenty-five in-depth interviews with pregnant women and mums with babies up to one year old – including five paired interviews with male partners.

	Total	NHSGGC	NHSA&A
	25 depths	17 depths	8 depths
Pregnant 28+ weeks	8	5	3
With babies up to 1 year	17	12	5
Working household	12	8	4
Non-working household	13	9	4

Other variables:

- age: 16-25, 26-35, 36-45
- first time and experienced
- working/on benefits/Universal Credit
- lone parents, BME

Random fallout across the participant group but a good mix of each variable was obtained