Equality Impact Assessment

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NHS WALES GIG CYMRU
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NHS

CONTENTS

From Welfare Foods to Healthy Start

1. Healthy Start replaced the milk and infant tokens and free vitamin supplements provided through the Welfare Food Scheme. The Welfare Food Scheme had been established in 1940 to protect all pregnant women and young children from wartime food shortages, but in later years was targeted on those in very low-income families.

2. Scientists, Government and stakeholders had long agreed the scheme was out of date. The Panel on Child and Maternal Nutrition of the Committee on the Medial Aspects of Food and Nutrition Policy (COMA) was therefore invited to review its effectiveness in 1999. COMA's remit included a specific assessment of how well the scheme served different population groups and its final report was published in 2002[1].

3. The NHS Plan 2000 set out Government's aim to reform the Welfare Food Scheme so as to:
   "use the resources more effectively to ensure that children in poverty have access to a healthy diet, [with] increased support for parenting and breastfeeding."

4. Proposals were published for consultation in autumn 2002[2]. We received over 500 written responses and a range of views were also expressed at a number of "listening events" and focus groups, some hosted by Sure Start centres. We published a summary of responses in March 2003[3].

5. During 2003, further focus groups involved 180 pregnant women and mothers with children who had experience of the Welfare Food Scheme. Participants included women of different ages and diverse cultural and religious backgrounds[4].

6. After a second smaller consultation on draft regulations Healthy Start was launched in Devon and Cornwall in November 2005. Introducing the scheme in one area for a year was logistically challenging but allowed processes and systems to be monitored and reviewed before full implementation. It also ensured that families elsewhere were not denied access to the new and better scheme for any longer than necessary.

7. During the introductory year we commissioned early quantitative research with beneficiaries, retailers and health professionals to assess

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[1] *Scientific Review of the Welfare Food Scheme – Report of the Panel on Child and Maternal Nutrition of the Committee on Medical Aspects of Food and Nutrition Policy*, Department of Health, 2002
[2] *Healthy Start - proposals for reform of the Welfare Food Scheme,* Department of Health, October 2002
[3] *Healthy Start – the results of the consultation exercise*, Department of Health, March 2003
[4] *Focus groups on proposed changes to the Welfare Food Scheme,* Department of Health, 2004

the scheme's early impact[5]. There was less scope to evaluate impact on women and families of different races in Devon and Cornwall than there might have been in other parts of Great Britain. But the operational problems arising from introduction of the scheme in an area less geographically self-contained would have been prohibitive.

8. At the same time, we commissioned a separate evaluation of Healthy Start communications materials involving a low-income pregnant women and mothers of various ages outside Devon and Cornwall and no previous exposure to information about the scheme[6]. This was followed up, in early 2007, by a small study exploring why a few families in Devon and Cornwall had not applied to take part even though invited to do so.

9. Annex A offers a background note about the Welfare Food Scheme and some examples of its shortcomings in terms of equality. Annex B summarises of the issues most relevant to equality that were raised during development of Healthy Start proposals, implementation and early evaluation, It also comments on the extent to which they have been addressed to date. Annex C includes some key nutritional facts that particularly influenced the policy decisions made about the design of Healthy Start.

What is Healthy Start?

10. Like the Welfare Food Scheme, Healthy Start offers a basic nutritional safety net to specified groups of pregnant women and young children. But this scheme, unlike the Welfare Food Scheme, also encourages women and families to make positive nutritional choices affecting their longer term health.

11. Key features of Healthy Start are:

    i. It provides vouchers with a set value (initially £2.80 per voucher, rising to £3.00 on 6 April 2008, and to £3.10 on 6 April 2009). These can be spent on liquid cow's milk, any fresh fruit, any fresh vegetables, and any cow's milk based infant formula at participating retailers.

    ii. Breastfeeding women receive the same number of vouchers for the baby as women who choose to bottlefeed (two per baby). Double vouchers continue to the first birthday or longer if babies are born early – until one year after the date they were due to be

[5] *Healthy Start – rapid evaluation of early impact on beneficiaries, health professionals, retailers and contractors*, Department of Health, June 2006
[6] *Healthy Start – qualitative research to evaluate communication materials among potential beneficiaries*, Department of Health, June 2006

born. Other women and children on the scheme get one voucher per week.

iii. Healthy Start branded vitamin supplements have been introduced. Any pregnant woman and any woman with a baby under 1 in a family supported by Healthy Start may claim the women's supplement which contains folic acid as well as the recommended daily amounts of vitamins C and D. Healthy Start children's vitamin drops containing vitamins A, C an D are available for all Healthy Start children over 6 months and under 4 years old. At local discretion, they can also be given free through Healthy Start to babies under 6 months old with poor vitamin status who are getting vouchers.

iv. Access to the scheme is via a short application form that must be countersigned by a midwife, health visitor or other registered nurse or doctor. The health professional signing the form is asked to offer advice and information on healthy eating and breastfeeding. Supporting materials are available to help them.

v. While the eligibility criteria for the scheme continue to be means-tested and are largely the same as for the Welfare Food Scheme, children are now supported up to their 4th rather than their 5th birthday. This means that Healthy Start funding can be targeted on the youngest and most vulnerable children. Any pregnant woman under 18 years old can also now get vouchers until her baby is born regardless of her financial circumstances.

The Legal basis for Healthy Start

12. Healthy Start is governed in Great Britain by regulations made under the provisions of the Social Security Act 1988 as amended by the Health and Social Care (Community Health and Standards Act) 2003.

13. Regulations brought the scheme into force in Devon and Cornwall in November 2005 (SI 2005/688), then extended it across Great Britain in November 2006 (SI 2006/2818). Later annual amending regulations have uprated the income threshold for families qualifying through tax credits – for 2010/11 the threshold is £16,190. Amending regulations have also increased voucher value twice – to £3.00 from 6 April 2008 and to £3.10 from 6 April 2009.

14. From 27 October 2008, consequential amendments to new social security regulations added income related Employment and Support Allowance to the qualifying benefits for Healthy Start. This has ensured that families who would formerly have been able to access Healthy Start through receipt of Income Support on grounds of incapacity, can continue to do so.

15. The statutory powers for Healthy Start are largely reserved. But Scotland and Wales have specific powers to determine the foods that may be made available through the scheme and the nature of any health advice given in their countries. Regulations governing the scheme in Northern Ireland are separate, but identical to the Great Britain Regulations. All 4 countries work together so that the scheme can be delivered consistently, coherently and cost-effectively throughout the UK.

Responsibilities for delivering Healthy Start

16. Delivery of Healthy Start involves a range of Government Departments, and organisations. Each is, like the Department of Health, required by law to ensure equality of access to the goods and services it provides and may also have some additional equality obligations.

17. Specific Healthy Start responsibilities most relevant to equality are:

18. <u>Department of Health</u>
    - To ensure that the range of foods available through Healthy Start in England continues to meet its population's needs
    - To ensure that the scheme and its governing Regulations for Great Britain meet the requirements of equality legislation
    - To ensure that contractual arrangements for delivery of central Healthy Start functions allow for equality of access
    - To co-ordinate central monitoring/evaluation of the scheme and its delivery, ensuring that equality issues are addressed
    - To produce generic Healthy Start public communication materials and supporting materials for health professionals and NHS organisations appropriate for the whole of the UK
    - To establish and manage relationships with Healthy Start leads within NHS organisations in England
    - To ensure that Healthy Start vitamin supplements are produced and available to NHS organisations and devolved administrations
    - To establish and maintain an antifraud strategy to ensure that funds are spent as intended on those who are most in need
    - To manage relationships with the devolved administrations, consulting them as necessary on policy, contractual and operational decisions for Healthy Start

19. <u>Devolved Administrations in Scotland and Wales</u>
    - To ensure that the range of foods available through Healthy Start in their countries continues to meet their population's needs
    - To determine the nature of health advice given by health professionals
    - To establish and manage relationships with their health services

- To co-ordinate supply of Healthy Start vitamins
- To produce and make available any additional country-specific scheme communications materials for the public, health professionals or health organisations that they may consider necessary in their countries

20. Devolved Administration in Northern Ireland
As for the other devolved administrations, and
- To ensure that Regulations governing the scheme in Northern Ireland are maintained and are equivalent to the governing Regulations for Great Britain

21. HMRC/Jobcentre Plus
- To ensure equality of access to qualifying benefits and tax credits
- To signpost Healthy Start through customer advisors and leaflets
- To provide regular and accurate data confirming eligibility of families with children under 4 for validation purposes

22. NHS organisations (Primary Care Trusts and Health Boards)
- To ensure that staff deliver their roles in Healthy Start effectively
- To stock, promote and supply Healthy Start vitamin supplements to those entitled to them
- To ensure that Healthy Start delivery is integrated with other local public health services, and that there is equality of access to all services

23. Healthy Start Delivery Contractors
- To process application forms from women and families fairly
- To issue Healthy Start vouchers and vitamin coupons promptly to those entitled to them
- To recruit sufficient retailers to accept vouchers, make prompt and accurate payments to them, and maintain an up to date searchable database of registered retailers
- To provide appropriate customer services for the public, beneficiaries, and retailers
- To ensure that sensitive data is protected, that processes are designed to minimise any risks of scheme abuse or fraud
- To provide mechanisms for scheme abuse or fraud to be reported, and to act upon reports or refer them for further action by enforcement agencies or Government as appropriate

24. NHS Counter Fraud Services (and equivalents across the UK)
- To ensure that potential fraud against the scheme is effectively investigated and any appropriate legal action taken, and to advise the Department of Health and its contractors on fraud prevention and management

Addressing the risks and potential: race

Range of foods

25. Healthy Start vouchers can currently be spent on any fresh fruit or vegetables as well as liquid cow's milk or cow's milk based infant formula. Because there is no restriction on the types of fresh fruit or vegetables that vouchers can be spent on, women and families can choose those which are familiar and acceptable to them.

26. Fruit and vegetables are an important part of a healthy balanced diet for all races. According to the 2004 Health Survey for England, the traditional diets of minority ethnic groups tend to contain more fruit and vegetables than the diet of the general population. There is therefore no reason to believe either that the inclusion of fresh fruit and vegetables is discriminatory to minority ethnic groups. To date there have been no complaints or feedback to suggest that any beneficiary is unable to use the fresh fruit and vegetables purchased with vouchers on the basis of ethnicity.

Retailer participation

27. The local impact of Healthy Start vouchers on ethnic minority groups will depend on whether local retailers make available the types of milk and fresh produce that they wish to spend vouchers on. Large supermarkets are increasingly tailoring ranges in specific stores to meet the needs of the local community. They may sell, for example, okra, mouli, plantain, Kosher milk and other products in demand locally. London has the highest concentration of minority ethnic residents in England and many London branches of supermarkets devote aisles to products preferred by local minority ethnic communities.

28. However, many minority ethnic families still rely heavily on small and specialist shops for their food purchases. The initial retailer recruitment campaign for Healthy Start involved a direct mailing to around 20,000 retailers across the UK that had previously provided milk through the Welfare Food Scheme, including a large number of small businesses. This was supplemented by mailings to a further 30,000 retailers of all sizes known to accept commercial money-off coupons. Supporting advertisements were placed in a variety of trade publications, including the *Asian Trader* and *Convenience Store* magazines and trade associations were asked to promote the scheme to their members.

29. We are also aware of several local projects to encourage participation among small retail businesses. For example, Bury PCT has had some success targeting small retail businesses that are difficult to reach

through national recruitment campaigns, including small shops in areas of high deprivation.

30. There are currently around 30,000[7] retail outlets across the UK registered to accept Healthy Start vouchers. We estimate that approximately 73% of all vouchers used currently are spent with non franchised multiple retailers (supermarkets). Of the remainder, around 15% are spent with independent or franchised multiple retailers, 5% with doorstep milk deliverers, 5% with chemists and the remainder with food co-operatives, box schemes or market traders[8]. The proportion spent with each category of retailer has changed slightly in recent months, with supermarkets gaining 3% , independent and franchised retailers losing 2%, and milk roundsmen losing 1%. As the numbers of registered retailers in each category has not altered significantly, this shift is likely to reflect the general economic conditions – supermarket prices are generally lower.

31. There has been localised good practice in one or two areas involving partnerships between retailers and NHS organisations to provide additional value to Healthy Start customers. For example, in Hastings and Rother PCT a project involved provision of fruit and vegetable bags in exchange for Healthy Start vouchers.

32. A current Department of Health Change4Life project pilot is encouraging "symbol group" convenience stores in deprived areas to stock better quality fresh fruit and vegetables and is promoting this in several ways. One of the ways was through the inclusion of a promotional flyer in envelopes with Healthy Start vouchers mailed to local families, and this method may be repeated during 2010/11 as more convenience stores join the project.

Communications

33. For the public and beneficiaries, a wide range of Healthy Start materials was initially produced, evaluated in 2006, and then refined. During 2009/10 we have reviewed all communication materials once again, and have embarked on a signficiant programme of rebranding, improving and expanding them. The key aims are to revive interest in the materials, to specifically encourage applications for the scheme from first time pregnant women, and to promote the importance of vitamin supplements in order to increase take up. New materials include an extended range of posters, improved application leaflet and user guide, and a suite of life-stage specific flyers and mini-magazines containing relevant public health messaging to be sent to all beneficiaries regularly with their vouchers. All are written in plain English, with the application leaflet also available bilingually in English and Welsh. Application forms must be completed in English.

[7] Source: Healthy Start Reimbursement Unit database, February 2010
[8] Source: Healthy Start Reimbursement Unit database, based on voucher redemption claims between 1 October 2009 and 31 December 2009

34. The content and layout of these materials have been carefully designed to be attractive, relevant, but inoffensive to all population groups. Cartoon-style images include non race specific pregnant and breastfeeding women, parents, and children.

35. We recognise that there are some minority ethnic communities with additional language needs. We have previously sought recommendations from the Central Office of Information (COI) Diversity Team on how best to meet these needs. The COI has already worked closely with both DWP and HMRC to develop their policies on materials in other languages.

36. COI advised that the vast majority of minority ethnic women in our primary target group (young pregnant women/mothers of young children on benefits, and pregnant women under 18) are likely to have been born in Great Britain and experienced the British education system. They are therefore likely to be comfortable in speaking and reading English.

37. However, there are clusters of non-English speaking women in certain communities due to the tradition of arranged marriages to partners from the sub-continent, and to the arrival of refugees from Civil War. These communities are the Bangladeshi, Pakistani and Somali communities. Their difficulties with English may be further compounded by low literacy in their own language.

38. We had originally previously produced bi-lingual materials in English with Bengali, Urdu and Somali which were well received. Our new range of materials will continue to include, simple bi-lingual posters and leaflets in English with each of these languages that can be used by health professionals and community advisers with their non-English speaking clients. These focus on the most important information about Healthy Start.

39. Over time, based on further feedback from our own market research among beneficiaries, from national surveys, and on research we commission on the impact of the scheme, we will periodically review whether we need to provide bilingual materials in other languages.

Vitamin supplements

40. Vitamin supplements containing vitamin D are especially important to women and children with dark skin and/or who wear clothing that limits exposure to sunlight. In particular, this includes women and children from Asian, African-Caribbean and Middle Eastern communities. Incidence of rickets is increasing with, according to some sources, up to one in one hundred minority ethnic children now affected. Supplements containing 10 micrograms of vitamin D taken daily by

pregnant and breastfeeding women, and children under 4, can prevent rickets and other health problems arising from vitamin D deficiency.

41. Introducing new Healthy Start branded vitamin supplements containing the Recommended Daily Allowance of vitamin D as well as other essential vitamins (C and folic acid for women, and A and C for children) was therefore an important step forward. These supplements are the only products that fully meet the Scientific Advisory Committee on Food and Nutrition's current recommendations on supplementation for pregnant and breastfeeding women, and for young children.

42. Primary Care Trusts in England are responsible for supplying Healthy Start vitamins to beneficiaries. They may reclaim the costs of bottles supplied through the scheme from the Department of Health. Similar arrangements exist in the other UK countries.

43. Claims for England until late 2009 suggested that uptake of both supplements was disappointingly low – less than 1% in some PCTs. We have therefore made increasing uptake a key priority, and as well as placing greater emphasis on the importance and role of vitamin supplements in new scheme communications for the public, and in supporting information for health professionals, we have also introduced a new vitamin coupon to make the process of claiming vitamins simpler.

44. It will be some time before the impact of the new coupon will be measurable through monitoring claims for payment by PCTs. However, information from NHS Supply Chain – from whom PCTS order their supplies – suggest that the number of bottles of both types of vitamins ordered between October and December 2009 increased significantly – by over 300% in the case of the women's supplements. We will continue to monitor this throughout the coming year.

45. We are also continuing to encourage good practice on vitamin supply within Primary Care Trusts, and have increasingly been able to put PCTs wishing to focus on this in touch with others who have successfully increased uptake. The number of PCTs including Sure Start Children's Centres in their supply arrangements is also increasing.

46. We now regularly provide quarterly feedback, PCT by PCT, via regional food and health advisors, so that this can be used in local monitoring and planning. A few PCTs are in the process of adding targets for supply of the women's supplements to their annual contracts with maternity services in the acute sector, which is a helpful development.

47. Trusts and other NHS organisations may order additional supplies of Healthy Start vitamin supplements at their own expense either to use in local projects with groups not supported by Healthy Start, or to sell to

the public at a low price. We encourage both practices as wider acceptance of the value of the supplements could increase their profile with Healthy Start beneficiaries, and there has been a small increase in the number of PCTs considering or doing this. For example. Birmingham PCTs continue to give universal access to Healthy Start supplements, Ashton Leigh and Wigan PCT provide them universally to pregnant women, new mothers and babies, and Blackburn with Darwen also have a local project. Indications are that universal supply does increase demand for the supplements among both beneficiaries and non beneficiaries of Healthy Start. However, the rate of increase among beneficiaries appears much lower and so universal supply without additional promotion to vulnerable groups is unlikely to offer a complete solution as it could increase inequalities. PCTs running projects are monitoring and evaluating them to help develop the evidence base.

Pregnant women and children in families including adults on spousal visas

48. We are aware that there may be some children under 4 years old living in households in which one parent or carer resides in the UK on a spousal visa that bars them from seeking personal support from public funds. Because of their visa restrictions, they may not themselves claim the qualifying benefits or tax credits for Healthy Start. However, because Healthy Start applications are accepted from either parent or carer in a household, provided one of them is claiming the qualifying benefits or tax credits and HMRC tax credits and the children are a part of their claim, they can still access Healthy Start.

49. In 2008, we also clarified with the Department of Work and Pensions the rights of persons legitimately in the UK on spousal visas to apply for their own National Insurance Number. A National Insurance Number is legally required by Healthy Start regulations for any pregnant woman qualifying to access Healthy Start in her own right before the baby is born. Yet their right to obtain a National Insurance Number for this purpose was misunderstood by one or two families and staff at their local Jobcentre Plus. Healthy Start Issuing Unit helpline staff are now equipped to give specific advice on this.

Asylum Seekers

50. In the past, lobby groups have requested access to the Welfare Food Scheme, and then to Healthy Start, for Asylum Seeker women and families with young children. The Government's policy is to support Asylum Seekers through payments made by the National Asylum Support Service (NASS). NASS provides an additional weekly payment to pregnant asylum seekers and those with children under 3 years old who are "destitute". Since the introduction of Healthy Start this payment has been set at £5 for children under 1 year old and £3 for pregnant women and other children under 3 years old.

51. Asylum seekers may also access vitamin supplements (but not the Healthy Start branded supplements as they not currently available through this route) via NHS prescriptions. Prescriptions are free for pregnant women, women with a child under 1 year old, and for children.

Addressing the risks and potential: disability

52. When scientifically reviewing the Welfare Food Scheme in 1999, COMA specifically considered whether there were grounds for the scheme or its successor to support children with special clinical and dietary needs arising from illness or disability. (Note: at that time, the scheme was providing support to around 20 children over 5 years old not attending school on grounds of disability. This support was withdrawn during 2005.).

53. COMA's conclusion was that the scheme was - and should be - a public health measure and not a medical intervention. It added that disabled children suffer from such a diverse range of medical conditions that no universal nutritional justification could be made for supporting them through this scheme.

54. Women and children are therefore not eligible for Healthy Start on the basis of illness or disability, or the illness or disability of a family member, alone. But they can access the scheme if they meet its usual qualifying criteria. Income related Employment and Support Alloance has been added to the qualifying benefits for the scheme to ensure that families that would previously have qualified through income support on incapacity grounds can still apply.

Allergies and food intolerance

55. In consultation, some respondents said that soya formula and milk should be included in Healthy Start for those who have an allergy or intolerance to cow's milk. We have not made them available through the scheme partly because of COMA's view that the scheme should be a public health measure rather than a medical intervention. But we have also taken into account the fact that the current advice of the Chief Medical Officer (published in 2004) is that soya formula should be not used as the first choice for infants with cow's milk sensitivity. It should only be used in the most exceptional circumstances.

56. Hydrolised protein formulas may be prescribed by the NHS if a baby has a proven cow's milk sensitivity, lactose intolerance, galaktokinase deficiency, or galactassaemia. NHS prescriptions are free for children.

57. Vitamin supplements produced for the scheme do not contain either milk or peanut derivatives. This responds to concerns from beneficiaries and health professionals that Abidec, which was

previously supplied for children towards the end of the Welfare Food Scheme's existence, contained arachis (refined peanut) oil. Many health professionals were not comfortable with providing it through the scheme because of concerns about undiagnosed peanut allergy in young children.

Access issues

58. Application leaflets can be requested by telephone directly from the Healthy Start Issuing Unit helpline. A copy of the form may also be downloaded from the internet, which may be helpful to those with mobility problems. Communications materials are available on request in braille and audio format. A minicom number is provided by the Healthy Start Issuing Unit for those with hearing difficulties.

59. Vouchers are issued by post 4-weekly to the beneficiary's usual home address, as confirmed by HMRC tax credits or Jobcentre Plus. So there are no mobility issues attached to receipt of vouchers. The vouchers can be used with a very wide variety of retailers including all major supermarket chains as well as independent retailers and doorstep milk deliverers and so it should be possible for all beneficiaries to use the vouchers where they do their regular shopping for milk, fruit or vegetables or formula.

60. The Healthy Start Issuing Unit continues to help any beneficiary locate the nearest shops to their home accepting vouchers. Beneficiaries and the public can also make their own searches for registered retailers by postcode via the Healthy Start website. Retailer details on the website are up-dated in real time from the central Healthy Start retailer database. Within the last 2 years, there have been no complaints about difficulty finding a local shop accepting vouchers.

61. All applicants to Healthy Start do have to get their application form signed by a midwife, health visitor or other registered nurse or doctor. Though this may present additional difficulties for someone with reduced mobility, the requirement for health professional involvement is a key principle of Healthy Start. NHS organisations are required to ensure that disabled people are able to access their services and so we expect Trusts to ensure that Healthy Start applications from disabled service users are covered by their local arrangements. The position is the same for receipt of Healthy Start vitamin supplements, which are also claimed from local NHS organisations.

Addressing the risks and potential: gender/sexual orientation

62. Healthy Start vouchers for children are claimed by the carer of the qualifying child. This can be either of the parents, another adult family member or legal guardian. Same sex couples, heterosexual couples,

and single adults with children are all equally eligible to apply and all treated in exactly the same way.

63. Vouchers for pregnancy must, however, be claimed by the woman who is pregnant, with a signature from a parent or carer in the case of under 16 year olds. This is because the health professional must confirm her Expected Date of Delivery when countersigning the form. It is also to encourage the pregnant woman herself to contact a midwife if she has not done so already. An important aim of Healthy Start is to encourage low income and under 18 year old pregnant women to make earlier personal contact with health professionals so that they can be offered appropriate advice and antenatal care. Allowing applications to be made for pregnant women by other members of the family would not achieve this aim.

64. When developing the application leaflet and form for Healthy Start, our aim was to ensure that they would not deter applicants of either sex or sexual orientation. Since the form was first introduced, we have received only one complaint about the wording on the grounds of gender equality. We did not make any change as a result of this complaint because it would have made it less clear that an application made during pregnancy should be made by the pregnant woman herself. This could have led to some women completing the form incorrectly, and not getting vouchers as quickly as they should. However, all Healthy Start materials continue to be reviewed regularly.

65. We have taken care to ensure that all our materials depict men as well as women in parenting roles, and have increasingly begun to depict "families" in light of feedback from single parents that they often valued the role of fathers not living with them and wanted to see this reflected in our materials.

Addressing the risks and potential: religion or belief

Range of foods

66. Healthy Start is not designed to treat people differently because of their religion or belief. Yet adding any fresh fruit and vegetables and including any brand of cow's milk formula suitable from birth has, as with race, given families flexibility to choose the products they prefer. Vouchers can be put towards the cost of, for example, Kosher milk or Kosher cow's milk infant formula. While specialist products such as this may be more expensive than some other brands, all Healthy Start families must make personal decisions on how to get best value from their vouchers. Nutritionally, all infant formulas are very similar even though prices vary. Most families will have preferences for particular

brands that will affect their choice - whether or not these are for religious or cultural reasons.

Vitamin supplements

Vitamin supplements produced through the scheme do not contain milk or alcohol. They are suitable for vegetarian diets.

Application process

67. Women from some population groups might have been deterred by any application process involving a health professional of a different sex or who was unfamiliar to them. But the application process has been designed - and publicised - as one that involves contact with a family's usual midwife or health visitor. Though we encourage applicants towards them, the forms can also be signed by any other registered nurse or doctor ensuring that families have some additional choice.

68. There is no requirement for any applicant to agree to accept any other health service before an application is signed. However, as a matter of good practice, health professionals are encouraged to give information about other relevant initiatives, such as cooking skills classes or parenting sessions that might be available locally. Health professionals are specifically advised that it is not their role to check whether the applicant is getting the qualifying benefits or tax credits they claim to be as this is inappropriate and could damage relationships with their clients.

69. To date we have received no complaints that any woman or family has felt unduly pressurised to take up any services offered by health professionals signing forms. Nor have there been any complaints that health professionals have acted inappropriately by asking for evidence of receipt of qualifying benefits or tax credits.

70. Because women from some groups may not always approach the NHS immediately when they become pregnant, posters and application leaflets are available for non-NHS organisations to order. The scheme is signposted in a wide range of leaflets about benefits and tax credits produced by HMRC and Jobcentre Plus. Customer advisers in local tax credit offices, HMRC callcentres and Jobcentres are asked to advise clients if they are eligible and tell them how to obtain an application form. This is included in staff guidance. Healthy Start has also been signposted as part of a publicity campaign prior to the launch of the new Health in Pregnancy Grant in April 2009, administered by HMRC.

71. Though the requirement to involve a health professional in the application process might be seen as a barrier to accessing the scheme by women and families less likely to approach the NHS, this aspect of the process is an important principle. Creating a direct link

between a scheme which has a clear public health role, and delivery of public health services by NHS organisations, is essential if better links are to be forged between the NHS and the communities they serve.

72. Without these links, implemented sensitively at local level, the educational element of the scheme would be weakened, Its full potential to help empower families with poor diets to change their behaviour could therefore not be realised. Other schemes, such as the Sure Start Maternity Grant and the new Health in Pregnancy Grant, have similar application processes for the same reason.

73. The general duties on NHS organisations to ensure equality of access are such that the NHS should be pro-actively seeking ways to engage better with hard to reach communities in relation to all services they provide. In England, the National Service Framework for Children, Young People and Maternity Services specifically includes an expectation that health professionals will signpost Healthy Start and Healthy Start vitamin supplements to all women and families, and will support the applications of those who are eligible.

Polygamy

74. We are aware that polygamy is accepted in some cultures, and legal in some countries. As we are aware that the benefits and tax credits systems have considered the needs of those in legal polygamous marriages, we have also looked at how our procedures affect them.

75. Healthy Start is available to all children under 4 in a qualifying household regardless of their particular relationship with the adults in the household. Any pregnant woman in the family may also claim, even if another pregnant woman in the household is already supported. Women and children in legal polygamous households benefit from this in the same way that stepfamilies and pregnant women of different generations living in the same household do. It is not possible however, for an adult in a legal polygamous relationship, step families or parents living apart to make duplicate claims for the same children. Verification of every application against data provided by HMRC tax credits and Jobcentre Plus prevent this.

Addressing the risks and potential: age

Pregnant teenagers

76. Some low income pregnant women under 18 years old were not able to access the Welfare Food Scheme because they could not access the benefits system. Because of the additional pressure that pregnancy can place on bodies that are still developing, and because under 18 year olds are much more likely to have a low birth weight baby than older women, we have addressed this through Healthy Start.

77. Pregnant under 18 year olds may apply for Healthy Start during pregnancy and will continue to be supported by the scheme until their baby is born, even if they turn 18 in the meantime and even if they are not receiving benefits or tax credits. Once the baby is born, they – or their carer - can claim Child Tax Credit and, if they meet the Healthy Start criteria, may continue to get vouchers and vitamin supplements for the baby.

78. Feedback, monitoring and evaluation suggests that pregnant under 18 year olds are under-represented on the scheme. New Healthy Start communication materials therefore now include a leaflet designed to encourage pregnant under 18 year olds to apply and we are continuing to explore other ways in which we can promote the scheme better to this group. Teenage pregnancy midwives in England have also been encouraged asked to promote the scheme to their clients.

Healthy Start – the success criteria

79. Healthy Start aims to use existing limited resources more effectively to ensure that children in poverty have access to a healthy diet and to give increased support for parenting and breastfeeding. In an increasing difficult public spending climate, and because of the general economic conditions, it is more important than ever that we achieve this in a way that is consistent with broader Government policy on supporting those on low incomes and encouraging healthy and sustainable diets.

80. We consider that we have been fully successful if:

    i. Estimated take up of the scheme is 80% or more[9] [achieved]
    ii. 90% of all Healthy Start vouchers issued are used by beneficiaries and returned by retailers [achieved]
    iii. women and families supported by Healthy Start understand that milk, fruit and vegetables make an important contribution to a healthy diet [largely achieved]
    iv. all women and families supported by Healthy Start are aware that they can claim free vitamin supplements through the scheme [not yet achieved]

[9] In the first version of this assessment, produced in 2008, we suggested that take up levels of 85% would indicate success. We have revised this figure downwards in light of take up rates of other forms of state support. For example, for 2005/67, estimated take up of Child Tax Credit was 82%, and for 2006/7 was take up of the Sure Start Maternity Grant was 53-63%. As those schemes provide much greater value payments, with no restrictions on how they may be spent, it seems unrealistic to expect the lower value, more restrictive Healthy Start scheme to achieve higher take up levels. Nonetheless, we wish to retain a sufficiently challenging target and consider that 80% reflects this.

v. 50% or more of eligible children and 50% or more of women entitled to the vitamin supplements regularly claim them [not yet achieved]
vi. all front line NHS staff working with pregnant women and young children are aware of Healthy Start and know the local arrangements for supplying the free vitamin supplements [partly achieved]
vii. all health professionals signing Healthy Start application forms are giving appropriate advice on breastfeeding and healthy eating when doing so, or ensuring that this information is offered by another appropriate person - such as an infant feeding advisor or health care assistant [largely achieved]
viii. 85% of midwives and health visitors are aware of the importance of the application signing process as an opportunity to signpost other services and make positive contact with vulnerable families [partly achieved]
ix. Retailer participation levels continue at around 30,000+ outlets across the UK, with all geographical areas having an appropriate level of coverage of outlets taking into account demographic and geographical considerations [achieved]

81. A longer term evaluation strategy to assess the impact of Healthy Start over time has been developed and encompasses equality issues. It will, however, be difficult very difficult to distinguish the specific health impact of Healthy Start from the broader impact of a range of Government and local policies to improve public health. A pragmatic approach to long-term evaluation will therefore be necessary.

Next steps (2010/11)

Healthy Start voucher and vitamin uptake

82. We will continue to monitor and evaluate the impact of the new vitamin coupon, new scheme communication materials, and local scheme promotional events held in early 2010, and to build on these in order to improve national and UK-level promotional activity over time.

Increasing the scheme's educational role

83. We will continue to provide life-stage specific, targeted information on breastfeeding, healthy diet, vitamins, and other relevant public health issues directly to beneficiaries along with their vouchers and will monitor the impact of the new materials. As resources allow, and within the context of "Transformational Government" policy, we will also further develop the Healthy Start website as a resource for beneficiaries and the NHS.

Healthy Start Vitamin Supplements

84. We will continue to encourage the development and sharing of local good practice on vitamin supply within NHS organisations, and to encourage PCTS to include Sure Start Children's Centres in their supply arrangements.

85. We will continue to monitor the extent to which NHS organisations are ordering stocks of Healthy Start vitamin supplements from NHS Supply Chain and claiming for bottles supplied to Healthy Start beneficiaries, and to provide quarterly feedback via regional food and health leads.

86. As resources allow, we will continue to promote to NHS organisations the value of these supplements as a cost-effective means of tackling vitamin deficiencies among local population groups not eligible for Healthy Start. We will also continue to encourage Trusts to sell Healthy Start supplements at a low cost to local families.

87. We will work with NHS Supply Chain to tender for replacement manufacturing contracts for both the women's and children's supplements, encouraging bids from companies that can offer value for money products that are certified Kosher and Halal, and with a view to securing a product for children that has a longer shelf life. This may require a shift from a medicinal product to a food supplement, and we will need to explore the impact of this.

Maximising voucher value

88. Decisions on voucher value increases will always have to take account of broader Government spending priorities, and other forms of financial support already being offered low income families. We already encourage families getting vouchers to seek best value for their vouchers but this can be more challenging if they do not have access to local supermarkets.

89. We will consult publicly on whether the scheme should be extended so that beneficiaries can buy frozen fruit and vegetables as well as fresh with their vouchers, increasing both voucher buying power and access to fruit and vegetables in areas where a variety of value for money fresh produce is more difficult to get. The consultation will also seek views on whether further measures are needed to reduce any risk that vouchers will be spent on products that are not allowed, which would weaken the public health impact of the scheme.

90. The timescale for implementing any change to the scheme will depend on the outcome of the consultation. Each UK country will have to make its own decision on whether the scheme should be extended to additional foods, but we will aim to make any change uniformly across the UK on the same date.

Encouraging good practice in integrating Healthy Start with other initiatives

91. We will continue to encourage NHS and other organisations carrying out local projects to promote the benefits of breastfeeding and healthy diet to explicitly link these to Healthy Start and use Healthy Start branding to ensure a joined-up approach. Where there is good practice and innovation in integrating Healthy Start with other local initiatives, we will encourage this to be shared.

92. We will explore and exploit opportunities at a UK and national level to make links with other public health policies and initiatives such as the Change4Life campaign in England, the Baby Friendly Initiative, and UK policies on breastfeeding and weaning. Any links will be managed in a way that is sensitive to the fact that some policy initiatives are country-specific and that the overriding need is to ensure that scheme communications materials remain generic across the UK, ensuring effective use of public funds.

Retailer participation

93. We will continue to monitor retailer participation levels, by retailer type, and will exploit any opportunities that may arise to promote the scheme to more retailers, particularly small and specialist retailers who may be harder to reach through blanket promotional activity.

Fraud and abuse management

94. All Healthy Start contractors have anti-fraud policies in place covering every aspect of their role, in line with our existing Fraud and Abuse Strategy for the scheme. We will ensure that these policies are reviewed and updated regularly.

Feedback and complaints

95. We will continue to pay close attention to feedback received directly and via contractors, with a particular focus on complaints, and will take this into account when developing further policy on Healthy Start.

Evaluation

96. We plan to award an 18-month research project in spring 2010 to evaluate the impact of Healthy Start, and to inform future research. This research will, among other things, encompass the extent to which the scheme reaches qualifying families across all population groups, and whether it affects any population group in a different way. We will also be including a Healthy Start “boost” sample in an additional survey to the National Diet and Nutrition Survey this year, and will continue to do market research among beneficiaries periodically to assess their satisfaction with the scheme and its communication materials, and awareness of their entitlement. Feedback from the research and from

surveys will be used to develop this Equality Impact Assessment further.

Longer term issues

97. As and when smart card technology develops sufficiently, we will explore the benefits, risks, and cost of moving to electronic “vouchers”. This is a step that must be considered very carefully to ensure that the widest range of retailers, including very small retailers, can continue to participate and that inequity is not created between those beneficiaries willing and able to use smartcards and those who are not.

Reviewing this Equality Impact Assessment

98. We review and republish this Equality Impact Assessment at least annually, and whenever the scheme’s governing Regulations are amended.

Annex A: The Welfare Food Scheme – a background note

The Welfare Food Scheme was established in 1940 as a universal wartime measure to protect pregnant women and young children. Over time its aim evolved into one of providing a very basic nutritional safety net for the most needy.

By 2005/6, "most needy" meant pregnant women and children under 5 in families getting:

- Income Support, or
- Income Based Jobseekers Allowance, or
- Child Tax Credit (without Working Tax Credit) combined with an annual family income of £13,910 or less.

Numbers supported varied as the numbers of families getting the qualifying benefits and tax credits fluctuated. In October 2005, according to the Welfare Foods Issuing Unit database, 724,000 individual pregnant women and children were on the scheme.

The scheme provided support in the form of tokens – either milk tokens or infant tokens. Milk tokens were issued for pregnant women and children over one year old. They could be exchanged for 7 pints of liquid cow's milk at a participating retailer.

Infant tokens were issued only for children under 1 year old and could be exchanged either for 7 pints of liquid cow's milk or 900g of cow's milk based infant formula powder, depending on whether the baby was breastfed or bottle-fed. If exchanged for infant formula, this had to be done via the NHS – usually baby or child health clinics.

Free vitamin supplements were available – mothers and children's vitamin drops - and were also claimed via the NHS. The supplement was less than ideal as it contained vitamin A which is best avoided in pregnancy (albeit in such a small quantity that it presented no safety issues). Women with babies who were bottlefeeding could not get the supplement for themselves – they were only entitled to it if they were breastfeeding.

The "one size fits all" approach did not give sufficient flexibility to respond to the various needs and expectations of different population groups. Some examples of its shortcomings were that:

i. Cow's milk is not the only source of protein, vitamins and calcium. Other sources may be more acceptable to some population groups yet those wishing to avoid cow's milk could not us their tokens and so lost out.

ii. Restricting infant formula supply to NHS clinics which often had short opening times especially disadvantaged those with mobility problems

iii. Infant tokens could only be exchanged for named brands of infant formula, which did not include any Kosher formula

iv. Lack of any direct link between the scheme and delivery of NHS public health services meant some beneficiaries did not get effective opportunities to access advice/information about breastfeeding, weaning and healthy diet from local health professionals

v. The vitamin supplements produced for the scheme were unpopular and. This particularly impacted on pregnant women and children with dark skins or whose clothing made them less likely to absorb vitamin D from sunlight, who would need them most. This includes women and children originally from Africa, the Indian sub-continent or the Middle East.

Annex B: Key points on equality extracted from reports/discussions during Healthy Start policy development and implementation process

Key: **COMA -** 1999 Scientific review of the Welfare Food Scheme
Consultation – responses to public consultations
Focus groups - Focus group discussions held in 2003 with beneficiaries of the Welfare Food Scheme
Stakeholders
Discussions with key stakeholders held between 2002 and 2005
Representations
Representations from miscellaneous individuals/groups outside of formal consultation mechanisms
Contractors
Feedback from contractors delivering the scheme
Evaluation
Findings of the various evaluation exercises carried out since November 2005
Parliament – comments made during debates on passage of the Health and Social Care (Community Health and Standards) Bill and about initial draft regulations

Equality Issue raised	**By**	**Addressed?**
Need a wider range of foods that is culturally sensitive – ie acceptable and accessible across the population groups	COMA Consultation	**Yes**. Any fresh fruit and vegetables added. Potential to extend to frozen fruit and vegetables is to be consulted on.
Scheme should accommodate needs of those with dairy intolerances or other specialist medical needs	Representations	**Partially.** The scheme is designed to provide nutritional – not medical support and so soya formulas and milk are not included. NHS prescribing can be used to support those with medical needs. Disability benefits exist to support those with a range of needs associated with sickness or disability. Choice over what vouchers can be spent on ensures that those with a dairy intolerance do not lose out.
Scheme should be widened to include 16/17 year old pregnant teenagers/scheme should make sure women of all ages have equitable access	COMA Consultation Representations	**Yes.** Scheme is open to all pregnant under 18s regardless of personal circumstances.
Scheme should be better promoted to under 18 year old pregnant women	Evaluation	**Yes.** Teenage pregnancy midwives in England are asked to promote it and new scheme

		leaflets targeting pregnant under 18 year olds were introduced in 2010/11.
Scheme should be widened to include children of under 16 year old mothers who are unable to access qualifying benefits or tax credits	Representations	**Partially.** The current situation reflects Government policy on access to the benefits system by minors. It will, however, be kept under review in light of any developments in the benefits and tax credits systems. However, children of under 16 year old mothers in the care of another relative who meets the qualifying criteria can access the scheme.
Scheme should support asylum seekers	Consultation Representations	**No**. Destitute asylum seekers who are pregnant/have children under 3 receive support via National Asylum Seeker Support Service. The value of the support has been aligned broadly with Healthy Start provision.
Equal value support needed for breastfeeding and non breastfeeding mothers	COMA Consultation Representations	**Yes**. All families receive the same value support.
Support for vouchers to be usable in a wide range of locations including the small and specialist shops often used by minority ethnic families.	Consultation Stakeholders Representations	**Yes**. Even retailers without sophisticated point of sale systems can register to accept Healthy Start vouchers. Set face value of vouchers makes handling simple. Wide scale recruitment exercise was undertaken with a follow up in 2007 targeting small shops identified through regional conferences including leaders of specific minority ethnic communities. Local projects to encourage registration from small and specialist shops are facilitated.
Voucher value should take account of the fact that specialist Kosher/Halal etc foods can be more expensive and formula use may be high in some population groups.	Focus groups	**Partially**. The value of vouchers is determined by the available budget, and the Government's overall spending priorities. It is also Government policy not to incentivise use of formula

		through Healthy Start and voucher value reflects this. The value of vouchers has increased from £2.80 to £3.10 between 2006 and 2010 and we are consulting on whether vouchers could be spent on frozen fruit and vegetables as well as fresh, which would increase their buying power.
One voucher with a relatively high value cannot be spent in a variety of small retailers, impacting particular on Jewish and other minority ethnic communities.	Focus groups	**Yes.** Extra support for babies or additional children is given as multiple vouchers rather than one higher value voucher. Vouchers are sent in 4-week batches and can be used at the same time or separately during that period.
Concern from dairy sector about knock on effect on delivery services which might be used by hard to reach groups	Representations	**Yes**. We cannot influence the price charged by milk doorstep delivery services. Milk purchased via this route is likely to be more expensive.and beneficiaries may not choose it. Independent analysis of this issue concluded that Healthy Start in itself would not have a significant impact on an already declining industry. Nonetheless, the scheme has been designed to be simple for small retailers including doorstep deliverers who wish to participate.
Concern about the need to address the needs of the "unseen poor" eg homeless families/travellers	Consultation	**Yes.** Those without permanent addresses but who receive the qualifying benefits or tax credits can use shared PO box numbers to receive vouchers. NHS Trusts must take account of the needs of all groups in delivering all services.
Vitamins should be reformulated, and promoted more widely.	COMA Consultation	**Partially**. Vitamins were reformulated and are promoted actively to the NHS and to beneficiaries, and a new vitamin coupon has been introduced to make claiming the supplements easier. The impact of this has still to be

		evaluated but early signs are positive. We will be seeking further improvements to the products (shelf life/acceptability for Halal and Kosher) as manufacturing contracts are retendered.
Consideration should be given to extending provision of free vitamin supplements to groups not able to take part in the scheme, eg children from ethnic minority groups.	COMA	**Partially.** This is not within the remit of Healthy Start, and Healthy Start funding cannot be used for this. But NHS organisations may purchase stocks of the supplements to use for local projects. They are also encouraged to sell them to the public at low cost. Increasing numbers of PCTS are using the supplements beyond Healthy Start, and this has been encouraged by the National Instituted for Clinical Excellence.
Query about the needs of children of sick and disabled mothers whose income disqualifies them from the scheme.	Consultation	**No**. Scientific review concluded that the needs of families affected by sickness/disability should be addressed through benefits targeting sick and disabled people.
Need for clear and unambiguous nutritonal messages to be given through the scheme.	Consultation Focus groups	**Yes.** Extensive generic materials available to health professionals containing evidence-based UK nutritional recommendations. This includes booklets, as well as a cpd-accredited online tutorial and parallel training article in an RCN magazine. Materials for the public contain nutritional messages that are clear, simple and consistent with messages given through other health campaigns. The materials available are being redeveloped in 2010.
Application process should not deter genuine applications and eligibility should not be linked to uptake of NHS services such as immunisation/health surveillance	Consultation Parliament Representations	**Yes.** Application form is short and relatively simple. Health professionals are asked to simply to “offer” advice/information when

		signing, but if advice is not accepted this does not affect the application. They are not required to verify the applicant's financial circumstances. They may not insist on acceptance of immunisation or other services/interventions.
Some (particularly minority ethnic) women may not contact the NHS as soon as they become pregnant, and so signposting the scheme through GPs and the NHS only may not be effective.	Focus group Evaluation	**Yes**. Guidance to advisors and call centre staff in Jobcentre Plus and HMRC Tax Credits asks them to signpost the scheme. All relevant leaflets for the public on benefits/tax credits/maternity/early years issues produced by Government reference Healthy Start. Any organisation in the UK may order supplies of Healthy Start posters and application leaflets for local display or distribution.
Broader measures are needed to improve minority access to health services	Focus groups	**Partially** NHS Trusts are required to ensure equality of access for all population groups and are responsible for ensuring this. We now provide feedback about Healthy Start and vitamin take up at PCT level to help regional leads and PCTs assess their effectiveness in relation to Healthy Start. Management information about scheme take up is shared with devolved administrations so they can do likewise.
The scheme should be integrated with local programmes targeting disadvantaged groups such as teenagers	Evaluation	**Partially**. NHS organisations are encouraged to make links between Healthy Start and other local programmes. Support is given for use of Healthy Start branding for such programmes. There is still scope for NHS organisations to do more, and we are encouraging it.
Simple guidance is needed for retailers so that it is easy for small/specialist retailers	Focus groups Stakeholders	**Yes.** Rules and procedures are kept simple and are

to understand the scheme.	Evaluation Representations	explained in simple guidance materials. Point of sale quick reference cards are also provided. A website for retailers is available.
Fraud/abuse by retailers should be combatted to ensure that beneficiaries from minority ethnic groups who are heavily reliant on small retailers are not "short changed"	Focus groups	**Partially**. Retailers are required to sign up to specific terms and conditions. All complaints of the rules not being followed are pursued with individual retail outlets and, if appropriate, with store head offices. Retailers can be removed from the scheme for persistent breaches but the focus is on education. We will be consulting in 2010 on whether further measures are needed to ensure that vouchers are accepted only for the products they are intended for.
Longer term evaluation of Healthy Start should assess the impact of the scheme in areas with large minority ethnic communities.	Evaluation	**Yes.** A longer term evaluation strategy has been developed. The first national research project is due to be awarded in Spring 2010, and will encompass equality issues. We are also monitoring using national surveys as well as management information from the scheme itself.

Annex CL Key Nutritional Facts Influencing Reform of the Welfare Food Scheme and initial direction of Healthy Start

Fruit and vegetables

- People in lower social groups are less likely to eat fruit and vegetables, with only 24% of DEs claiming to have eaten at least 5 portions on the previous day compared to 41% of ABs
  (FSA consumer attitudes survey 2005)

Pregnant teenagers

- low maternal ages is associated with a number of adverse outcomes, including:
  - low nutrient intake in pregnancy (even when adjusted for social class)
  - low prevalence of breastfeeding
  - early introduction of cow's milk
  - low uptake of folate supplements

  (COMA, 1999)

- Rates of infant mortality and the risk of low birth weight amongst teenage mothers are 50% and 25% greater respectively than average (Social Exclusion Unit, 1999)

Breastfeeding

- The World Health Organisation recommends that all infants should be breastfed exclusively for the first 6 months of life.

- Breastfed infants are 5 times less likely to be admitted to hospital with infections such as gastroenteritis or respiratory infections during their first year of life, and less likely to become obese in later childhood

- Mothers who breastfeed are less likely to develop pre-menopausal breast cancer and are more likely to return to their pre-pregnancy weigt

- Though breastfeeding initiation rates have increased since 2000 and the largest increase is among women who have never worked (from 54% up to 67%), those who are least likely to breastfeed are still young, less well educated women from disadvantaged groups

Vitamin Supplements

- Rickets, caused by vitamin D deficiency during pregnancy or early childhood is becoming increasingly common among children in Asia, African-Caribbean and Middle Eastern communities across England, with up to one in a hundred minority ethnic children affected.

- The Department of Health advises that pregnant and breastfeeding women and children under four should take a supplement containing 10 micrograms of vitamin D.

- The Department of Health recommends that all women who are planning a baby or might become pregnant should take a daily supplement containing 400 micrograms of folic acid from before conception until 12 weeks pregnant. However, only 75% of women take a supplement at any point during their pregnancy, and ethnic minorities have a considerably lower level of uptake with only 54% of Asian mothers and 45% of Black mothers taking a supplement at any point during pregnancy.