Poverty Proofing© the Maternity Journeys in areas of Greater Manchester: Oldham and North Manchester

Healthcare Report

Children North East

Because growing up can be hard

Contents

Introduction

Poverty Proofing© was developed by Children North East (CNE) and is a nationally recognised tool. It is designed to educate and enable health care professionals to identify, acknowledge, and reduce the impact of poverty, advocating for equality of access to healthcare, services and technologies that contribute to overall health outcomes experienced by those living in poverty. We understand that minimising the impact of poverty on healthcare provision is key to breaking the link between an individual's income and their opportunity to live a long, healthy life.

Children North East were commissioned to undertake Poverty Proofing© work by Greater Manchester Poverty Action (GMPA). The cohort the work focused on was pregnant women and their new born child (the maternity journey and the first 12 weeks post-partum) living in the most deprived 20% of Greater Manchester as identified through the Indices of Multiple Deprivation.

Rather than Poverty Proofing© a clinical pathway, this project took a unique multi-agency approach and focused on the financial wellbeing, advice and support services available for new and expectant parents along the maternity pathway.

Through a process of stakeholder consultations with colleagues from academia, GMPA, Public Health, Northern Care Alliance, Manchester University NHS Foundation Trust and Maternity Voices Partnership, it was agreed that the project would take a geographical focus centring around Oldham and North Manchester. These areas fit with the criteria for levels of deprivation and there was a willingness from the settings to be involved.

The work took place from August 2023 until February 2024.

Local context

Two hospitals in Oldham and Rochdale: The Royal Oldham Hospital and Rochdale Infirmary, took part in the Poverty Proofing© work, both are part of the Northern Care Alliance (NCA) NHS Foundation Trust. North Manchester General Hospital, part of the Manchester University NHS Foundation Trust (MFT) also took part in the work.

33% of pregnant women in Greater Manchester and Eastern Cheshire (GMEC) are from Black, Asian, or Minority Ethnic backgrounds which is increasing, particularly in Bolton, Manchester, Oldham and Rochdale. Over 40% of women from these backgrounds book later than 10 weeks of pregnancy. Manchester has higher than the national average number of asylum seekers/refugees who face unique health challenges and additional support to overcome the barriers they face when attempting to access care. Manchester has the fourth-highest rate of infant mortality in England (6.4 per 1,000 compared to 3.9 per 1,000 for England in 2015–17).

Almost 250,000 children are living in poverty in Greater Manchester (GM), which equates to around one in three (GMPA 2024). It is Manchester itself that has the highest level of child poverty at 44.7%, with Oldham following closely behind on 43.6%. These figures compare with the UK wide figure of 29%. Oldham had the biggest increase in child poverty in GM between 2014-2022, with a percentage point rise of 11.1%.

The Poverty Proofing© ethos

No activity or planned activity should identify, exclude, treat differently or make assumptions about those whose household income or resources are lower than others.

Poverty Proofing© principles

Voice

The voice of those affected by poverty is central to understanding and overcoming the barriers that they face.

Place

We recognise that poverty impacts places differently, and so understanding place is vital in our response. Organisationally, we also need to be clear about why and how decisions are made. This understanding of context is essential.

Structural Inequalities

The root causes of poverty are structural. What structural changes can we make at an organisational level to eliminate the barriers that those in poverty may face?

The Poverty Proofing© process

STAGE 1: Training and consultation with staff

Six three-hour training sessions were delivered. These sessions were offered to staff and stakeholders in both Oldham and North Manchester and a total of 59 people attended.

STAGE 2: Scoping

Time was spent gathering information about the different settings and how they work. This stage included conversations to learn from front line staff and management, observing interactions and reviewing key areas including websites and communications.

STAGE 3: Patient and community consultations

We spoke to 154 people in total. This included 118 people in various hospitals and clinics and 36 people in different community venues.

STAGE 4: Feedback session and report

A feedback session to representatives from GMPA was held at the end of January 2024, in which we discussed our findings and opened up the opportunity for discussion around the key themes. We then produced this final report.

STAGE 5: Review

Around 9 months after completion, CNE will return and conduct a review: identifying impact, good practice and potential considerations moving forward.

Common Themes

The next sections of this report highlight the most common themes to emerge from the Poverty Proofing© consultations. These themes are presented alphabetically and do not reflect any kind of hierarchy of importance.

Communication

Health related costs

Navigating & negotiating appointments

Patient empowerment

Staff awareness & guidance

Travel

For each of these themes, the report covers:

- **What works** – what is happening now to support those experiencing poverty
- **The barriers and challenges** – faced by those experiencing poverty
- **Recommendations** – each recommendation comes with a set of considerations for 'poverty proofing©' the service

Communication

In this theme, we explored:

- Digital inclusion (access to devices, connectivity and skills needed to engage)
- Language and cultural support
- Readability of materials
- Record keeping and communication preferences
- Ability to contact the service
- Available communication channels
- Awareness of service offerings

Communication is important to consider in Poverty Proofing© both from a health literacy perspective of how information is communicated and understood and in ensuring there are reciprocal lines of communication between services and service users. [O'Dowd (2020)] reported that availability of care was a particular concern for those on a low income and there were significant inequalities in care availability for the most deprived areas. Communication is a key factor in ensuring availability of care.

What works

For those people with English as a second language, and for those who speak and understand no English at all interpreter services were being used. We heard from people who told us they could access an interpreter on the phone when they arrived for their appointment and that this worked really well for them.

For some women it was easy for them to contact their midwife with any questions or concerns they had as they had been given a mobile number they could ring. Others explained that they felt reassured that they could attend triage if they were worried. Having these open channels of communication was important for people.

Women spoke positively about the convenience of the digital apps, MyMFT and Badgernet, especially in relation to receiving appointments. They said having appointments pop up on their phone made sure they didn't miss appointments and it took the pressure off remembering to bring letters or appointment cards with them.

The barriers and challenges

Language and cultural barriers

There were issues very specifically for those people who rely on interpreters and whose first language is not English. Whilst having access to interpreters was helpful for some families, there was a feeling amongst some staff that there are not enough interpreters available and that the costs are prohibitive. Staff also fed back that interpreters can often not turn up, with no prior warning given or alternative arrangements made.

"My BSL interpreter sometimes doesn't turn up, but nobody tells me about this in advance, so I just have to go ahead with the appointment without that support."

Language barriers can mean people are unable to make informed decisions about their care and can also incur extra costs as described by this staff member;

"There was a woman who didn't have her HC2 certificate on her at the pharmacy, so they wouldn't give her the free prescription. The woman didn't actually understand what the HC2 certificate was for or what it meant."

"Many don't understand information they're given so can't make informed choices. They end up not accessing appointments."

Staff described how the use of male interpreters within certain communities can also be a barrier. For example in Asian communities there are times when the interpreter is known to the family and the woman will not disclose anything for fear it will get back to her husband.

Staff explained that telephone interpretation is preferable to in-person as it retains anonymity for the pregnant woman, giving her more opportunity to open up about financial and or other concerns, which in turn allows the midwife to ensure that she gets the help she needs.

A specialist midwife spoke about the difficulty for midwives trying to engage with the Roma/Gypsy community, due to issues of trust and feelings of discrimination from all services, especially those with a link to social care – they fear the risk their children will be taken away.

Readability of materials and verbal communication

Given the diversity of languages spoken in GM, very little of the information displayed in waiting rooms was available in any language other than English. We noted welcome signs in many different languages around the entrance to the building but then this doesn't continue into the building itself.

A representative of the interpreter team explained that, *"Some Urdu-speaking doctors are not using interpreters, yet are not using the correct terminology to explain things. Some words in health don't have a meaning in different languages and we need to educate women in a way that they understand, for example 'Cervix' can be explained as 'the opening of the womb' instead of using the word Cervix."*

Available communication channels

Despite the easy access some woman had to their midwife, others spoke of their frustration with communication leading to unnecessary journeys or having important bookings being delayed or screenings being missed. We heard from women who'd been told to *'ring next time before coming'* for their appointment, which is a barrier especially when you don't have a phone or the data to make the call.

"I was told to come early today for a whooping cough vaccine, but then got told on arrival that they don't do that on Tuesdays, so now I'm going to have to go to the doctors for it."

"I needed a code from the midwife but I couldn't get in touch. Turns out I could have done it all online, but no-one told me. I ended up being 14 weeks when I got my appointment so was too late for screening. My 20 week scan was late too – 22 weeks. Communication is a problem."

"I went for another vaccination but when you're pregnant you don't want to be walking up and down, then the lady goes, "Sorry, the lady who usually does it isn't here today. Sorry but next time ring before you come."

Digital apps – MyMFT (North Manchester) and Badgernet (Oldham)

There were mixed responses about the use of digital apps. Some women explained that they loved them because they could see everything in one place and they found it easy to understand. Whilst others said they could not see their notes from consultations. Whilst some questioned this with their midwife, others just seemed to accept that this was how it was and didn't think to query it. Women felt that the apps were not being updated very quickly and that this may have consequences, because if test results and information are slow to be inputted, then resulting medication or treatment may be delayed.

"It's not updated very quickly, the information and tests results took a long time to get through. The test was done, but because the midwife didn't get to put it on for a week or so, I couldn't get the medication I needed."

People explained about appointments being changed on the app but then not being notified, meaning they incurred costs for unnecessary journeys.

A representative from a local charity described, *"People are not being told about appointments being cancelled, as it doesn't come up as a notification. They would have to go right into their appointment section on the app to find out."*

Some women were able to utilise all the features of the app, whilst others found it really difficult to find the information they needed or understand what the information was telling them because of how it was written. Midwives sometimes ended up trying to coach women on the phone how to navigate the app.

"You don't know where your notes are, it all says the title of each one is the same, it's hard to find what you need. What medication you're on – there was something on the medication because I was wondering why it's there. It was only after a couple of weeks that I figured out I was low in iron. It's put on the app before you've been told. Just a notification to get medication – but nobody contacted me to tell me this information."

The apps are almost exclusively in English. The interface, welcome pages and information sections are all in English. There is an option when Badgernet is first opened to change the language. However, in real terms, as a midwife demonstrated, very few words actually change, whilst the majority of words remain in English. There is an option to send out some

leaflets in different languages, but the choices are limited, and the midwife has to action this otherwise the default is English.

Whilst the introduction of digital apps has created an efficient and effective communication channel for many, others are left digitally and culturally excluded or unable to afford the devices themselves, the required wifi or data costs.

"Because we are now digital, lots of women are struggling with digital access and language. Lots of Asian families are phone sharing. We are trying to work with teams to improve communication."

"Using a partner's email address, there might be domestic violence, he can see where she is with appointments, he has access to her personal information."

"If you don't have a phone, you don't see your appointments, notes, information, test results, anything. Salford hub has internet that people can use – eg Jewish ladies are not allowed internet access on certain days of the week – religious beliefs."

Lack of communication between different systems

Midwives explained that some women will choose to birth in the hospital nearest to where their mothers live. This was quoted as being especially prevalent in Asian communities where for example, the pregnant woman may live in Rochdale but choose to birth in Oldham, or there may be occasions where a woman receives specialist care in one area but sees the midwife in a different area. However, information doesn't necessarily transfer between the two areas, e.g. a woman receiving midwifery care in Wigan, where paper notes are still used, but receiving diabetes care in North Manchester, where they use MyMFT app – they don't have access to each other's notes, nor do they update records on each other's systems, leading to incomplete updates and knowledge of the woman's medical condition, and important safeguarding information is potentially missed.

"I see the midwife in Wigan, we live there – I've seen about three different ones. You end up explaining the same things over again. They don't know about my condition, I have to tell them everything. I come to North Manchester for the diabetes care, I've been coming for the last 10 years, this is my third pregnancy. But I've been told that I have to see the midwife in Wigan, because I don't live in the North Manchester area. But the problem is that there's a complete lack of communication between the two areas. I have the MyMFT app for my diabetes care, but they don't update my paper notes for Wigan, so my midwife in Wigan tells me 'they're useless and don't tell her anything.' They don't have access to all the information from North Manchester. They're on two completely different systems."

This failure of systems to communicate with each other relies on self-advocacy and puts the burden of responsibility onto the woman to articulate the details of her medical care and needs.

In North Manchester the issue was highlighted that their digital app is known by four different names, which consequently causes a lot of confusion for women when trying to

initially register for the app. The system is called Epic, MFT call it HIVE, when women look in the app store they need to look for My Chart, and the letter they get tells them to sign up with MyMFT.

A sign-up text message is received but then there's no further help or instruction to navigate the app. We heard how this was confusing and off-putting, more so for those whose first language was not English.

Recommendations for communication

Barrier	Recommendations and things to consider
Appropriate access to interpreters	• Where possible, allow women the choice of having a face-to-face interpreter present or an interpreter on the telephone. This preference could be logged from the beginning of her journey. • There needs to be mutual accountability between the hospital and the interpreter service, to ensure that women are informed in advance of their appointment if the interpreter will not be present. Where possible, a replacement interpreter should be provided or the woman needs to be offered the opportunity of rearranging her appointment.
Readability of materials for those whose first language is not English	• Have welcome signs in different languages to create a sense of belonging and to make everyone feel welcome. • Helpful maternity information displayed in waiting rooms should ideally be available in other languages. Investigate if this can be achieved.
Lack of information displayed in waiting areas	• The time families spend in waiting areas could be better utilised by displaying useful information posters for them to browse. This could include not only medical and care information, but also information about financial support and wellbeing relevant to maternity – e.g. Statutory Maternity Pay, prescription and dental exemptions, Healthy Start Scheme, Sure Start grant, etc.
Ineffective communication	• Remove the need for women to 'ring up and check', before attending their appointment. • Ensure women are informed of any changes to appointments in advance rather than when they turn up. • Consider sending text messages out to everyone in advance if, for example, a particular service won't be happening that day due to staff absence. This would prevent women making unnecessary journeys.

Issues with the digital apps, Badgernet and MyMFT	• Develop a process that ensures all women have access to their notes and test results in a timely manner. Ensure the relevant staff know how to do this and provide training if necessary. • Investigate why notifications are not always getting to women to inform them of any changes to appointments, e.g. is it a training need/human error or IT/system error? • Offer women some basic training in navigating and using the digital app, to ensure better engagement with it. This could be provided by people external to the medical staff. • Investigate fully the language capabilities of the apps, in order to improve access for as many women and families as possible. • In North Manchester, agree on and ensure all staff use the same name e.g. 'MyMFT' when referring to the app. Any written or verbal instructions given for signing up to the app should explicitly state that they need to look for 'My Chart' in the app store. Avoid using any other names for this system in front of patients, to avoid confusion.
Access to devices	• If a woman is using the digital app to access her maternity care, consider the implications if she is on a shared email address and shared device and if other methods of communication might be safer. • If digital access is not possible or safe for a woman, then what is the alternative? It would be useful to be clear about what this would be, and to be able to implement alternatives. • Investigate links with local charities/businesses who might be able to provide women in need with refurbished phones and free data for the duration of their pregnancy. This has worked successfully in other areas.
Joined up communication across Trusts	• When women are making decisions about where to give birth, ensure they are informed about potential communication difficulties across different trusts and what the impact of this might be for their care. • Investigate whether this can be more joined up.

Health related costs

In this theme, we explored:

- Maternity exemptions (prescriptions, dental costs)
- Maternity benefits (Healthy Start Scheme)
- Additional costs

Having a baby has a lot of associated costs; such as cots, prams, clothes, nappies, wipes, formula and baby food. Many families will experience a drop in income for the duration of maternity and paternity leave and this can be stressful financially. There are hidden and additional costs of attending medical appointments for scans and to see midwives and consultants for the whole of pregnancy. There are exemptions and benefits available to help people, but as discussed in this section, many are going unclaimed because of complicated processes and a lack of awareness and clear advice.

What works

There is successful work going on in North Manchester to improve the uptake of Healthy Start Vouchers (HSV), which involved setting up a Greater Manchester Healthy Task Force Group. This is a whole systems approach to increase the Healthy Start uptake. There are now 14 Healthy Start Champions in North Manchester. Healthy Start vouchers are advertised on posters, put in Children's Centres, on the back of toilet doors, etc. The 'business cards' can also be given out in community settings. The Healthy Start Scheme 'is a kind of nutritional safety net.' There is lots going on around upskilling the staff in Sure Start centres, educating them to understand the barriers faced by those in poverty and learning how to help them. Whilst there is slower uptake in diverse areas such as Cheetham Hill, where lots of residents have English as an additional language, some areas are now at 100% uptake for HSV.

The barriers and challenges

Discrepancies exist around what women are told and have access to in relation to free prescriptions and dental care.

Many staff were under the impression that everyone gets the free prescription form (FW8) at their booking appointment. However, we found this not to be the case and the reality on the ground did not match this impression. Across the Poverty Proofing© consultations with women at all stages of pregnancy, the issue of not receiving free prescriptions was one of the most common themes. Many women did receive this form at booking, but some were seemingly made to wait until after their first scan, usually around 12 weeks, as if to provide the 'proof' of pregnancy, which meant an extra journey then to see the midwife, at

unnecessary additional cost, and it also created delays in being able to get prescriptions free of charge.

Some women had not been given any information about free prescriptions and dental care, despite being several months into their first pregnancy or in some cases, even being pregnant with their 3rd or 4th child. One lady, who was having her 4th baby, was not aware of free prescriptions. This was despite all of her children being born in Rochdale. At the time of the conversation, she was also in need of emergency dental care, but again, free dental care was not something she was aware of being eligible for.

"I only knew because in the pharmacy they told me that I can get free prescriptions. I paid a few times because I didn't know, when it was not obvious."

"Every time I'm pregnant I get pain in my teeth. I didn't know that I could get free dental care. I haven't got a dentist." (a woman pregnant with 3rd child)

There have been women receiving £100 fines for claiming free prescriptions when pregnant, but not having the certificate to prove it (especially if having to wait until after the 12 week scan). This has caused unnecessary stress to pregnant women and a undue financial penalty.

"I got my exemption certificate from the midwife but had to wait for the certificate to come through, but they didn't tell me not to use it until I got my certificate and I got a fine. I argued my case and I was able to just pay the cost of the prescription."

"I had no certificate, I have penalty debt letters. I have 3 up to now. I have told them I'm expecting. What the NHS said is that you need to get the certificate from my midwife. They said you don't need to pay the penalty charges and I will date it back to my appointment. I then received confirmation, but they accepted it from the date it was sent. My partner said we will still receive debt letters. I've had another 2 since, I've had low iron so I started to have to get prescriptions and acid reflux so I need other prescriptions. No certificate in place that's why penalty charges, the midwife made a mistake and forgot to give the form. The prescription itself is £9.90 then penalty charges if you don't pay it by this date you will get charged £100. When I found out I was pregnant I told my GP right away then first scan, during that time you should be made aware of certificates and things like that. Whether it's the scan or community midwife it should be about what you should know about. But when you attend you have a scan, it's beautiful, but it's just basic information they don't mention anything financially. One thing a pregnant woman doesn't want is penalty charges, I just think it's unacceptable. We have to have stress about proving that I was expecting. All I'm planning is having a child, but all these debt letters – it panics me. It can make someone depressed. I'm very lucky with my partner, he helps me every month, we're really good together. I'm really worried that another one [debt letter] is gonna come."

There were occasions where women had been given the FW8 paper form, but then had to provide their own envelope and stamp to send it off. One midwife explained that in the past, she would have given the woman the FW8 form along with a prepaid envelope to send it off. However, she said that recently staff have only been given the forms themselves

(ie not the envelopes) to give to the women. Whilst the cost of an envelope and stamp may seem quite insignificant for many, for a person struggling with the effects of poverty, it's another barrier, an extra hoop to jump through.

We were accompanied by a specialist midwife for community engagement when carrying out Poverty Proofing© consultations in hospitals and clinics in Oldham and Rochdale. During this time, if we came across a woman who didn't have the exemption certificate, this midwife was able to access a digital version of the certificate there and then. This could be used immediately and it took around 90 seconds to fill in the digital form. This really highlighted a possible solution and way to avoid unfair and unnecessary cost and stress.

Lack of Information around Healthy Start Vouchers (HSV) and free vitamins

Despite the successful work around HSV in North Manchester, as with free prescriptions, we found there seemed to be a lack of knowledge around HSV from women consulted. Some reported not having been given any information about HSV, or were buying vitamins themselves, unaware that they may be entitled to free ones. Staff described that on Badgernet there is a tick list within the app to tick if the woman has been told about HSV, but that it's not a mandatory tick list so not everyone does it.

"HSV – I was never told. Anything we have heard about is from friends, family, colleagues, not from the maternity service."

"I applied for HSV about 2/3 months ago but I was unsuccessful. They said my income on Universal Credit (UC) was too high, I was dead confused about it. I've applied for it again today with {the midwife for community engagement} and have been successful. Applied today for prescriptions too. The midwife didn't say anything about this."

Sometimes women struggle to get signed up to HSV due to the personal information they input not matching the information on the DWP database, so they then think they are not eligible to apply. This creates a need to reapply, which is very off-putting, especially for women whose first language is not English and it creates long delays to receiving entitlements.

Staff said, *"It's common for DWP to misspell a person's name, which then doesn't match up – causes delays in receiving support."*

Recommendations for health related costs

Barrier	Recommendations and things to consider
Not everyone is aware of free prescriptions and dental care	• Make uniform the point at which everyone receives their exemption certificate. • Doing this at the first appointment rather than after the scan seems the most timely. • Explore universally and routinely completing the digital exemption form with women at the first appointment

	as a way of poverty proofing the current barriers to accessing this. At the very least make sure women are universally and routinely informed. • For those women applying for the paper format of the FW8 certificate, they should be told explicitly by the midwife not to claim free prescriptions until the certificate arrives, or they will be fined £100. Instead, they should keep any receipts and claim these back retrospectively, on receipt of the certificate.
Lack of information around the Healthy Start Scheme and free vitamins	• Consider replicating the successful work being done on HSV in North Manchester across GM? • Again, make it a universal and routine part of the booking appointment to inform all women about HSV and free vitamins. • Utilise Badgernet as a way of prompting and explore the possibility of a midwife enquiring there and then into whether the woman is eligible to claim.

Navigating and negotiating appointments

In this theme, we explored:

- Flexibility of appointments
- System and process of booking
- Hidden costs of appointments
- Knowledge on how to navigate the system

Life can be particularly unpredictable when living on a low income. The challenges, for example around childcare or zero hours' contracts can make attending appointments very difficult. Pressures on the NHS around waiting times and stretched services can mean there is little scope for flexibility and strict discharge policies are applied for those who miss appointments, effectively severing access for those with changeable circumstances. Furthermore, social problems often accompany poverty, and sometimes life can be chaotic, which makes consistent appointment attendance difficult. Availability and flexibility of care are important for improving access to health care for those on a low income. The King's Fund (2021) report states that, "services need to be flexible, accessible, responsive and offer continuity of care."

What works

Families expressed satisfaction with the ease of the digital app in providing them with appointment times. Others spoke positively and appreciatively about making appointments directly with the midwife, or by speaking to a member of staff on the reception desk. Some clinics/hospitals were clearly flexible and gave a range of times to choose from, which people really appreciated.

"It's pretty easy to book appointments, I called last week on Monday to complain and right away I got one."

"I get to choose my appointment times. She'll (the midwife) get her diary out and give times to choose from. This works well for me getting time off work."

Many staff were incredibly passionate about wanting to help people and would be flexible in the way they worked in order to achieve this. Being able to accommodate people's needs when arranging appointments was an area in which many staff would try their best to be flexible and accommodating. However, the NHS was described by one staff member as, *"system-centred and process-driven, with rigid systems, meaning the system won't let us be flexible and provide that help."*

The barriers and challenges

As well as the positive comments relating to appointments, overall there were very mixed responses when people were asked about appointment flexibility. Many explained that they were simply given a time and venue to attend, with no real option to change it.

A woman and her husband explained, *"My husband takes half a day's leave to bring me to appointments so that's half a day's pay lost. I'm 29 weeks and he's taken off three half days so far. We both get Fridays off work so we try to arrange appointments for Fridays, but that's not always possible."*

Inflexible appointments have clear consequences for people juggling childcare arrangements. Some families explained how challenging it was to attend their appointment at the allotted time, whereas a little bit of flexibility would make things significantly easier and cheaper.

The example below highlights the extra cost incurred in needing to get a taxi after her appointment, her reliance on family members to look after her children and take her home, and the stress she said all of this created. Families without a support network, who are unable to afford childcare, are in a very difficult position.

"I come here every two weeks. I think about childcare, who'll pick my kids up? Now my husband picks the kids up from two different schools, takes them to my sister's house, then goes to work. I then have to get a taxi from here {hospital} to my sister's, and wait around until my brother in law gets back from work and then he takes us home."

One staff member felt that, *"Everyone should do training on poverty proofing, especially frontline staff. If they knew how difficult it was just to get out of the door with three kids, on a low income and on public transport, they wouldn't turn someone away who is 10 minutes late for an appointment."*

In some cases, appointments could be more thoughtfully coordinated to mitigate against costs. For example, a woman had to come for extra scans because she smokes, then was expected to see a community midwife in between – *"This was too many journeys,"* according to one midwife. There were also occasions when women were expected to attend two different appointments on the same day, and one woman received two appointments for the same timeslot but in different locations.

This member of staff told us that "*they will always choose the scan rather than the midwife appointment, so they will DNA the midwife appointment, because they're expected to attend too many."* This has implications in terms of cost for the NHS, but also means that women miss important medical and personal care.

A husband explained, *"Once they booked her in two different appointments in two different hospitals, one was 8 o'clock and one was 8.20, one in Rochdale and one in Oldham. Because it's a multiple pregnancy they want you to see the right people, but you can't be in two places at once. It was on me to sort it out, it's all just additional time that you don't need. The appointment comes up on the Badger app, you think it would come up. We waited three hours for a scan because they 'missed her off the list'."*

People in waiting rooms didn't know how long their appointment would take, but it was very common for people attending the hospital/clinic to be kept waiting around for a period of at least 2-3 hours per visit. The delay appeared to be not so much for the scans, but rather for waiting to see the consultant. One person described them as *"insane wait times."* This would impact on car parking charges, time away from work, childcare arrangements and potentially require the need to get something to eat and/or drink, at cost to the patient. While people had a general acceptance of lengthy wait times, services would benefit from better understanding the significant consequences of these long wait times, especially for those people already struggling financially.

"I'm under specialist care so come every few weeks. I need time off work, but that's ok, I'm a teacher and my employer's fine about it. But we don't know how long we're going to be here – yesterday we waited two hours past our time. People who get paid hourly would find this hard."

"The appointment times are just a rough guide. My appointment for the scan was 20 minutes behind, but we both work, we're both taking time off work to be here. Last time we thought about not coming because of the waiting time. It was in Rochdale that we waited for 3 hours, it's also the attitude of the staff."

Children were not allowed to attend appointments with their parents. This appeared to be a rule that many women felt wasn't made very clear. The result of this was that women turned up with their children, only to be told when they arrived that they were not allowed in. This was a barrier for anyone who didn't have someone they could rely on to look after their children while they attended their appointment. Secondly, however, if it is a necessary ruling that can't be avoided, then it could be advertised clearly, so that everyone is aware.

"Baby's not allowed in the room with scans and stuff and she's not been told. It's not highlighted that children are not allowed in, which makes it difficult because they need to find childcare. We don't have a lot of family to leave her with. I've taken the day off to come with her [mum of pregnant lady]. It still means I've taken one of my holidays."

We heard from a member of staff in a vaccination clinic who explained that DNA (did not attend) numbers were high at a cost of £100 to the NHS per missed appointment. An example was given on a Sunday clinic where there were 55 DNAs out of 199 booked appointments at the vaccination clinic.

"It's only a 5-minute appointment, but people still have to travel, pay for parking, and arrive by a given time. We should do it as a drop-in instead."

Recommendations for navigating and negotiating appointments

Barrier	Recommendations and things to consider
Inflexibility of appointments	• Try to maximise the opportunity for patients to choose their own time slot. Consider whether a 'Choose and

	Book' system could be implemented, with the option of online and telephone appointment booking. • Make patients aware they are able to change their appointment if necessary and give clear guidance on how to do this. • Consider how patients in poverty are able to change their given appointment time if they have no access to the internet or online portal. • Investigate the possibility of having drop-in sessions for vaccinations, rather than fixed appointments. • Having the time flexibility of a 'drop in' makes it much easier to attend for those people using public transport. • Explore whether appointments and financial welfare advice services can be 'clustered' together around the scan as this seems like a good opportunity when there are high levels of engagement.
Lack of co-ordination around appointments	• When two appointments are needed on the same day or consecutive days, can they be clustered together into one, to minimise journeys required, if this is more convenient for the patient?
Long waiting times at appointments	• Explore the process of organising appointments, especially where it involves a scan **and** consultant consultation. How can the waiting time in between be kept to a minimum? • Communicate expected appointment length in advance and have measures in place for if they overrun, such as food, drinks, snacks or vouchers.
Children not allowed to attend appointments	• If this rule is essential, ensure that it is clearly communicated to women from the outset, both verbally and written. Can there be any flexibility, under particular circumstances? Perhaps a special arrangement can be made for women who otherwise won't be able to attend the appointment? • Investigate whether crèche facilities can be made available.

Patient empowerment

In this theme, we explored:

- Welcome and inclusion
- Relationship building (continuity of care)
- Participation and perceptions of pregnant women and new parents
- External support
- Health literacy (patient comprehension and self-advocacy)
- Person centred care and support

Being in poverty can be hugely disempowering and contribute to reduced literacy skills (Literacy Trust, 2012), lower educational attainment, lower levels of confidence and less engagement with health behaviours and healthcare (Sheehy-Skeffington & Rea, 2017). Services can support this by tailoring support to different education and literacy levels, working alongside pregnant women and new families to build health literacy and confidence in managing their health as independently as possible and ensuring there are opportunities to share their views and shape services.

What works

There are fantastic organisations that exist, who are committed to supporting people, e.g. one charity spoken to ensures that dads are given a voice, a purpose, and are supported in the maternity journey.

People relayed some great examples of friendly, welcoming reception staff, who go above and beyond in order to be approachable and kind to everyone who comes in. This has such a hugely positive effect on people in helping them feel at ease and that they belong.

"The guy on the desk is fab, very hard working, always smiling."

Many women have spoken very positively about the care they have received from their midwife. Women seemed to particularly appreciate it if they had the same midwife for the duration of their pregnancy, as this allowed them to forge a meaningful, trusting relationship with them, and meant they didn't have to keep repeating the same information over and over to each new midwife (information which could be traumatic to relive and difficult to talk about.)

"I see the same midwife, it's good because I don't have to keep going over the same stuff about my anxiety and depression."

The barriers and challenges

Staff and women from different ethnically marginalised communities have described the fear that can exist for women when being asked questions within maternity, whether this is by midwives, Health Visitors, etc.

"From the professional side, there are questions to ask, but there needs to be clarity. The midwife needs to make it clear that all the questions she's asking me are to make sure I'm safe, not to get me into trouble. When you're not in the system yet, you think it's all a trap to get you deported. There's a need to make it really clear why the midwife is asking me all these questions."

Similarly, a woman from a focus group explained how, *"A Hungarian woman has been told again and again that she'll need to pay for her care. Instead, they should be talking with her about how they can spread out the payments to make sure she isn't faced with a big bill at the end. Have a compassionate approach in helping her deal with it. It's about us supporting people."*

Pregnancy and employment

Some people have left their employment when pregnant, having not known whether or not they were entitled to any financial support. Sometimes there was a fear attached to the decision to leave work, of not wanting to rock the boat, especially for those people on visas; while others described feeling intimidated into leaving.

"I worked at a care home and as a cleaner. I came to the end of my contract at the cleaners. They were really good, fine about appointments. I continued working at the care home but they would ring me up to work even when I had an appointment, so I stopped working because it was too stressful."

"I finished work, I told my agency I was sick and I quit. I have been told by my friends that I might have been able to claim sick pay, but I'm scared to get into trouble. My husband is a doctor. I didn't want sickness to mess with my residency."

The burden of responsibility often lies with the individual and not the employer to help support and navigate maternity and paternity pay rights and entitlements. This leaves people open to possible workplace dishonesty, corruption and misinformation, and means people may not receive what they are entitled to nor at the appropriate time.

"At the point of finding out I was pregnant I had no help, there needs to be something in place on next steps, I can't apply for MAT leave until 26 weeks, employers should know, I only work 10hrs part time and I'm already on UC. My work cut my hours down when they found out I was pregnant so they wouldn't have to pay it but a girl I work with worked it out for me and I went back with the evidence off the Gov. website."

"I've not had much information, just asked a friend who's had paternity pay. I work at the DWP. At Natwest bank I'd have got 6 months' full pay. They also give 9 months' full pay for maternity pay. I'm going to request I can build up my holiday entitlement and take a month after baby's born."

"Never really discussed financial support – would've been really good to know. For things like childcare, only learned about it through friends or word of mouth."

"I've applied for maternity allowance but still waiting to hear. I found out on Google. It's been me who's proactive with work, giving them forms, etc. asking friends of friends, etc."

Some people described the financial impact of moving on to SMP, where they will experience a massive drop in earnings as the maternity leave progresses, leaving them struggling to make ends meet. A small handful of others have expressed how much better it was that their employer spread the payments evenly over the duration of maternity leave, making it much easier to budget.

"I am in a privileged position in that I am on a good salary and so is my husband, but we will face a massive drop in income when I go on SMP. When I worked for the NHS this was averaged out across the whole period, now at the university it's not and I face this drop."

While some people have said that their employer carried out a risk assessment for them at work, others have said that this was either not done correctly or not done at all. One woman explained how she started feeling sick at work, to the extent that she needed to stay at home, was not given any information from anyone around rights at work and was then dismissed for failing to turn up to work.

"I work in a bar. They did a risk assessment but just filled it in themselves basically. The midwife here has just advised me to email them and tell them that I've been advised by the midwife to redo the risk assessment."

There was evident inequality around access to information and work-related benefits, dependent upon whether the person was in self-employment, zero hours' contracts, precarious contracting versus those in employment where there's HR, leave, flexitime, and official policies and procedures. What also became apparent was how dads in particular were less likely to access their paternity rights and were often afraid to ask about it due to fear of repercussions from their employers, especially in more fleeting, short-term, working class, low-skilled labour and manual professions.

A representative from a charity explained, *"Some dads ask us where to get financial support, but we signpost them to the local authority. Before birth, men worry about money. After birth, they worry about missing baby's life by working. Lots of working dads won't look into what they can get – stigma, failure. Self-employed and zero hours' contracts – just take what they can. There's nothing for self-employed. It's a different conversation for mums and dads. Mums get told what they're entitled to. This information needs to reach every dad too, needs to be through the maternity system, not through us. There needs to be education for employers. Businesses will give as little as they can. There is a lack of information – nobody knows exactly what's available. What would good look like? – a*

leaflet of what's available, rights from employer, etc. By law, dads are entitled to go to two scans. Some information gets sent out to dads, but it can get lost in a pack. It needs to be given directly. Hospitals are the best place – 96% turn up to appointments."

Other benefits

There was a lack of knowledge and understanding around benefits such as Universal Credit (UC), especially for people who had never claimed benefits before. In these situations, people might have only found out what they were entitled to if they had family, friends or colleagues who happened to mention it. An example of this was one new mother who went back to work part-time after 9 months' maternity pay. She didn't know that she was entitled to claim Universal Credit, until a friend told her. Consequently, she missed out on several months' worth of payments. *"If there were SureStart baby groups, I could have found out from them."*

"I split with my partner during pregnancy and went on UC – I had no help with this other than a friend who happened to know what to do."

"I split up from my husband after my first child and it was only when my cousin, who was going through the same thing, told me I could apply for UC that I even looked into it. I'd checked all the calculators online and it said I couldn't make a claim but I thought I might as well try. I had no idea I could claim UC when on maternity leave but it topped me up and this was a massive help. Unfortunately, I had waited a while and used my credit cards, if I'd have known sooner it would have made a massive difference to me."

Recommendations for patient empowerment

Barrier	Recommendations and things to consider
Cultural misunderstanding and fear	• Make clear **why** certain questions are being asked – i.e. to support them and make sure they are safe. Build trust and provide reassurance. • Work with VCSE networks to establish community links who can then liaise with the maternity service on the needs of the community. • Establish patient participation groups to improve communication and give more opportunity to share patient voice. • Pregnancy Circles – a pilot model of care in Oldham, aimed at empowering pregnant women and enabling them to create bonds with others. It works in a group format, with women developing the skills to take some responsibility for aspects of their own care, such as taking their own blood pressure. Consider models of care like this and how they can be extended across different GM boroughs, with a view to empowering

	more women and relieving the time pressures on midwives.
Pregnant women and dads struggling with employment rights and benefits	• Empower pregnant people by referring them to **Maternity Action**, Home - Maternity Action a charity who can inform them of their rights and support them with their employer. • Look at the influencing role of GMPA and whether this can be a campaigning / policy issue. • By opening up financial discussions with everyone early on, people will be far more aware of their rights when negotiating with their employer later in the pregnancy. • Take into consideration dads, raise awareness of their needs and where they can go for support. • Promote financial support services in waiting rooms by displaying information.
Pregnant people relying on advice from friends, family and colleagues	• Explore ways of making sure pregnant people have access to correct advice from reliable sources. • Again, opening up those financial conversations directly and intentionally with everyone from the outset, equips people with the information they need to navigate this tricky area and lets them know who to turn to if they need further support. • Display information about financial support services in waiting rooms to remind people about where to go for help. Can this be displayed in different languages? Investigate how this could be achieved.

Staff awareness and guidance

In this theme, we explored:

- Unconscious bias, stigmatising language and behaviours
- Awareness of financial circumstances and patient barriers
- Diversity and inclusion, relatable to poverty
- Staff knowledge of support available
- Inverse care law (lower levels of support in low income areas)

Research has shown that those living in England's most deprived areas tend to receive the worst quality healthcare, for example with longer waits and worse experiences accessing appointments. Quality of care was worse in the most deprived areas for all of the 23 indicators analysed and in 11/23 indicators, the inequality gap was widening (O'Dowd, 2020). Pregnant women and new parents will have different needs depending on individual, demographic, systemic and social needs and countless other factors. This theme is around identifying the social and economic needs of our pregnant and new families and giving holistic care so that they can be fully supported.

What works

Maternity services benefit from specialist midwives, called ROMES (Rochdale and Oldham specialist midwives). They work with the most vulnerable women and can provide them with cots and other important items if they don't have access to them. All appointments are done at the woman's home with the ROMES, which means they have a far greater understanding of the woman's circumstances and can provide very tailored, specialist care, working alongside other specialist support in areas such as housing. The ROMES develop good relationships with charities across Oldham, Rochdale and Tameside, enabling them to have access to necessary items and equipment.

Some local charities offer invaluable services to pregnant women and new families. They often have a strong presence in waiting rooms and family hubs, where they can discuss with families the compassionate, confidential support they can offer, including early learning, breastfeeding and perinatal support, and parent-infant mental health.

The barriers and challenges

The service from ROMES midwives was held up in Poverty Proofing© training sessions as good practice for how it works within financial disadvantage and deprivation. This was held up in contrast to 'traditional' midwife services where these women (not classed as vulnerable) were highlighted as being underserved when it came to financial and welfare help and support.

"We don't do this piece of work (i.e. specialist care as provided by ROMES) with our 'traditional women,' it's only if they tell us. This group may go under the radar, if they don't say or ask there is an assumption that women will be able to afford what they need."

"Some staff rely on the woman to ask if she needs help, otherwise they'll assume all is well. No one, when she comes into hospital, should not be thinking 'what's she going home to?' – those wider determinants are missed."

"Because I'm not British, I have only been here two years ago on a spouse visa, I'm not aware of entitlements – to be fair I've not really asked."

"We ask if they have secure housing, we don't ask too much about finances. If it's not there on the questions, then it's down to the individual."

'Being overstretched' along with 'not feeling equipped with the expertise or confidence' were given as possible reasons as to why 'traditional' midwives don't go in depth into areas linking to financial support.

Another reason was about staffing numbers and how it was felt this contributed to levels of support midwives were able to give and how this could look different if commissioning of staffing resource was linked to deprivation or need:

"For example, you might look at two areas, North Manchester is all food banks and deprivation and somewhere like Withenshawe is more affluent. There is a huge difference in need, but all they ever say is 'you have the same levels of staffing.' But the need is not the same."

From the women's perspective, they said generally that financial well-being aspects had not been mentioned to them and that they had not been asked directly by their midwife or any other health professional about this. There was a feeling as described by these women of 'just being left to get on with it.'

"She never really discussed financial support – it would've been really good to know. For things like childcare, I only learned about it through friends or word of mouth."

"Finances were not really ever discussed. Just had to do it all myself. Would've made things easier if asked, I would have a better understanding."

There were mixed responses when asking how people would feel about being asked financial related questions. A few said they would feel judged, whilst the majority said they'd find it really beneficial, especially if it was their first baby.

It was the belief of this professional that it should be the responsibility of the midwife to have a holistic approach (i.e. not just medical) to every woman's care. *"It's not about 'my lady.' As a midwife, I have a responsibility to look after any woman who is standing in front of me, it's not about her being 'mine.' You can be asking those questions (e.g. finances, housing) while you're taking her blood pressure, etc. If her blood pressure is up, then you ask 'why is that?' We should be asking where she's going home to. Instead, we have a woman 2 days' post-section being discharged to a hotel. How can that be safe?"*

As part of this work, it was possible to see that Badgernet (uncertain about MyMFT) does have specific questions contained within the form relating to finances. Halfway down the 77-page form, in the 'Other Issues' section, are two boxes specific to 'financial difficulties' and 'housing problems' with yes/no boxes to tick and space for the midwife to write details in the box. There are two further sections, both near the end of the form, which relate to financial wellbeing and support. The first of these, in the 'Topics Discussed' section is a 'Work and Benefits' question, where the midwife can tick whether they have discussed these topics with the woman: Parent's guide to money pack, Employment Rights and Maternity Benefits. Finally, on p.72, is the tick box list to show which of the following have been discussed: Qualifies for Healthy Start Vouchers, Referral to income maximisation services, Money and debt advice services, Financial capability support.

Recommendations for staff awareness and guidance

Barrier	Recommendations and things to consider
Women not routinely asked about any financial wellbeing or welfare aspects	• Make asking all women about their financial situation a universal and routine part of their maternity care. • Include discussions about employment rights and maternity benefits, Healthy Start Vouchers, and if necessary referral to income maximisation services, money and debt advice services and financial capability support. • All of these are explicitly included in the Badgernet booking form. • Carry out further work to ascertain is this is the same for MFT.
Expectation is on the woman to ask for help	• Many people in poverty will never ask for help – stigma, not wanting anyone to think they can't manage. • Opening up the conversation directly and intentionally with **everyone** as part of their care, will help overcome

	the stigma and ensure that women get the financial support they need.
Midwives skills, capacity and resource on asking financial wellbeing questions	• Carry out further work to ascertain whether it is practicable for midwives to do this work and what are the barriers behind not asking – some examples have been highlighted in this report but it would benefit from further work. • Possible solutions might include: • Revising or reducing format of Badgernet to promote the importance of financial wellbeing questions being asked by moving them near the beginning. • Gathering this information earlier during the booking assessment. • Evaluating the aspects of Badgernet based on how it is used in practice. It needs to work for staff and patients. • If time is tight in the booking assessment to get through everything, can the length of the appointment be extended? • If the midwife focuses on the clinical side, are there other partners who could take care of the financial elements to free up clinical capacity? • Consider commissioning resource in a way that links to need. See work on The Scottish Deep End Project • Roll out Poverty Proofing© training for all staff as a way of raising awareness of the issues and disseminating the findings from this work.
Knowledge around entitlements of refugees and asylum seekers	• This is an area worthy of further exploration and development, given that Manchester has a higher than national average number of refugees and asylum seekers. • Things to consider would be workforce training and development, empowering maternity staff in this subject could help to improve the outcomes of this community of pregnant women. • Maternity Action offer training – see their website.

Travel

In this theme, we explored:

- Upfront travel and parking costs
- Uptake of travel reimbursement scheme
- Accessibility of locations
- Travel guidance available

Healthwatch UK (2019) showed that travel is a key issue for patients, with 9/10 people consulted saying a convenient way of getting to and from health services is important to them, more so than choice over where to be treated and digital access to services. Difficulties with transport were also identified as a common reason that patients will miss appointments. There is a phenomenon known as the poverty premium, where those with less money end up having to pay more for essential items, which further perpetuates the cycle of poverty. For some families, who do not have access to a car, public transport and taxis are more expensive than it would be to drive.

What works

Nothing was specifically raised in this section, relating to effective travel.

The barriers and challenges

Conversations with staff have revealed that because of the way the Hive system contract has been set up, many prescriptions can only be dispensed from the onsite hospital pharmacy. It doesn't allow for collection from local pharmacies. This has an impact on travel expenses and takes extra time to travel. Sometimes a prescription might only give 2 weeks' worth of medication, meaning a journey to the hospital pharmacy every fortnight.

"My medicine, it's a problem to come back. I ask many times to get medication for 28 days but I can never do. Today they have given me medicine, I will see if they can give it for 28 days. I'm just checking the medicine, one is every 28 days, one is 14. I have to come in each time."

"I needed to get my iron checked, so I had a blood test. I was told to come back to the hospital pharmacy another day to collect my prescription, it couldn't be sent out to my local pharmacy."

We heard about how travel on public transport was often difficult, time-consuming and expensive. Only one person out of everybody spoken to had been given any information regarding the NHS Healthcare Travel Costs Scheme (HTCS), and that was from a lady at the Home Office. The majority of staff asked had never heard of it, nor did they know anything about the process for claiming, meaning families are missing out on the chance to claim back travel costs, despite being entitled to do so.

"I have sciatica, sometimes I can't walk, I need to take taxis. I'd rather walk if I could. It would be good if women could get travel costs reimbursed. I have to come to more appointments because of my hypothyroid."

"I have to travel for scans, it's two buses and a 15-minute walk. We get a taxi because it's the same cost as two buses for both of us."

"I came on two buses to get here today. It took about one and a half hours. Last month, I had four appointments here, but this month I've only got two. Nobody has told me about any travel cost scheme."

The HTCS was not advertised, nor was any information about it displayed in any of the waiting rooms visited. Unless a woman happened to know about the scheme already from another source, she would have no way of finding out about the possibility of reclaiming her travel costs.

In the event of a pregnant woman wanting to make a claim, she would have a relatively long walk from maternity into the main building level 2, as forms are only available from the General Office there. This could be particularly challenging for those who are heavily pregnant or those who have another underlying health or mobility condition. Opening hours of the General Office are limited: Mon-Fri 9am-1pm and 2-4pm, with last payments taken by 3.30. This may create difficulties for any woman who wishes to make a claim on the day of her appointment, if her appointment falls outside of these hours. She will need proof of benefits and bus tickets to process her claim.

Through discussions with staff at the Facilities Office, there is no facility available for reduced car parking costs within maternity, despite the frequent attendances and lengthy waiting times. Reduced parking can be given to outpatients who are frequent visitors, but only to those with specific health conditions, such as cancer.

Recommendations for travel

Barrier	Recommendations and things to consider
Prescriptions can only be dispensed from the hospital pharmacy	• Investigate whether this can be changed to allow people to collect their prescription from a pharmacy local to them.
Availability of NHS Healthcare Travel Costs Scheme	• Promote the claiming back of travel expenses. Put up posters around the service to increase awareness. Information on this could also be included in appointment letters or leaflets. • Make all staff aware that the NHS Healthcare Travel Costs Scheme exists. Provide clear information on who can apply and what they are entitled to claim for.

	• Consider having a Healthcare Travel Costs Champion within the team who can talk through the process of applying to the scheme and regularly review the policy which may require updating. • Raise awareness that the scheme also includes 'unavoidable car parking charges', which may help car users. • Ensure that the process for reclaiming travel costs is not stigmatising for people. Consider providing a private space to fill in forms where a person will not be identified as someone who needs to reclaim expenses. • When travel reimbursement is currently based in an alternative location to the clinic, consider having a petty cash tin available in every clinic so claims can be dealt with immediately. • Once someone has claimed travel reimbursement once, consider whether there could be a system to remember this to save making a new claim each time. • The scheme works on a reimbursement basis. Consider the possibility of introducing pre-loaded travel cards or similar for people who may not have the money upfront.
Frequent visits – cost of parking	• Is there any way parking costs can be removed or reduced for the duration of pregnancy? Consider advocating for free parking for patients. This has been successfully adopted on other sites, such as within Tees, Esk and Wear Valley NHS Foundation Trust. • Consider providing parking vouchers for those attending regular appointments in maternity.

Considerations for GMPA: Calls to action

This report has highlighted 24 barriers across 6 poverty-related themes.

Many of the actions outlined here may not be within the gift of GMPA, although they have a key influencing role to play. The interventions would benefit from high-levels of engagement, cooperation and a multi-agency response.

The individuals and organisations involved in the project expressed a genuine interest in learning about the findings from the work, with a view to making real change within their own organisations. This is a really progressive and positive point at which to jump off from and it is recommended the following steps are taken:

1. Reconvene the professionals and stakeholders who attended the initial Poverty Proofing© meeting to disseminate the findings to this group along with copies of the final report.
2. Children North East can facilitate this session by feeding back on the work and the report with a view to creating some collective actions and next steps.
3. Carry out a series of online sessions to disseminate the findings to the individuals and organisations involved in the work.
4. Children North East can also facilitate these sessions and will return to carry out a review of the impact of the work in 6-12months time.
5. Circulate the final report or a summary report to these organisations.
6. Continue the conversation with these organisations to collaborate on and feed in their actions to an overarching task force.

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Because growing up can be hard