

Project Title: Integrated parenting and financial wellbeing support

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Plain English Summary

Background

Almost one in three children in the UK lives in poverty, which is harmful in lots of ways and damages children's health. Family Hubs and charities support families that face money difficulties. This is called financial support. Other organisations teach people about parenting through parenting programmes. Financial support and parenting support are usually provided separately to parents. We know that some families could benefit from both things, so we wanted to find out whether combining financial support and parenting support could help children and families.

Methods

To find this out we:

- interviewed designers of parenting programmes, staff in Family Hubs and people who offer financial advice about our idea of combining financial and parenting support.
- looked for published research to see if financial and parenting support had been combined before.
- worked with a local Council to find out whether they collected information that would be useful if we wanted to test a new programme that combined financial and parenting support.

Key findings

Staff in Family Hubs thought providing financial and parenting support together was a good idea but were concerned about knowing enough about each topic and about whether families would feel they were being judged. Designers of parenting programmes were concerned about how easy it would be to add financial support to existing programmes and what it would mean for staff training.

We found 11 programmes combining financial and parenting support, but none were tested in the UK.

We learned the information that Councils collect is very complicated and we couldn't use it to test a new programme.

Conclusions

A parenting programme that includes financial support would be useful. It is important that we work with people who support families and with parents to create a new combined programme so that it works well and is relevant to the parents that use it.

Summary of research findings

Aims and Objectives

Our aim is to understand if integrated parenting support (PS) and financial well-being support (FWbS) for families has the potential to improve child health and health-related outcomes. Our objective in this development grant was to inform the future design and testing of a programme of this type and to address four main areas of uncertainty.

Our project had four work streams (WS):

WS1: To identify existing models of financial and material support, including debt and welfare advice, provided to families by Family Hubs (FHs) in England, and to learn how families access and use this support in different places.

WS2: To hear from family practitioners and from debt and welfare advisors about the potential for providing financial support to families receiving parenting support, including how, where, and by whom this could be delivered.

WS3: To understand how parenting and financial support could be integrated into a programme that would deliver the greatest benefit, as well as what would be needed to enable the programme's adoption and implementation in the most efficient and equitable way.

WS4: To assess the feasibility of working with Family Hubs and partner organisations to access and combine data on families' financial situations, parenting, and parents' and children's outcomes as a way of informing future evaluations.

Methods

WS1: National survey and follow-up interviews

Upon ethics application, a draft survey was drawn up. As some time had passed before the project start date in March 2024, a second draft of the survey was created which allowed for questions to be updated. This second draft survey was sense-checked by two Family Hub (FH) Managers. Questions were reviewed by the team, and amendments were made to optimise the response data for use in creating models of integrated support. The survey was delivered using Qualtrics. FH Managers or Commissioners were invited to complete the survey, which was circulated by email or phone to FHs in the 121 Local Authorities in England that receive Government Transformation Funding, provide services for children 0-19 years old (in line with the FH offer), or are transitioning into a FH model. The survey was live for three months (20th June to 24th September 2024).

We asked respondents if they were willing to be contacted for a follow-up interview and 41 agreed. We contacted each of them by email with an information sheet and consent form. Our original intention had been to use maximum variation purposive sampling but this was not possible because we received fewer survey responses than anticipated. Of the 41, over half (n=23) replied and participated in an interview. Interviews lasted approximately one hour and followed a semi-structured approach based on a topic guide. They were audio recorded

and transcribed verbatim, then analysed in NVivo v14 software using a five-stage framework analysis method.

WS2: Practitioner views on acceptability and feasibility

Draft topic guides were reviewed by the research team, and amendments submitted to the University of Exeter Medical School Ethics Board. Two semi-structured online focus groups were conducted with Parenting Practitioners (PP) (n=6) and Debt and Welfare Advisors (DWA) (n=6) working within FHs in December 2024. Participants were invited via FH managers or commissioners who responded to our survey or participated in an interview. Each focus group took 90 minutes, and was audio-recorded with participants' permission, transcribed verbatim and fully anonymised prior to analysis. Framework analysis was conducted using NVivo v12 software. Written informed consent was obtained prior to participation, and participant codes were used to ensure anonymity and confidentiality. Participants received a voucher as a thank-you for participation.

WS3: Systematic scoping review

A systematic scoping review was conducted (protocol: <https://doi.org/10.17605/OSF.IO/V6XTM>). The process was informed by an information specialist. In a deviation from the planned activities, due to the paucity and heterogeneity of interventions/studies identified through initial searches, we made the decision to adopt a scoping review approach, with broader research questions. Databases and 'What Works' clearinghouses were searched as planned, with expert consultations and targeted searches using programme names used as additional methods. Original research questions were to investigate: (1) models of parenting support (PS) programmes with integrated financial well-being support (FWbS); (2) the effectiveness of these models on parent and child outcomes; (3) the contribution of traditional FWbS vs PS elements towards outcomes; (4) the individual components that contribute towards intervention effectiveness; and (5) factors that enhance or limit successful implementation. Through our decision to conduct a scoping review rather than a systematic review, questions two through four were no longer in scope. We therefore created two new research questions to capture the breadth of information that we expected to find.

The final research questions for the review were as follows:

1. What PS programmes with integrated (components of) FWbS exist? What do they do in general, and how are they delivered?
2. What do those programmes do in terms of FWbS and PS and how (if at all) are these elements integrated?
3. What is the nature of evaluation studies of these (including what is measured and how, especially financial well-being)?

All articles identified through each of the three methods were double screened against a Population, Intervention, Control, Outcome framework (PICO) for inclusion. We did not restrict by geography or date. Data collected included, as planned and set out in the funding application, details of the intervention, model components, setting, provider, outcomes measured, individuals involved in delivery, and mode of delivery.

We did not search ABI/INFORM database as subsequent scoping searches found it contributed no new relevant studies. However, we did search Web of Science core collection, expanding our net from Social Science Citation Index alone, and added several other databases (CINAHL, Global Health and Embase) plus two focused on grey literature in health and social science (HMIC, SSCI).

Focus groups with parenting programme developers

Topic guides were reviewed by the research team, and amendments submitted to the University of Exeter Medical School Ethics Board. Two semi-structured online focus groups were conducted with UK-based Parenting Programme Developers (PPDs) (n= 9) in January 2025. An additional two PPDs were interviewed separately, due to their availability. PPDs represented a mix of Parenting Programme Alliance (PPA) member programmes and non-PPA programmes in the top 10 most implemented in FHs according to our survey. PPDs were recruited via the PPA or cold emails to UK-based programme representatives. Each focus group lasted 90 minutes and was audio-recorded with participants' permission and transcribed verbatim. Focus group data were analysed using framework analysis. Written informed consent was obtained prior to participation, and participant codes were used to ensure anonymity and confidentiality. Participants received a voucher as a thank-you for participation.

WS4: Feasibility of using routine data

We drew on data generated by the survey (WS1 above) to understand whether routine data were collected on key constructs by FHs across the country. Key constructs were defined in WS3 and taken broadly across the areas of child health, parent health, parenting and financial wellbeing. We also worked with a case study site in South West England to explore the nature of the routine data collected by FHs receiving Transformation Funding as well as that shared with or by associated organisations, including the NHS, public health and children's services. We explored whether data on family income, employment, parenting, parent/carers' health and wellbeing, children's health and development and service use were routinely collected, and mapped any local data sharing partnerships. We attended monthly FH partnership meetings in the case study site to identify relevant organisations and conducted eight meetings with representatives from these organisations to understand the data environment. We did not record meetings but took notes. We synthesised findings from these meetings, the survey and data records and sensechecked findings with case study site contacts. We aimed to produce a data checklist for establishing the availability of data in future evaluation sites.

Findings/Discussion

WS1: National survey

The criteria for success for WS1 were: (1) Response rate from >65% of FH across England to the survey; and (2) A taxonomy of integrated parenting/family and FWbS models.

There were challenges with survey publicity, which meant that 41 local authorities responded to the survey out of the 121 that were contacted (34% response rate). First, the National Centre for Family Hubs (delivered by Anna Freud) was unable to support as much with the

survey distribution as planned owing to staff turnover. Second, the General Election on 4th July 2024 (two weeks after our survey opened) limited distribution channels. Contacts were followed up three times over eight weeks to prompt response, with limited results. Despite enthusiasm for the topic, the change in government and uncertainty around the continuation of FH funding made this a challenging landscape in which to conduct research, with high staff turnover resulting in reduced capacity for many hubs.

However, we were able to successfully develop a taxonomy setting out seven models of integrated PS and FWbS in FHs (see below).

WS1: Follow-up interviews

Interviews were conducted with 23 participants. The first two were each conducted by two researchers to ensure consistency, and all subsequent interviews were conducted by one researcher. By combining the results of our survey and interviews, we created a taxonomy of models of integrated PS and FWbS in FHs (Table 1). We theorise that integration can take place either (a) at the service level (including within a programme) or (b) at a system level, incorporating multiple services from the wider system.

Table 1: Models of integrated parenting and financial wellbeing support in Family Hubs.

Integration Model	Level of Integration	Lay Summary Description of Model
Signposting	System	FH practitioners direct parents to external FWbS services or resources through a range of media (i.e., in person, posters in the FH, online). FH practitioners or FHs more generally provide parents with information on how to access external FWbS services or resources.
Outreach Sessions	System	An external FWbS organisation attends a FH to raise awareness about their service they offer or deliver a one-off FWbS session to families. Outreach sessions do not involve input from the FH but are delivered independently by the FWbS organisation, aligning with the FWbS organisation's mission or values and aiming to encourage future engagement with their organisation.
Co-location	Service	Co-location sees an external FWbS provider having a designated space (i.e., a room) within the FH to offer their services, either on a permanent, regular or ad hoc basis.
Referrals	System	FH practitioners formally connect a parent with a FWbS service by sharing their data i.e., their contact details and/ or their financial information. A referral could take the form of an informal or formal telephone call to an organisation, an email, or the completion of an online form.
Parenting Programme	Programme	FWbS is delivered in the context of a parenting programme either through specified programme content or in an ad hoc

		manner (i.e., naturally emerges as a topic of interest in a parenting programme).
Family Hub Practitioners (Direct Provision)	Service	FH practitioners provide direct provision of FWbS to parents in the FH. This could either be via the provision of goods (i.e., food, baby clothes, white goods) or through services (i.e., conducting benefits checks, helping with grant applications).
Multi-model	System, Service and Programme	FHs deliver a combination of some or all the integrated PS and FWbS models above.

WS2: Practitioner views on acceptability and feasibility

Two semi-structured online focus groups were conducted with Parenting Practitioners (PP) (n=6) and Debt and Welfare Advisors (DWA) (n=6) working within FHs in December 2024.. PP and DWA had a range of experience and represented a mix of local (n= 2) and national (n= 2) debt and welfare organisations, as well as Local Authorities (n=2).

While the acceptability of integrating PS and FWbS was generally high amongst participants, with integration perceived as logical and potentially beneficial to families, barriers identified included the potential for the stigmatisation and alienation of parents. Perceptions regarding feasibility were mixed. Barriers included the ability of PPs to deliver complex FWbS to families, due to limited knowledge and opportunities for training. A key facilitator was the involvement of a trusted PP at all levels of the intervention, and collaborative partnerships between Parenting Support Organisations and Debt and Welfare Organisations to provide more complex FWbS to families.

WS3: Systematic scoping review

The success criterion for workstream 3 was to have a ‘systematic rapid review input, which identifies “best bet” packages of components for intervention optimisation in WP2’ of the PGfAR.

A total of 5289 records (3141 screened after de-duplication) were identified from databases, experts, registries and targeted searches. After two rounds of screening, 11 articles representing 11 programmes were included in the review.

None of the interventions were trialled in the United Kingdom. Five were from the United States of America, and one each from Australia, Canada, India, South Africa, Tanzania and Zimbabwe.

All programmes had a stated aim to improve parenting or family functioning, whether by improving skills, knowledge, attitudes or behaviours, or by changing parenting practices. In contrast, not all programmes explicitly aimed to improve financial well-being; only seven aimed to decrease the effects of living on a low income (or other financial hardship) on child health, parent health or parenting by including FWbS.

The majority of programmes principally offered PS with minimal FWbS. The FWbS largely entailed money management (budgeting, saving, communication about finance), with seven programmes including this. Three programmes included the provision of goods, while debt reduction, support to boost income and a savings and lending scheme appeared once each. Only three programmes offered more than one kind of FWbS. The most common method of integrating FWbS within a programme was by having distinct modules, units, sessions, topics, lessons or materials on the subject (n=7). No programme was universal.

Although it was not possible to identify the impact of individual components within these programmes, the findings that only 11 programmes were identified, and these were heterogenous in design, with limited FWbS input relative to PS and no universal element, show that further work is needed to develop an integrated PS and FWbS programme.

Focus groups with parenting programme developers

In January 2025, two online focus groups were conducted with UK-based PPDs (n= 9) and two developers were interviewed separately (to preserve the collaborative nature of focus groups as best as possible, the views of other participants were discussed with them). The 11 developers represented a mix of PPA member programmes and parenting programmes that are not in the PPA but appear amongst the top ten most implemented in FHs, according to our survey (WS1). Developers were recruited via the PPA, or cold emails to a UK-based programme representative. Challenges identified by participants included the structural difficulty of embedding FWbS into existing programme models, uncertainties around practitioner roles and training, and the capacity of services to deliver complex financial guidance. Key facilitators included the presence of trusted PPs to mediate sensitive conversations, and strong inter-agency collaboration between parenting and debt and welfare services.

WS4: Feasibility of using routine data

Managers in FHs who responded to questions about data collection in the survey (n = 55) reported the extent to which data on key constructs were routinely collected (Table 2).

Table 2: List of constructs and N(%) of Family Hubs reporting data collection

Construct	N Collected (%)
Child health and wellbeing (e.g. mental/ physical health, developmental milestones, behaviour)	39 (80%)
Disability and Special Education Needs (SEN) status	39 (80%)
Parent participation in parenting programmes	39 (80%)
Parenting (e.g. capacity, skills, stress)	34 (62%)
Parent/carer health and wellbeing (e.g. mental/ physical health, alcohol and drug use)	32 (58%)

Financial well-being (e.g. financial stress, debt)	18 (33%)
Benefits received	17 (31%)
Income	11 (20%)
Unsure	3 (5%)
None of the Above	3 (5%)

Work undertaken in our case study site revealed a complicated and inconsistent pattern of data collection and data sharing between partners in the FH network. This is likely to be similar in other regions, although the pattern is influenced by the status of the funding received (FHs receiving Transformation Funding, versus not), the commissioning arrangements (Local Authority delivered versus commissioned/sub-contracted), and the technical data systems adopted by organisations (e.g. EStart, Eclipse, SystemOne). The use of different data systems by different organisations, or organisations' differential access to the same system, mean that sharing routine data is not always easy.

FHs in receipt of Transformation Funding are required to return a set of data regularly (some quarterly), to the Government's Start for Life programme. This includes professional/workforce activities and characteristics (e.g. metrics on staff attendance at learning and development), FH and funded service usage and reach (e.g. metrics on service users and demographics), parent outcomes (e.g. metrics relevant to funded services such as parent-infant relationship, perinatal mental health, breastfeeding), and FH maturity self-assessment data. These data fields do use common metrics/measures and could potentially be used for evaluation across regions, but FHs that do not receive TF are under no obligation to collect/return this information and are able to determine their own data needs. Thus, this would limit any future sample to those in receipt of this time-limited funding and would provide no guarantee once the funding ceases in 2026 that these data would be collected or returned. The use of standardised measurement tools (e.g. Outcome Star) was evident but this was more likely to be adopted at a FH-level than a regional level, where FHs are delivered by different providers.

Our case study site was a model of commissioned delivery where the local authority sub-contracts delivery of the FHs to local/national providers, often trusted third-sector organisations. This is a common arrangement across the country with approximately one third of FHs that responded to our survey delivered by sub-contracted organisations rather than the local authority. The consequence of this arrangement is an additional layer of data complexity, where the contracted organisations adopted their own data systems and/or had independent protocols for data that they collected. Furthermore, no standard data sharing agreements appeared to be in place to facilitate linkage with data held by the local authority. This is exacerbated by the view of some professionals that GDPR or organisational policy prevented them from sharing data with other organisations/professionals working with the same family. Some data is also routinely collected in non-digital format, for example the Personal Child Health Record (PCHR) or 'Red Book' which collects data on children's health

and development. As such, use of this data for a future evaluation would require us to extract information from paper records, which would be labour- and time-intensive.

Our synthesis of findings across WS4 activity led us to conclude that it would not be feasible or practical to undertake a trial in a FH environment relying on routine data alone. We developed a checklist of constructs for future evaluation of an integrated intervention, some of which (secondary outcomes) could be triangulated or supplemented with routine data, where available.

Conclusions

Any future trial of an integrated intervention in FHs delivered as part of a Programme Grant would need to adopt primary research data collection to ensure the consistent and accurate collection of primary outcome data. This could be supplemented by or triangulated with commonly available routine data for secondary outcomes, where possible, but common constructs (e.g. parenting stress) are likely to be collected via different methods in different regions/FHs (e.g. Outcome Star, PS measure, single question).

Patient and Public Involvement

Aim

The aim of Patient and Public Involvement (PPI) within the study was to work with parents in the local and wider communities to actively input into research decisions throughout the study.

Methods

A PPI group of seven parents/carers, with experience of engaging with Family Hubs and those without experience of these services, was established at study outset. The membership was diverse in terms of ethnicity and socioeconomic status. Group members had no experience of involvement; therefore, a member of the research team met individually to introduce the concept of involvement and provide a welcome pack detailing what PPI is, what to expect from involvement, and how they would be supported. The PPI group preferred online meetings; therefore, they met online monthly. The proposed agenda was shared ahead of time to give an opportunity for amendments. All meetings were conducted in plain language. The start of meetings was dedicated to 'catching up', fostering a strengthening partnership between the members. A progress report was then provided to the group; based on group feedback, the reports were sent ahead of meetings to enable members to read them and prepare questions. The remainder of the meetings followed different formats depending on the research decision requiring input. In some circumstances a simple discussion was held, in others a traffic light rating system was used. Local communities were also actively involved in this study. We reached out to several local community groups with an interest in providing parenting and financial wellbeing support for parents. Two workshops were held to get their input on key research decisions. Creative methods, such as pictures and flash cards, were used to prompt discussion and ensure the workshops met each person's accessibility needs. A PPI impact log was maintained and used to produce an accessible summary of the impact that parents had on this study. This summary was shared with the PPI group and local community groups involved in the study.

Creative engagement events were held at Family Hubs in Plymouth to share study findings with parents in an accessible way.

Results

PPI within this study had numerous positive impacts. These included:

- Reshaping the definitions of parenting support and financial wellbeing support used in the study so that they were more relevant to parents/carers.
- Informing the terminology that was used in parent-facing documents so that people would feel comfortable with potentially challenging topics (e.g., financial stress).
- Informing the outcome measures that parents would be comfortable with and identifying approaches to mitigating parents' feelings of unease with potentially uncomfortable outcome measures.

Discussion and conclusions

PPI had significant impacts upon this study. This may have been due to several factors. First, time was taken to engage with a broad range of Family Hubs across Devon and Plymouth to invite people to be involved who had never previously been involved in research. This meant that new perspectives could be a part of research decisions. Second, time was taken to meet each PPI group member individually and a welcome pack was prepared for them, creating the conditions for a trusting relationship to form. A portion of each monthly PPI group meeting was dedicated to enabling further bonding within the group. This created an environment in which people were comfortable to share their thoughts and ideas. Third, the importance of values-led PPI was already embedded within this team, which meant that parent input was repeatedly sought on study decisions and acted upon. The desire by the research team to develop a service that is relevant to parents/carers who would use it fostered a positive attitude towards local community involvement, which further influenced study decisions.

Reflections

The involvement of local communities in addition to the involvement of the PPI group is a real strength of the study, as it enabled the parents/carers in the local area and those further distributed throughout the South-West and beyond to have a voice in shaping the research. The impact of involvement in the study was captured using a PPI impact log. This simple approach was chosen to support timely completion throughout the study. However, the use of a more detailed approach, such as the Public Involvement in Research Impact Toolkit (PIRIT), may have enabled a greater depth of information to be captured.

Data sharing statement - See link

[\[https://www.nihr.ac.uk/documents/nihr-position-on-the-sharing-of-research-data/12253\]](https://www.nihr.ac.uk/documents/nihr-position-on-the-sharing-of-research-data/12253) for the NIHR position on the sharing of research data. The NIHR strongly supports the sharing of data in the most appropriate way, to help deliver research that maximises benefits to patients and the wider public, the health and care system and which contributes to economic growth in the UK. All requests for data should be directed to the award holder and managed by the award holder.

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