RESEARCH ARTICLE

Mitigating the impact of child poverty in a highly diverse population: feasibility and acceptability of co-located welfare benefits advice in healthcare and community settings

[version 1; peer review: 1 approved with reservations]

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Abstract

Background

Children growing up in poverty experience poorer health and reduced life opportunities, especially in families where one or more child has a disability. The Healthier Wealthier Families approach is designed to mitigate the impact of child poverty by co-locating welfare benefits advice (WBA) and health appointments in places parents routinely access. There are two aspects to co-location: i) a simple integration of referrals between clinical practice and WBA; and ii) on-site delivery of WBA in trusted locations. To date, co-located arrangements have shown positive financial impacts and potential for alleviation of stress, but have rarely been tried in ethnically and linguistically diverse families nor with families with a child with a disability. This pilot study evaluated the feasibility and acceptability of co-locating WBA within healthcare and community settings in East London, targeting families with children under two or with disabilities.

Methods

The research was conducted across three sites in two boroughs where WBA was available in health or community services. The study analysed financial impact data from 174 referrals at one site and conducted interviews with 55 parents and 12 stakeholders covering all

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sites. Project QI monitoring data were also used.

Results

The intervention was largely acceptable to families and feasible to deliver. At one site, 60 families gained an average of £7933 annually in additional income and support. Three key themes emerged: i) co-location enhanced service accessibility by leveraging existing trust; ii) language barriers presented significant challenges; and iii) financial advice services substantially impacted families' lives.

Conclusions

Success factors included flexible delivery, streamlined referral processes, and culturally sensitive approaches. However, implementation requires attention to language support and privacy concerns within close-knit communities. While the intervention showed promise, the findings suggest co-location cannot fully overcome systemic inadequacies in the welfare state. Future research should examine long-term sustainability and scalability.

Plain Language summary

Many families with young or disabled children do not claim welfare benefits they are entitled to, usually because the system is too complex, stigmatising, or inaccessible. This study examined whether placing welfare benefits advisors within health and community centres in East London, where families already attend appointments, could help them access financial support.

Working across three sites in Tower Hamlets and Newham, we found that co-locating welfare benefits advice with health services was both acceptable to families and feasible to implement. At one site, 60 families received an average of £7933 per year in additional income. Families appreciated the familiar, non-stigmatising environment; professionals valued the straightforward referral systems. Language barriers and the availability of interpreters were the main challenges, especially in these ethnically and linguistically diverse communities. Future services should invest in professional interpretation and multilingual resources co-designed with communities.

Keywords

Welfare benefits advice, language barriers, child poverty, co-location, health care and community settings.

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1 Introduction

In the UK, over four million children live in poverty, severely impacting their health, education and life chances. Early intervention through family income support is crucial (Academy of Medical Sciences 2024), yet the UK's welfare system remains complex and inadequate (Griffiths et al., 2022), with £24.1 billion in benefits unclaimed annually, including £1.5 billion in Disability Living Allowance for children and £2.4 billion in Carer's Allowance (PIP, 2025). Families with disabled children face compound barriers: complex application processes, digital exclusion, language difficulties, and stigma around benefit receipt. Nationally, 742,000 children miss out on Disability Living Allowance and 553,000 unpaid carers fail to claim Carer's Allowance (PIP 2025).

This paper examines the acceptability and feasibility of co-locating welfare benefits advice (WBA) in healthcare and community settings in two East London boroughs, focusing on families with disabled children and/or children under two.

Programmes that co-locate WBA with health service delivery for families rely on mechanisms that make it easier to access financial help while engaging with routine child health appointments. Easier access to WBA should improve incomes, reduce child poverty, and may improve mental health and wellbeing. There are two key co-location mechanisms at play: i) integrating referrals to financial advice services within routine child health appointments (e.g., health visiting); and ii) offering welfare benefits advice appointments within health care facilities that parents routinely attend (e.g., clinics, GP services). Naven et al. (2012) is an example of the first mechanism. They report on a programme in Glasgow that tasked health visitors and early years staff with asking mothers of children under five if they had money worries and directing those who responded positively to local advisory services. This resulted in an average gain of £3404 per family (Naven et al., 2012). Similar results from a referral-based scheme were found in Australia where the 'Healthier, Wealthier Families (HWF)' programme achieved gains of A$6504 per family annually (Price et al., 2023). These comparisons are not adjusted for inflation. Both programmes reported improved parental well-being. Reece et al. (2022) suggest the second mechanism, physical co-location, might boost service use, as healthcare settings offer anonymity, trust, and reduced stigma. Their study also found advisors reported better confidentiality through co-location, which helps target vulnerable individuals and could reduce health inequalities. However, while early life is a key moment for intervention, studies focusing on families with disabled children or under-twos are rare (Reece et al., 2022), and family support services rarely address poverty directly through on-site economic support (Axford and Berry, 2023).

The current study took place in 2023–2024 in two boroughs of east London, where there were high levels of child poverty, ethnic diversity, and high housing costs, with a notable proportion of disabled children from Bangladeshi backgrounds (Tower Hamlets SEND and Inclusion Strategy 2024–2029; Newham Local Area SEND and Inclusion Strategy 2023–28).

At the time of the study, child poverty rates in Tower Hamlets and Newham stood at around 46% after housing costs, affecting over 75,000 children (Tower Hamlets 48%; Newham 43.6%) (Trust for London 2024). National data indicate higher poverty rates among lone parents (44%) compared to couple families (25%) (JRF Poverty Report 2024) and among families with disabled children (43%) (DWP 2024). Disabled children live in 'substantially more disadvantaged material circumstances than non-disabled children' (Blackburn et al., 2010, p. 9). Children's chances of receiving welfare interventions increase substantially with neighbourhood disadvantage (Bywaters et al. 2016). Concurrent with high levels of need, welfare benefits have reduced through benefit freezes and claim restrictions. Griffiths et al. (2022) highlight the inadequacy of Universal Credit for basic needs. The Trussell Trust (2024) reports that 65% of foodbank support went to families with children, with 30% going to families with three or more children. In Tower Hamlets, 45% of families reported food insecurity, and 22% had used food banks (Cameron et al., 2021). East London families face high financial insecurity and may need welfare advice, but their complex needs require careful service delivery to ensure accessibility. Bywaters et al. (2003) found that low uptake of services by Bangladeshi and Pakistani parents of disabled children was attributed to institutional racism, language barriers, lack of culturally appropriate services, bureaucratic complexity, and false assumptions about extended family care. In relation to help with finances, there are barriers relating to lack of awareness of qualifying criteria, overwhelming complexity of the system and a public discourse of stigma attached to claiming welfare benefits (PIP 2025).

The current study reports on the acceptability and feasibility of a co-located WBA service in the complex delivery environment of Tower Hamlets and Newham ('the pilot study'). The pilot study was developed through collaboration between academic researchers, welfare advisors, clinicians, and public health professionals as part of the ActEarly initiative (2019–2025) (Wright et al., 2019). The collaborating local authority welfare advisory teams (operating as 'our money', 'residents' support', and 'social welfare advice') provided guidance on welfare benefits, debt management, social tariffs, and discounts - collectively referred to as WBA. This was in the context of the London Assembly's pledge to

make welfare advice access an 'in principle' right for all residents (London Assembly 2023), emphasising the need to find effective delivery methods, especially for families with children.

The research aimed to fill a gap in relation to mitigating child poverty in an area of high need. While money advice services existed in both boroughs, none specifically targeted parents or operated within health and community settings that parents regularly visited. This study addressed two primary research questions: (1) How acceptable is co-located WBA to families and professionals in a highly diverse, multilingual East London context, and what conditions shape that acceptability? (2) What does the implementation experience across three contrasting sites reveal about the feasibility of co-located WBA in health and community settings? A third, subsidiary question examined preliminary financial outcomes: what financial gains did co-located WBA generate for families during the study period?

2 Methods and approach

The pilot study evaluated the acceptability and feasibility of integrating referrals to money advice services that were physically sited within three East London health and community centres, thus adopting both key co-location mechanisms. We examined acceptability as the perception of service users and professional stakeholders as to whether co-located WBA with health services, known locally as *Healthier Wealthier Families in East London*, was seen as appropriate, fair and reasonable in relation to the dimensions of the Theoretical Framework of Acceptability (Sekhon et al., 2022). The second construct, feasibility, was considered as the practicality of the intervention in terms of resources, and alignment with the priorities of the host service, in the perception of professional stakeholders (Klaic et al., 2022).

Klaic et al.'s (2022) context-dependent framework is particularly valuable for research on service co-location among complex populations. Their model identifies five sequentially interconnected concepts - acceptability, fidelity, feasibility, scalability, and sustainability - emphasising how these factors must be continually reassessed as interventions expand to new settings.

While other studies have approached these concepts through implementation metrics (Price et al. 2023), organisational partnerships and workforce engagement (Naven et al. 2012), or measures such as recruitment and retention rates (Eldridge et al., 2016) the current study adopted a primarily qualitative analytical approach, attuned to the particular, dynamic environment, with attention to local factors such as service structures, workforce dynamics, and community needs (Klaic et al. 2022).

The pilot study was governed by a multi-stakeholder group drawn from clinical practice, service delivery and management, Quality Improvement and academic research, which met on a regular basis to review progress and implement changes, guided by Beardon's (2022) Health Justice Partnerships. Monitoring data informed assessment of both feasibility and the Klaic et al. (2022) concept of fidelity, or implementation as intended.

2.1 Intervention development

Implementation began with facilitating regular meetings of WBA, host providers and researchers across three pilot sites, which were: i) an NHS neurodisability clinic serving children and young people (Site 1); ii) two local authority children and families' centres serving families with children under five (Site 2), and iii) a voluntary sector run community health centre (Site 3). Following Beardon (2022), the focus was on building collaboration and establishing new referral processes. The researcher (SFL) maintained a proactive site presence and managed stakeholder needs. Site 1 utilized the Quality Improvement (QI) methodology to develop change ideas, set targets for referrals and track progress through PDSA – Plan, Do, Study, Act - to step up staff and service users' promotion of referrals.

The sites differed in important respects. **Site 1** was a large specialist clinic for children and young people with disabilities. Project funding secured a WBA for one day per week. Clinicians used a simple online referral system that incorporated a screening question: "Do you have money worries?" WBA scheduled client meetings in a dedicated room, provided ongoing support and shared outcomes data with clients' consent. The WBA's record-keeping system enabled practitioner feedback and a "leader board," ultimately generating 174 client referrals. **Site 2** comprised two children and family centres where the local authority WBA service was looking to expand. Despite extensive promotion through leaflets, targeted letters, and a summer 2023 campaign, the WBA struggled to attract referrals, resulting in reduced service frequency. Over the study period there were only 20 referrals. Moreover, the service's benefits calculator had limitations, lacking guidance on applications and monitoring financial outcomes. **Site 3**, a community centre connected to a health centre, had an established WBA service run jointly by social prescribing and welfare advice teams. To address data limitations from Site 2, we sampled parents from Site 3's database of 170 clients, selecting those with children under two who had engaged with the WBA team in 2023. Financial data remained limited.

2.2 Ethical approval and informed consent

The study received ethical approval from UCL IOE Research Ethics Committee (REC1757) and NHS ELFT's Governance and Ethics Committee (GECSE G2302d). A two-stage informed consent process was used for parent participants. Following their first welfare benefits advice appointment, money advisors introduced the study to parents and, for those who expressed interest, obtained written informed consent to share their contact details with the researcher and to participate in a follow-up telephone interview. Parents were provided with a Participant Information Sheet at this point. The researcher subsequently contacted parents to confirm their willingness to participate and arrange a date and time for the interview. At the point of the interview, approximately three months later, the researcher re-explained the study's purpose and the voluntary nature of participation before obtaining verbal informed consent to proceed and audio-record the interview for transcription.

Stakeholder participants were recruited via email invitations that included information about the study. Those who wished to participate were asked to arrange an interview via Microsoft Teams. At the start of each interview, the researcher explained the study and its voluntary nature, then obtained verbal informed consent to proceed with and record the interview for transcription.

2.3 Data sources

There were four data sources. These were: i) phone interviews with parents who had attended WBA appointments; ii) phone interviews with professional stakeholders who had hosted, delivered or referred to WBA services; iii) financial outcomes data from Site 1; and iv) researcher observations and notes of multi-stakeholder QI meetings for updates on implementation issues such as early referral challenges, data sharing, and site-level tasks. These notes tracked real-time service development, including small adjustments to data pathways and ongoing efforts to sustain referrals.

2.4 Parent participant characteristics

At the time of WBA appointments, all clients in Sites 1 and 2 who met our criteria of having a disabled child or a child under two and living in Tower Hamlets or Newham were asked if they would take part in research interviews. At Site 3, eligible parents were telephoned after initial consent had been arranged during the WBA appointment. Twenty seven parents agreed from Site 1, 10 parents from Site 2 and 18 from site 3 (n = 55).

Table 1 outlines key parent participant demographics of those participating in interviews (no data available on all referrals). Most were primary caregivers. Site 1, focusing on children with disabilities and serving a wider age range, showed larger family sizes. The participant group reflected the local population's diversity, with Bangladeshi and Pakistani families forming the largest ethnic group (n = 26). Health challenges were common among both parents and children, while only 30 (including 1 pensioner) participants or their partners were in paid employment.

2.5 Data collection and analysis

Parents who consented at the point of WBA appointments were contacted immediately to schedule interviews three months after their initial appointment, totalling 55 telephone interviews between August 2023 and May 2024. Interview challenges included parent non-responsiveness, scheduling difficulties, and language barriers. Some participants used family members as translators when needed. The implications of this for data quality are discussed in the Strengths and Limitations section. The interview questions, based on similar programmes (Price et al., 2023; Naven et al., 2012) and the Theoretical Framework of Acceptability (Sekhon et al., 2022), covered background information, work and financial situation, experience with money advice, financial impact, and mental and family wellbeing. Participants received a £25 shopping voucher for completing the interview.

The 12 professional stakeholder interviews, conducted near the project's end, included clinicians/practitioners (community paediatricians, matron and transition nurse, occupational and speech and language therapists, clinical lead health visiting) and service hosts/providers (general manager, debt and benefits team leader and advisors). These interviews were coded based on the acceptability and feasibility of implementation processes: setting up, referrals, and access.

The analysis process involved transcribing audio recordings and reviewing interview transcripts, followed by summarising responses under three domains: family circumstances, access to advice, and impact on family life. All participants were assigned codes as pseudonyms, for example, PA, WA and RA indicate P = parent, W = welfare benefits advisor and R = referring clinician or practitioner, to help anonymise data.

The project team collaboratively developed a coding framework after reviewing sample transcripts. This framework, focusing on access and impact, guided the identification of significant findings. The approach was hybrid: the framework was developed inductively from sample transcripts and then applied deductively alongside the acceptability and

Table 1. Participant parents in Sites 1, 2 and 3: Household characteristics and health needs of children and parents.

	Site 1 (n = 27)	Site 2 (n = 10)	Site 3 (n = 18)
Main caregiver to children			
Yes	25	10	18
No	2		0
Number of children			
1	7	4	5
2	6	4	13
3+	14	1	
Child passed away		1	
Ages of children	9 mos – 29 years	5 mos – 9 years	5 mos – 17 years
Living with partner			
Yes	21	10	12
No	6	-	6
Number of adults in household			
1	5	10	5
2	19		10
3+	3		3
Household member with disability			
Yes	27	0	4
No	0	10	14
Ethnic group			
White British	1	1	1
European	5	-	1
Bangladeshi/Pakistani	11	6	9
African/Black British	9	3	7
Employment			
Self			
Unemployed/carer	21	7	16
Working/maternity leave	4	3	2
Pensioner	1		
Partner	1	2	
Unemployed/carer			
Working	8	6	5
Children's needs	Severe disabilities, language and communication difficulties, Down's syndrome, mobility problems, wheelchair users, severe autism, feeding and sleeping issues, cerebral palsy	Not mentioned, babies not sleeping at night	Asthma related to housing quality, Speech delay requiring constant attention, ADHD, Autism, non-verbal daughter
Health issues	Sciatica, spinal stenosis, depression and anxiety, bereavement, falls injuries, mobility problems	Mothers with babies stressed	Recovering from C-section/ sleeping on floor Ovarian cysts, prolapsed uterus. Back pain from C-section. Chronic pain due to bursitis

feasibility concepts described above (Klaic et al., 2022). The researcher then conducted iterative transcript analysis, with regular meetings between the researcher (SFL) and project lead (CC) to review and refine codes and themes. Data quality and quantity varied across participants, lending itself to qualitative analysis. Three thematic maps were generated to illustrate theme coding, definition, and supporting examples.

The third data source, financial outcomes, referred to the average financial benefit gained, and the type of welfare benefit. This data were obtained for all those families where some financial benefit could be identified. For this data, we had access to the whole data set in site 1, not just those completing an interview. Alongside these financial data, we used researcher notes from weekly QI meetings to understand how the service was operating in practice. These notes were taken during routine meetings and recorded issues as they arose, such as "no internet" and delays in receiving anonymised data from WBA. Documenting these issues in real time enabled us to monitor how small adjustments were made to improve referral flow, data handling, and site processes, including promotional events and reminders to clinicians and practitioners to raise the service with families.

3 Findings

3.1 Acceptability: Financial impact

Financial outcomes data demonstrated substantial financial benefits to family income (Table 2). During the project period, of 174 referrals in site 1, 60 families achieved total gains of £476,023, averaging £7,933 per family annually. Due to data sharing restrictions, we could not directly link these financial outcomes to specific parent participants. Table 3 shows how the welfare benefits system provided the primary source of new income, with 51 awards of Universal Credit, legacy benefits, and carer's allowance (some families may have had more than one award). These results are particularly significant given that the service targeted high-risk groups (Marmot et al., 2020) (see Table 1), where financial impact tends to be more pronounced than in universal, low-risk populations. The findings align with comparable studies of family-focused interventions (Naven et al., 2012; Price et al., 2023), consistent with the value of co-located services across different countries and contexts.

3.2 Acceptability: perceptions of parents and stakeholders

Our qualitative analysis revealed three main themes addressing acceptability and feasibility: i) acceptability through co-location (accessibility, awareness, and trust); ii) feasibility conditions, specifically the language and cultural barriers encountered in delivery; and iii) acceptability through the impact of financial advice on family wellbeing and parental identity.

Theme 1: Co-location: Access, awareness and trust

Co-locating money advice services with routine health appointments provided accessible, tailored support, reaching families who might not otherwise seek financial advice. The findings highlight three key aspects: accessible service, increasing welfare benefits awareness, and familiar space in diverse communities.

3.2.1 Accessibility

Co-location improved service access by reducing physical and logistical barriers, particularly benefiting families with limited resources, mobility issues, or busy work and childcare schedules. The Site 1 NHS clinic, already equipped for children with disabilities, provided a comfortable, trusted environment that offered anonymity and avoided perceived judgment. One stakeholder emphasized that "they already know that there's a ramp there, there's an entrance exit, catered to them" (WB). The physical integration of services proved particularly valuable for families managing multiple appointments. A clinician noted, "If they see people coming in, they don't feel anybody in their community is going to know … why you're going somewhere about money" (RD). This anonymity was especially important in close-knit

Table 2. Financial impact of co-located WBA in a neurodisability clinic.

Total referrals	174
Number eligible for awards	60
Benefits and other support gained	£476,023
Average gained	£7933
Range	£144 - £30,168

Table 3. Number of awards gained by benefit type.

Award	Outcome (n)
BBC Children in Need Emergency Grant	2
Benefit Award - Universal Credit	31
Legacy benefit – other	10
Carer's Allowance	10
Child Benefit	5
Council Tax Reduction/Benefit	4
Disability Living Allowance	6
Pension Credit	1
Total	69

communities where financial difficulties carried social stigma. The convenience of combined appointments significantly increased service uptake, with families appreciating the efficiency of addressing multiple needs in one visit.

3.2.2 Stakeholders awareness and integration

Healthcare professionals reported enhanced understanding of financial impacts on family wellbeing. One clinician reflected, "My radars are more sensitive towards the financial aspect now" (RD), while another noted a new awareness of "food and fuel poverty" (RG). Money advisors gained valuable insights about families with disabled children, discovering that many remained unaware of available support despite regular health service engagement. One advisor emphasized that many families "didn't know that they could actually have disabled living allowance right now, even without a full diagnosis" (WB). Another noted, "It's so much harder to cope with if you have children that have additional needs. These families, they are really disadvantaged … often not receiving their full benefits entitlement" (WC).

A quick referral pathway was essential, with one clinician noting, "I bookmark the link so that it was quite quick to find – it takes about a minute to fill it up" (RB). Clinicians found satisfaction in offering practical help, stating it "made me feel good that I've been able to provide something that parents need" (RG). Another clinician added that "Having a possible solution to a problem that feels outside of my realm was incredibly powerful" (RC).

The integration of services led to improved identification of needs and faster response times. Healthcare professionals began incorporating financial wellbeing questions into their routine assessments, creating a more comprehensive approach to family care. One clinician observed, "We're now picking up issues we might have missed before, and we can act on them immediately" (RE). This integrated approach allowed for early intervention in financial difficulties, often preventing crisis situations from developing.

3.2.3 Trusted space in diverse communities

Trust proved crucial in East London's diverse neighbourhoods, particularly where cultural stigma surrounded disability and help-seeking existed. Parents emphasized the importance of understanding: "We need a place to show our situation… where people understand, can advise us" (PA). Another parent noted, "there's an understanding that there is something to be done. It makes you feel more comfortable" (PC). The familiar healthcare setting enhanced comfort levels, with one welfare advisor noting, "In new places, people can be anxious. When it's somewhere where they're comfortable with already, they tend to be a bit more open at the start" (WC). The NHS location specifically "makes people more willing to fully divulge information and to feel safe doing that" (WC). The proximity of money experts also helps clinicians offer support: "It's easier to say, 'Would you like to talk about finances? The person's just outside." (RE).

Cultural sensitivities particularly affected certain communities. A clinician observed that "a lot of our Bengali families are really, really anxious about things being shared, or people finding out their business" (RE). Others misinterpreted money advice offers as charity "that was helping them and they kind of got … offended at first when I mentioned it" (RE). Similar concerns affected asylum-seeking families who were "very anxious to access anything, because they're kind of worried or not sure, finding it hard to trust people" (RC). Women in complex situations, dependent on men for finances in cases of domestic violence or absent partners, also struggled, often not knowing how to access help. The co-located money advice

service, offering culturally sensitive and accessible financial support within a familiar health setting, was crucial for encouraging uptake among these vulnerable groups.

Theme 2: Feasibility: communication, processes and language

3.3.1 Communication challenges

Welfare benefit applications present significant challenges due to bureaucratic complexity and language barriers. Parents who often find it "not easy to ask for help … without good language" (PK) and feel overwhelmed by "[husband] said there's so many questions, it's difficult" (PQ), particularly valued money advice services that guided applicants through the process, with one parent noting they help by showing "where to go and what to apply for," simplifying the experience: "The money advice in clinic told me where to go and how to apply and Boom! Oh yeah, I'm here" (PD). A money advisor noted that "two thirds of people that we see English is not their first language. This makes it hard to understand what help the child actually needs" (WA). Language barriers affect parents in multiple ways, with some feeling judged by professionals due to their limited English, creating an added burden as parents often feel "they should be grateful" and hesitate to ask for additional assistance (RC).

The complexity extends beyond basic language comprehension. Parents with specific learning needs face additional challenges. One parent with dyslexia expressed feeling "a bit slow, like I'm not using all my intelligence and my faculty" (PC), particularly when facing timed online applications: "They give you a time, oh, you've got 20 minutes left or you've got 5 minutes. I have to read, they don't consider the fact that you have to type" (PC).

Digital literacy compounds these challenges, with one parent admitting, "Using the internet, that's not good. I'll use it, but it's the basics really" (PBS). These challenges often result in missed support opportunities, even for those with seemingly proficient English skills. Translated materials alone are often insufficient: they assume a level of literacy in the first language and still require proactive staff efforts to highlight information to families' attention, with one clinician noting, "Most of our resources are in English, if they are translated, we were expecting people to be able to read" (RC).

Parents rarely discovered the money advice service through clinic posters and leaflets due to visual clutter and parental anxiety. A clinician described overcrowded displays: "There are so many adverts that are just a waste … When I asked the families, 'Have you seen that? It's just outside there?' They don't see it" (RD). A parent added, "When you come here with the child, you have worries about the child and the appointment … so maybe you are anxious and don't look around" (PK).

3.3.2 Application process challenges

The complexity of welfare benefit applications, exemplified by the 70-page Disability Living Allowance (DLA) form, creates significant barriers. As one stakeholder noted, "The DLA form is completely overwhelming … [for a family] running a house, looking after a sick child" (RA). The process requires multiple appointments and extensive documentation. An advisor explained, "Some people might need to do half the form and come back, because it's a lot" (WB). The combination of complex paperwork, evidence gathering, and waiting for diagnoses can extend over months. This prolonged process particularly impacts families who are "barely keeping their heads above water" (RC), struggling with managing paperwork and digital benefit applications. The service developed strategies to address these challenges, including breaking applications into manageable segments, providing extended appointment times, and creating simplified guidance documents. Advisors noted the importance of patience and flexibility, "because you've listened so actively, and so well, you've picked up on something that's not been noticed before" (WB) recognizing that rushed applications often resulted in errors or omissions that could delay vital support.

3.3.3 Interpreter services: benefits and challenges

The use of interpreters, while necessary, presents complex challenges affecting service delivery, sessions often run longer due to the "three-way conversation that can be quite overwhelming" (WB). Time constraints create additional pressure, as "As soon as their time is up, they will say, sorry, we have to go" (RD). Community dynamics significantly impact interpreter effectiveness. Families often distrust interpreters from their own background, fearing information breaches within tight-knit communities, "that interpreter can go and tell another 10 families because they are from the same language, same community" (RD) and fears of social stigma, as "sometimes it feels like that person as part of your community is seeing that you're struggling with your finances" (RC). One clinician observed, "With Bengali health professionals, parents don't trust them to not tell other Bengalis, 'Oh, do you know who's been referred to this money

advice' or … who needs help with money" (RD). Another stakeholder noted, "I have a lot of [issues] with our Bengali families who request specific interpreters, or don't want specific interpreters if they think they're close to their community or might find out things about them" (RE).

Using family members as interpreters raises additional concerns, particularly regarding financial independence and gender dynamics. A clinician observed: "If I'm talking to some of the mothers, they would say, 'Oh, I don't know, because my husband speaks English, and my husband does all the paperwork'" (RB). This highlights how family dynamics and cultural expectations can create barriers to effective support, especially for women with limited access to financial information. These challenges required developing flexible approaches to interpretation services, including careful matching of families based on community dynamics, and establishing clear confidentiality protocols.

Theme 3: Acceptability: financial agency, parental identity and family wellbeing

3.4.1 Enhanced financial agency

Access to financial advice significantly improved families' control over their resources and decision-making capabilities. Parents reported increased confidence, with one noting, "Knowing where to find help gave me confidence in what to do now and next" (PD). Better financial management allowed families to maximize resources: "With bulk shopping, the money can go further. We can eat properly and get clothes for summer" (PJ). Financial flexibility "makes a real difference in your heart" (PA) and increased real-life choices: "Now I'm stress-free. If I have time, I walk; otherwise, I can take the bus" (PA). Targeted support in the form of hardship grants provided crucial relief: "A one-off payment of £130 was helpful for necessities like food and bills" (PR). Parents often prioritized their children's health through special diets and home-prepared food. One explained, "I make him a packed lunch daily because he has problems chewing" (PC). Another added, "We buy more meat for him. It's expensive, but we try to give them the best" (PB). Financial support impacted food choices, allowing culturally appropriate selections beyond food banks. A parent noted, "I don't go to food banks often now because they don't usually provide the African food I eat" (PD).

Money advisors focused on building sustainable financial capabilities, teaching parents "how to read financial documents, improve their understanding of what different types of benefits are with how they're paid and how to access their accounts" (WC). This approach helped families navigate complex systems, with one parent noting: "We asked about Universal Credit because they were not paying us the right amount … now we are dealing with the claim which they have to backdate" (PN). The impact is significant for families with children who have special needs, sometimes resulting in lump sum back payments for debts or savings. The impact extended beyond immediate needs; understanding benefits entitlements enabled some parents to work part-time, balancing income from carer's allowance with time for their family. As one advisor noted, "They now have the space to focus on them and their children" (WB). This flexibility in work arrangements proved particularly valuable for families managing complex care needs.

3.4.2 Parental identity

Financial stability impacted parents' ability to fulfil their provider role. One parent poignantly asked, "If it's by love, it was not difficult, but by money, when you have no money whatever, suppose I love my daughter, but I can't give her food, so how to understand that Mama loving me?" (PA). Another described previous restrictions: "Before that, I felt like I couldn't really do anything with him. And I felt like he was missing out on so much" (PP). This highlights how greater financial stability can strengthen family relationships and boost parental self-esteem.

For families with children having special needs, financial support proved crucial for accessing essential services and items. One parent explained their need for specific utilities: "With the electricity and water bills, the house was supposed to be warm for [son] because he's been taking clothes off" (PN). Another highlighted technology needs: "We have to get this Sky internet so that my son can listen to his music. Music calms him down" (PJ). Financial assistance can make a substantial difference to transportation, as evidenced by one parent's struggle: "Because of the bus ride and the loud noises, it just increases the pain and everything" (PE), and another's relief: "Now we can buy the petrol so [husband] can drop us in the morning. If we don't have the money, we have to use the bus and it's stressful with my son struggling, between pulling him and shouting in the bus" (PE).

3.4.3 Family wellbeing: "mental pressure is really less now"

The reduction in financial stress had profound effects on family wellbeing. One parent reflected, "Before the benefit, as a mum, every single penny I spend I have to think no, but now, at least I'm comfortable and I know in my brain if I do this

and that, I can manage this way and that way. It's like mental pressure is really less now" (PA). Another emphasized the impact on mental health: "We can pay the bills right now and not worry about my mental well-being because I cannot sleep throughout the night thinking about what is going on financially" (PN).

The emotional impact of empathetic support proved significant: "We're sitting in a corner, no one is paying attention. Sometimes you just need someone who can feel what you feel" (PB). Financial stability enabled family activities previously out of reach, with one parent reporting "We went out and been to the pictures as a family" (PJ), while a young person described being able to "go out with my family without feeling like a burden to everyone" (PE). The ongoing availability of support created a mental safety net, with one parent noting, "It's a big relief to know that in case of anything I can contact [money advisor] and she will help" (PJ). This security helped prevent future financial crises and maintained family stability over the longer term, as another parent emphasized: "There is help if I really get despair. There is somewhere to go before I get to despair because the service can give information regarding benefits" (PC). Another emphasized: "Most of the time I feel more in control. And I know if anything I can always get in touch for advice" (PO).

4 Discussion

This study assessed the acceptability, fidelity and feasibility of co-locating welfare benefits advice (WBA) services within healthcare and community settings across three East London sites where the population has high levels of financial and health need. The study was particularly interested in the conditions for successful implementation of the intervention in a multi-ethnic community and one where many potential service users had limited English language, low confidence with digital applications and learning disabilities of one kind or another. This meant that acceptability was interpreted broadly, to encompass impact on participants as well as whether the intervention itself was delivered in a way that was fair and reasonable. As a novel intervention in site 1, we employed a Quality Improvement approach to implementation which meant that changes to the initial design were regularly introduced and evaluated for impact on referrals. For this reason, fidelity, or implementation as intended, is interpreted broadly to refer to the general health justice principles as outlined by Beardon (2022). For feasibility, we were looking for evidence in the perceptions of professionals that the intervention could be practically accommodated in service delivery.

We found that the co-location of WBA and routine health appointments was acceptable to both parents who were service users and professional stakeholders in the east London context. First, substantial financial benefit accrued to about one third of the referred families in site 1 (60/174). These families were very impoverished and largely unaware of the benefits available to them. Easy to access on-site WBA made a positive impact on the incomes of this group. Second, integrated WBA with health appointments was acceptable where it reduced physical and logistical barriers for parents, especially those with disabled children. It was important to participants that the WBA service was delivered in a trusted, familiar and non-stigmatising environment, that was already adapted to service user needs. Integrated and on-site delivery offered convenience and time efficiency for parents. Third, participants found the integration of WBA valuable when it was culturally sensitive, to, for example, language needs of parents, their learning needs, and digital competencies.

For professionals who delivered WBA, hosted or made referrals to the WBA service, both components of the intervention were acceptable. For clinicians in site 1, having an integrated referrals system that was easy to use and time efficient was essential to drive up referrals. in site 2 and 3 there were no data on equivalent mechanisms. in site 1, referrals were monitored through a Quality Improvement leader board. Forty-three clinicians and practitioners used the referral form over the study period, with the most active individual submitting 22 referrals. Other referrals came from schools and self-referrals, suggesting the service reached families through various access routes beyond the clinical encounter. In all sites, professional participants saw a positive impact of integrating discussion about referrals into their routine interactions and reported professional satisfaction from being able to direct patients to expertise they needed that was conveniently located 'just outside'.

Professional stakeholder participants found the intervention to be feasible where it was simple to operate, easily integrated into demanding clinical caseloads, and offered practical solutions that they could not provide themselves. Running the WBA service in a health or community service required some practical facilities, such as a private room, telephone and internet availability, and copying facilities. in site 1, a regular coffee morning hosted by a nurse was a useful 'bridge' to WBA appointments, as parents could talk to their peers and a trusted professional about the service and its utility. Posters in waiting areas to advertise the WBA service were not sufficient in themselves to prompt parents to take up the service; they were often too busy with children or anxious about the upcoming encounter with a clinician to see the poster. A further indicator of feasibility in the east London context was the provision of interpreters. This was a challenging area, difficult to prescribe in advance, as any choice of who should be an appropriate interpreter had to consider the cultural sensitivities and potential stigma of consulting an advisor about financial matters.

Overall, participants reported that integrated financial advice services substantially enhanced families' financial resilience and well-being. The higher gains in our study compared to other evaluations of co-located welfare benefits may reflect the concentration of multiple deprivation indicators in our study area. Recent analysis suggests that significant proportions of entitled support remain unaccessed even among those receiving some benefits (PIP, 2025).

Our finding that healthcare settings improved service accessibility through existing trust relationships aligns with Reece et al.'s (2022) observation that universal healthcare settings provide anonymity, trustworthiness, and reduced stigma. Parents reported feeling comfortable accessing advice in NHS settings because it normalised support-seeking and eliminated the stigma linked to welfare offices.

Our diverse sample offered insights into how language and culture interact with service delivery in urban contexts. We go beyond financial gains, exploring families' experiences and how institutional barriers operate alongside, and often through cultural factors (Bywaters et al., 2003). These challenges persist even when services are physically accessible. Issues such as interpreter availability, quality, confidentiality concerns, and the complexity of welfare terminology in translation continue to create difficulties. This finding indicates that physical co-location alone is not enough; services must be designed with linguistic accessibility as a central feature. This builds on recent conceptual work emphasising emotional aspects of language difficulties for migrant women (Isik and Birmek, 2025) by demonstrating that addressing unclaimed benefits requires not only simplified processes but also active structural mechanisms to overcome these barriers.

In terms of feasibility considerations, the three sites showed different levels of success in implementation, highlighting differences in: flexible delivery methods (drop-in versus appointment-based); integration with existing services; staff training and cultural competence; interpreter provision; and community engagement strategies. Sites with more flexible, integrated approaches achieved better outcomes, although all faced challenges with language accessibility. These differences reflect wider patterns found in national research: people are often asked to share the same information multiple times with different services, and local authorities need secure, permission-based methods to understand a household's full circumstances, including possible eligibility for other types of support (PIP, 2025). Sites that improved data sharing and referral pathways reduced duplication and increased efficiency. The varied results also demonstrate that providing timely help during life transitions can prevent individuals from falling deeper into financial hardship.

5 Conclusions

Financial help that is integrated into routine health care is acceptable to families when shaped by sensitivity to their family, cultural, linguistic, digital and learning needs. It requires an empathic and time-sensitive approach, with hands-on help, sometimes over several appointments. Healthcare settings inherently reduce stigma by situating financial support within holistic family wellbeing, using clear and respectful language about the impact of missed support on health, debt, and wellbeing. The intervention is acceptable to professionals when the facilities are available to accommodate the WBA service, the referral system is simple and easy to use, and the practice of asking about money worries is embedded into routine clinical encounters and reinforced by visible indicators such as posters and forums such as coffee mornings. The intervention implementation was usefully supported by QI methodology, as constant monitoring and review of referrals helped direct where, when and to whom reinforcing messages were required.

In terms of Klaic et al.'s (2022) framework, there are also tentative indicators of the two remaining elements: scalability and sustainability. Newham is a Marmot local authority which has pledged to address health inequity. Following the pilot reported here the borough public health team and the local trust (East London Foundation Trust) funded the WBA service in site 1 for a further period and have subsequently committed to funding a full-time advisor position to be located in other specialist health clinics. Furthermore, the project team have obtained NIHR funding to evaluate a trial of Healthier Wealthier Families in Tower Hamlets aimed at mothers (and fathers) of newborn children. In this version health visitors integrate a question about money worries into routine care and a WBA service is available for parents around the time of childhood immunisations in children and family centres.

The major obstacle to scaling in a multi-ethnic and disadvantaged area is access to language support. Service development must invest in professional interpreter services, develop multilingual resources co-designed with communities, train staff in working effectively with interpreters, and create confidentiality protocols addressing community concerns.

But there is also a need for system integration. While DWP's Universal Credit data sharing commitments provide a foundation, collaboration with health, education, and housing sectors can extend reach further (PIP 2025). Health settings are ideal partners, particularly for families with disabled children who have frequent healthcare contacts. The policy

environment is increasingly supportive (London Assembly 2023); national strategies give councils greater power to shape local support (PIP, 2025). Our findings provide evidence for operationalising these commitments through co-located services.

5.1 Strengths and limitations

The main strength of the study is the collaborative partnership approach to evidence gathering, enabling access to a sizeable sample of families with diverse needs, including those with disabled children. Limitations are that we could only obtain access to financial data in site 1, and it is highly likely that the sums accrued to the Site 1 families are larger than would be the case for families where there is no disability. The cross-sectional nature of the study prevents evaluation of longer-term effects on family well-being and children's outcomes. Language barriers may have excluded some participants, although interpreters were used where possible. The study cannot establish the optimal balance between co-location and alternative service delivery models. Moreover, while our findings show significant financial benefits for participating families, we cannot determine how many eligible families did not access the service. National data suggest that even successful interventions only address a fraction of unmet need (PIP 2025).

Data availability

UCL Research Data Repository: Dataset and extended data supporting paper 'mitigating child poverty' from the 'Healthier Wealthier Families in East London' study. https://doi.org/10.5522/04/32204796 (Cameron, C. 2026).

The project contains the following underlying data:

- Anonymised data: transcribed interviews from parents and stakeholders, coding maps.
- Extended data: questionnaires, consent forms, information sheets, supplementary table, ethics applications, data sharing agreement.

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The study examines the feasibility and acceptability of providing welfare benefits advice alongside healthcare and community services in Tower Hamlets and Newham. It focuses on families with a disabled child and/or a child under two.

Below are a few suggestions for improving the manuscript:

1. Clarify exactly what the financial outcomes represent — pp. 8–9, Tables 2–3; abstract. This is the most important reporting issue because the £7,933 figure is prominent throughout the paper. It would be helpful if the authors explained:
- Whether gains were confirmed awards, payments received or estimated entitlements.
- How recurring benefits, backdated payments and one-off grants were combined.
- Whether “annually” means projected income over 12 months or income actually observed.
- Whether gains represent net additional household resources after any changes to other benefits.
- The financial observation period and whether referrals had comparable time for claims to be resolved. Table 2 labels the 60 families as “eligible for awards”, whereas the text describes them as having achieved gains. These are different categories and should be reconciled.

2. Distinguish acceptability, financial benefit and effectiveness — pp. 8, 11–13. Financial outcomes are presented under “Acceptability: Financial impact”. However, financial gains and acceptability are distinct: a service may be acceptable without producing an award, and an award does not establish that the process was acceptable. The paper would be clearer if financial outcomes were reported separately, with acceptability supported by participants’ accounts of their experience.

Several statements also go beyond the design, including claims that the intervention: “significantly increased service uptake”; prevented crises; maintained family stability over the longer term; showed that more flexible sites achieved better outcomes.

There is no comparative design, financial data are unavailable across sites, and longer-term

outcomes were not assessed. These statements should be framed as reported experiences or plausible mechanisms. A controlled evaluation is not necessary for this paper's stated purpose, but the conclusions need to reflect that purpose.

3. Explain whose experiences are represented — pp. 6 and 14. Parents were recruited after attending an advice appointment. The interviews therefore capture people who had already accessed the service, while those deterred by language, mistrust, inconvenience or other barriers may be absent.

Where records permit, the authors should report, by site, the numbers eligible, approached, consenting and completing interviews, with reasons for non-participation where known. Referral totals should not automatically be treated as interview recruitment denominators.

It would also be helpful to identify whether interviewees included families who received no award or had unresolved applications. Their experiences could materially change the assessment of acceptability.

The conclusion should be qualified as acceptability among participating service users and professionals, rather than families generally. The claim that the sample reflected the local population's diversity also needs a supporting comparison or more cautious wording.

4. Make the differences between sites central to the feasibility analysis — pp. 5, 12–13. Site 2 generated few referrals and reduced its service frequency. This is an important feasibility finding that deserves more analysis than the broadly positive overall conclusion allows. A comparative implementation table could describe:
- Service operating dates, staffing and appointment availability.
- Referral pathways and opportunities to identify eligible families.
- Interpreter provision and application support.
- Implementation changes and the evidence informing them.
- Available monitoring data and barriers at each site.The status of Site 3 needs particular clarification: it appears to have been an established service added to address limitations at Site 2. Was it an original intervention site, a later implementation site or an additional qualitative sampling site?

The sites differ in population, service maturity, funding and support intensity. Consequently, differences cannot confidently be attributed to flexibility or co-location alone.

5. Strengthen qualitative methods and researcher reflexivity — pp. 6–8. The account of collaborative coding and iterative analysis is helpful but could be more explicit about:
- The qualitative analytic approach used.
- Who conducted interviews and coding.
- How the inductive themes related to the acceptability and feasibility frameworks.
- How contradictory or less positive accounts were examined.
- How observations and meeting notes informed the analysis.
- The rationale for sample adequacy.

The researcher helped implement the service and subsequently evaluated it. This provides useful contextual knowledge but may also influence what participants disclose and how findings are

interpreted. A reflexivity statement should discuss this relationship and any steps taken to encourage candid criticism.

Financial and interview data could not be linked, which also limits conclusions connecting particular financial gains with reported wellbeing improvements.

Is the work clearly and accurately presented and does it cite the current literature?
Yes

Is the study design appropriate and is the work technically sound?
Yes

Are sufficient details of methods and analysis provided to allow replication by others?
Partly

If applicable, is the statistical analysis and its interpretation appropriate?
Partly

Are all the source data underlying the results available to ensure full reproducibility?
Yes

Are the conclusions drawn adequately supported by the results?
Yes

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: Children's Social Care and Mental Health.

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard, however I have significant reservations, as outlined above.