The Current State of the Healthy Start Food Scheme in the South West of England: A Qualitative Analysis with Stakeholders

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Abstract

Introduction: The Healthy Start scheme (HS) was introduced in 2006 to provide a nutritional safety net for economically disadvantaged UK families. Uptake has been poor, with at times only 60 per cent of eligible families in the South West of the England registered. Online registration has recently been introduced, and this study explores the impact of this, plus the current state of HS, and why uptake has been low.

Methods: Qualitative semi-structured interviews were held with local stakeholders. Thematic analysis was conducted on interview transcripts. Participants were recruited online using purposive and snowball sampling. Interviews occurred over Zoom and used a standardised topic guide.

Results: Seven participants were recruited, and analysis revealed three key themes: i) HS barriers, ii) the importance of local teams, iii) suggested improvements. The online switch has streamlined applications, but HS recipients are hindered by digital poverty. Recent inflation and the cost-of-living crisis have blunted the impact the credit has for families.

Conclusion: HS has potential to reduce childhood food insecurity but is restrained by low uptake. An increase in funding for local teams along with a national advertising campaign would improve awareness. Families need help overcoming the digital poverty highlighted by the online switch. Eligibility should be expanded to families on Universal Credit with children under the age of five.

Keywords: Diet, Food insecurity, Nutritional sciences, Healthy Start, Health inequalities, Child health

Introduction

Overview of Healthy Start

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The Department of Health and Social Care introduced Healthy Start (HS) in 2006 (Parnham *et al.*, 2021) with the aim to provide a nutritional safety net and improve access to a healthy diet to women and children from economically disadvantaged families in the UK (Department of Health, 2010). It is linked through the NHS Better Health programme which merged Change4Life and Start4Life to improve early childhood health.

Women are entitled to access the scheme if they are over 10 weeks pregnant or have a child under the age of four, and are on certain benefits (NHS, 2023). The scheme was digitalised in 2021 to replace vouchers with pre-paid cards to purchase cow's milk, fresh, frozen or tinned fruit and vegetables and pulses, and infant formula based on cow's milk (NHS, 2023). The scheme also gives access to vitamins for the same period. Vitamin card and food cards are run separately. This study focuses on food cards.

The benefit of a healthy diet

A diet low in fruit and vegetables is linked to increased morbidity and mortality. The UK has high dietary inequalities with regions outside London seeing higher dietary risk for preventable disease (Steel *et al.*, 2018). For children in school year six, obesity prevalence in the most deprived areas is 30.1 per cent versus 13.1 per cent in the least deprived; 26.8 per cent of children in the UK were obese or overweight in 2022/23 (Stiebahl, 2025).

A healthier diet with more fruit and vegetables intake typically costs more compared to a less healthy one (Rao *et al.*, 2013). This can mean low-income households are dependent on more processed foods which can be cheaper and easier to store, although high in energy and nutritionally poor (Darmon and Drewnowski, 2015). There is a significantly lower intake in fruit and vegetables in those from a lower socioeconomic background because of the greater cost constraint (Mackenbach *et al.*, 2015; Yau, Adams and Monsivais, 2019). The government has committed to HS as part of its plan to tackle childhood obesity in the UK (HM Government, 2016).

Effectiveness of Healthy Start

Healthy Start replaced the previous Welfare Food Scheme (WFS) and added fruit and vegetables along with milk as items that people needed to increase their intake (Walker, 2007), giving a higher energy intake versus the WFS (Mouratidou *et al.*, 2010). Analyses of current effectiveness of HS has given a mixed picture. HS increases the quantity and range of fruit and vegetables used by families, with recipients stating it helps improve the family diet (McFadden *et al.*, 2014). For every

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£1 of credit, HS improves fruit and vegetable purchasing by £1.14 (Griffith, von Hinke and Smith, 2018). While not being a huge increase, this adds up for families and makes the difference between having fruit and vegetables in their diet or going without. HS also boosts the meeting of recommended reference intakes of vitamins and minerals (Griffith, von Hinke and Smith, 2018).

Contrasting evidence has shown that HS gave no significant difference in fruit and vegetables intake, and in all-food purchasing versus non-participating households (Parnham *et al.*, 2021). Because of this, it is difficult to know whether the scheme improves family diets. Interestingly, long-term analysis has shown that despite HS beneficiaries having lower fruit and vegetable consumption, the increase in consumption between 2001 and 2014 remained similar between HS and control groups (Scantlebury *et al.*, 2018). This may suggest that HS has allowed eligible families to maintain their fruit and vegetable intake over time where it may otherwise have fallen, thus achieving its aim of providing a nutritional safety net. While not increasing fruit and vegetables purchasing, HS may free up money that would otherwise have been spent on fruit and vegetables, helping families overall financial situation.

Uptake barriers

Numerous barriers to HS use exist. These include a complex eligibility criteria, low awareness and inappropriate targeting of advertising (Jessiman *et al.*, 2013; McFadden *et al.*, 2014). Women of low literacy or for whom English is not their first language also have difficulty applying. The old application system also involved a complex application form requiring a healthcare professionals' signature (McFadden *et al.*, 2014; Moonan *et al.*, 2022). Data from February 2023 indicates that just 63.5 per cent of eligible families in England are registered for HS. Financial analysis estimates that the government only spends approximately half of the allocated HS budget due to poor uptake. Families missed out on £41.6 million in 2017 (Crawley and Dodds, 2018). HS is currently an opt-in system relying on individuals knowing they are eligible and applying. This is a known barrier. The move from opt-in to opt out for organ donation has improved numbers of donors, and this study investigates whether this could work for HS (NHS Blood and Transplant, 2021).

Guidance on maternal and child nutrition from the National Institute for Health and Care Excellence (NICE) includes the promotion of HS by health visitors and midwives (NICE, 2015). However, staff report difficulties having the time to bring this up and hindrance by the complicated application and eligibility (Lucas *et al.*, 2013; McFadden *et al.*, 2015; Moonan *et al.*, 2022). Difficulties persist once families can register. Frustration was reported at the old paper-

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based system because the credit had a fixed monetary value; if these funds were not fully used in one shop, then money was lost (Lucas *et al.*, 2013).

The value of HS credit increased from £3.10 per week to £4.25 per week in 2021 to combat inflation and protect fruit and vegetable intake (Department for Work and Pensions, 2020). Subsequent high inflation and the cost-of-living crisis have likely negatively impacted recipients and eroded any benefit of that uplift. HS changed in March 2022 by shifting from the paper-based application and voucher scheme to a new online application with participants receiving Mastercards (Spelling, 2021). The aim was to simplify applications and improve user experience; however, certain groups of people such as mothers under 18 and recipients of certain benefits cannot apply online, which adds confusion.

Healthy Start in the South West

Low uptake is a poorly understood issue both locally and nationally. The South West (SW) of England, specifically the counties of Devon and Cornwall, was the site of the original HS pilot scheme (Symbia/Tavistock Institute, 2005). However, official uptake data for September 2021–February 2023 indicates that only 60 per cent of eligible families in the area were enrolled on the scheme, lower than the national average (NHS Business Services Authority, 2023). Rurality has been suggested as a hindrance to HS engagement and Table 1 shows significant variation in uptake regionally over time (McFadden *et al.*, 2014). We examine this link as part of our investigation.

	Percentage (%) of eligible beneficiaries signed up							
Local Authority area	**Sep-21**	**Oct-21**	**Nov-21**	**Dec-21**	**Jan-22**	**Jan-23***	**Feb-23***	**Average**
Plymouth	62	57	66	73	73	69	70	67
Torbay	63	57	58	66	69	66	66	64
Cornwall	58	55	61	66	66	60	61	61
East Devon	53	47	65	68	75	66	66	63
Exeter	55	49	58	62	62	60	63	58
Mid Devon	54	48	58	64	63	59	61	58
North Devon	56	51	57	65	65	58	60	59
South Hams	55	56	55	62	62	54	55	57
Teignbridge	59	52	57	59	64	55	56	57

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Torridge	55	51	57	63	64	56	69	59
West Devon	52	47	51	60	55	56	54	54
					Area average			**60**

Notes: (*=Post online switch) (Feb 2022–Dec 2022 no published data available).

Table 1: Percentage of eligible beneficiaries signed up to the Healthy Start scheme by SW local authority area for September 2021–February 2023.

Aims and rationale

This study explores the current state of the HS scheme in the South West and how to improve uptake through interviews with key stakeholders. The study focused on three main areas to provide recommendations on how the scheme could evolve locally and in other rural areas nationally. The investigation topics were:

1. The switch from paper to online – Investigation of stakeholder perceptions of the impact locally and whether it has improved the uptake and experience of HS recipients.
2. Further development – Exploration of stakeholder views of how the scheme can be improved to increase uptake from its current level.
3. Potential change to an opt-out system – Understanding stakeholder views on moving HS to an opt-out system.

Methods

Overview

A qualitative approach with semi-structured online interviews was used to explore stakeholder perceptions of HS in the South West. Reporting followed the COREQ 32-step checklist for interviews to give transparent reporting (Tong, Sainsbury and Craig, 2007). Ethical approval was given by the University of Exeter FHLS Sports and Health Sciences Ethics Committee (Ethics Application ID: 529569).

Reflection

Research was conducted by a male medical student in his fifth year of university studying an intercalated BSc in Sport and Exercise Medical Science. The topic was chosen due to the

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investigator's interest in General Practice and Public Health, and to gain experience of conducting qualitative research, of which this was his first experience.

Recruitment

Participants were recruited via purposive sampling. A literature search identified that the main stakeholders in HS were council commissioners, health visitors, children's centres, food banks and charities. We approached stakeholders from each of these groups in four key local authority areas in the South West (Exeter/Devon, Plymouth, Torbay and Cornwall). Contact details for identified participants were sourced from internet searches and they were contacted via email. A set email template was used. Emails were sent with a participant information sheet (Appendix A) detailing the project and a copy of the consent form. If no response was received, a follow-up email was sent two weeks later. Participants signed the consent form, and a completed copy was saved by the investigators and given to participants. Further snowball sampling was used on all participants as they were asked if they had any relevant contacts to approach. Due to resource limits, a maximum of ten participants was set by researchers. If snowball sampling exceeded this limit, it was agreed the project supervisor would interview any additional participants as part of a wider body of research. Participants were professionals providing their personal opinions.

Interview format

Interviews were organised at an agreed time between participant and researcher. Semi-structured interviews were used to meet the research questions but allow flexibility to discuss perspectives not prior conceived by the researcher. A topic guide (Appendix B) was used to standardise interview questions. This was piloted with the project supervisor before use. Participants were asked at the end of the interview if they had any further comments. Participants were interviewed once. Interviews were online over Zoom and audio recordings were made using QuickTime Player, for which participants gave their consent. Recordings were transcribed by the researcher.

Data management

Data was stored following University of Exeter guidance in a password protected OneDrive account. Storage followed a pre-set data management plan that was submitted as part of the ethics application and was in full GDPR compliance. Folder access was controlled by the

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investigator and shared only with the project supervisor. Transcripts were all link-anonymised, with a master record sheet stored in the folder.

Analysis

The transcripts were thematically analysed using NVivo 1.7.1. The process followed Braun and Clarke's (2006) six stages of thematic analysis, which was used as guidance. Stage one, familiarisation, was accomplished by the investigator personally transcribing the audio recordings. Coding used a mixed deductive and inductive approach as initial codes were created from data familiarisation during transcription. There was then flexibility to add further codes during analysis. The transcripts were analysed for the first time using pre-set codes and further codes were created as they appeared. Transcripts were analysed for a second time using the full set of codes. The coding of the first transcript was checked with the project supervisor to ensure the correct process was being followed. The codes were then used in the analysis of subsequent interview transcripts. Transcripts were analysed for a third and final time with the inclusion of any codes added during the remaining transcripts. The remaining stages of Braun and Clarke were followed as themes were created from the codes, reviewed and then named before being used in producing the report.

Quality of research

To ensure high-quality research, methodology was checked against Yardley's (2000) characteristics of good research. *Sensitivity to context* was met by a prior literature review, giving researchers understanding of HS and informing topic guide design. *Commitment and rigour* were met by following Braun and Clarke's guidance for thematic analysis alongside using the guidance of the project supervisor. *Transparency and coherence* were met through use of the COREQ checklist. Points made in analysis were backed up with raw quotes from the transcript. *Impact and importance* were met as the aim of the study was to appraise the current state of the HS scheme in the South West and improve future uptake.

Results and analysis

Recruitment

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In the first round of recruitment, 16 stakeholders were approached to represent each of the four stakeholder groups in the local authority areas and a further two participants were contacted via snowball sampling. Allowing for a follow-up email at two weeks, Table 2 shows the results of recruitment.

Outcome	Number of participants
Agreed to participate	7
Declined due to not having enough time	3
Declined due to non-involvement with HS	1
No response to email contact	7

Table 2: Results of recruitment showing number of participants (n).

Two participants were contacted via snowball sampling. Participants gave us contacts at national charities involved with HS to explore their perspective. Both contacts agreed to participate when approached. One interview was conducted by the research team in the same process as other participants. The other stakeholder just agreed to participate in a similar larger study so did not have time to additionally participate. However, they and the researchers of that other study allowed observation of that interview and use of a recording. Transcription and analysis were then conducted in the same way as other interviews. The decision to include this interview was agreed with the project supervisor on the grounds that the studies had very similar design, and data from the interview would benefit this analysis. Only sections relevant to this study were transcribed and analysed.

Participant roles are shown in Table 3; to provide anonymity, no further descriptive information is given. Six participants were interviewed. One participant (P3) chose instead to summarise their views on HS in an email as they said their comments were only brief and did not justify participating in a full interview. They gave written consent for the comments to be included, and it was agreed with the project supervisor to include them as they benefitted the analysis. The email was analysed following the set methods.

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Participant code	Role
P1	Local government
P2	National charity
P3	Local charity
P4	National charity
P5	Health professional
P6	Local government
P7	Local government

Table 3: Participant roles.

Summary of themes

Thematic analysis of transcripts resulted in the discovery of three key themes. These themes with the associated sub-themes and codes are presented in Table 4. The first of the themes identified was *HS barriers.* This theme was broken down into reasons both existing and new as to why there is low uptake of HS. The second theme was *The importance of local teams* and was split into the sub-themes of the benefit local teams provide, and then how local teams require additional support. The final theme was *Suggested improvements* and focused on how the HS scheme could be developed.

Theme	Sub-theme	Codes
Theme one – Healthy Start barriers	Existing barriers	Complex application (recipients) Complex organisation (staff) Food desert Not reducing food insecurity Paid phone line as a barrier * Poor awareness (recipient) Poor awareness (staff/promoters) Low uptake Rurality of South West as a barrier
	New barriers	Digital poverty Impact of cost-of-living crisis Monetary value not high enough * Online switch missing an opportunity

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Theme two – Importance of local teams	Benefit of local teams	Improving uptake Local innovation Local teams supporting applicants
	Local teams needing more support	Local teams need more resources * Local teams need uptake data * Lack of local control
Theme three – Suggested improvements		Need for physical promotion Need for wider eligibility criteria Opt-out Removing barriers Role for supermarkets to play Suggested change

Notes: * = Codes that were also suggested as improvements.

Table 4: Description of themes and sub-themes with the associated codes generated in transcript analysis.

Theme one – Healthy Start barriers

The first of the three themes identified during the interviews was HS barriers. This explored reasons for low uptake, including reasons why eligible recipients could not apply to HS, barriers for recipients once they were signed up and reasons why HS did not provide the nutritional safety net for those people. The barriers were split into the sub-themes of existing and past barriers, and then newer barriers which have arisen recently. Key quotes are presented in Tables 5 and 6.

Existing and past barriers

One existing barrier that was raised was the complex structure of HS that impacted on recipients and coordinators. For recipients, the previous paper application form was complex, requiring a long form to be completed, signed by a healthcare professional and then posted. Being only available in English made it difficult for those for whom it was not their first language and the complexity impacted those who had poor literacy.

The switch to an online system was in part done to remove this barrier and thus help applicants. However, it was raised that the complex eligibility criteria for HS has remained a barrier for applicants: they are frequently unsure if they are entitled to the scheme and therefore do not attempt to sign up. Not all of those who are eligible are able to sign up online and must email or phone the helpline; this also complicates the application process.

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The complex structure and eligibility were also problems for staff involved with promoting HS. It is difficult for them to know if families are eligible for the scheme, thus complicating promotion. A more simplified eligibility criteria would mean they could promote the scheme on a wider basis and reduce confusion about eligibility. The narrow criteria mean that recipients frequently fluctuate in and out of eligibility, creating uncertainty over whether they are going to have that nutritional safety net of HS.

The rurality of the South West was another barrier. Poor access to Wi-Fi and phone service because of geographical inequalities in availability makes applying online very difficult for some families. Local coordinators felt this was overlooked by the national HS team when designing the online system. The concept of 'food deserts' was also a barrier. The rurality and large size of the South West meant families previously lived in areas with no access to HS because of a lack of supporting stores. Instead, they often relied on local convenience stores for food as they were the only shops in range. Introduction of the card system has improved access; it can be used in any stores with the correct merchant code. Interestingly, food deserts remain as there are regions of the South West where families are still isolated with access only to expensive convenience stores rather than cheaper supermarkets. This problem was raised even in large cities such as Plymouth, highlighting inequalities in accessing affordable food.

The fact that the HS helpline is a paid-for telephone line is a significant barrier. Those entitled to HS are of the lowest incomes and some of the most in-need families in the country, yet it was frequently raised how unfair it was that these families needed to pay when using the helpline. The online switch frequently gave problems requiring use of the helpline, and that persists. Combined with long wait times when calling, this represents a significant financial drain to HS applicants and a financial barrier to sign up.

The final existing barrier identified was poor awareness of HS. Families did not sign up because they were unaware of eligibility or did not think that they were entitled to it. Improvements in advertising would help improve awareness and remove that barrier. Similarly, local coordinators reported they had had feedback from those in the community who should be involved with HS promotion that they were not aware of the scheme or who was entitled. Improved awareness of the scheme would help the coordinators promote sign-up. This has been shown to be effective through the HS Champion scheme in Cornwall and Plymouth.

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Code	Quote	Participant
Complex application	'Historically it was when they had to complete the form and then they had to go and get it signed by a health professional. It was like first of all there's a barrier completing the form, and then they've gotta take it somewhere, and then they've gotta post it, and it was at their expense as well doing it.'	Participant 7 – Local government
Complex application	'But actually, it's not everyone that can apply online, its only if you're in receipt of like certain benefits, and if you're in receipt of other benefits or you're pregnant and you're under the age of 18 then actually you can't apply online and you have to send them an email, and through this process, it isn't actually this straightforward.'	Participant 1 – Local government
Complex organisation	'A lot of people have said they were eligible before to sign up and now they're not eligible and they don't know why. And that's this kind of very strict criteria.'	Participant 6 – Local government
Rurality of SW as a barrier	'There's places like…out by…where there's just no Wi-Fi.'	Participant 5 – Health professional
Food desert	'So, they'll be living in a place where their local co-op charges like 50 per cent to 70 per cent more than it would be if they had transport and they were able to get to a bigger supermarket which is cheaper, or they could get wonky veg. So very difficult for people living in those areas – have they got transport to get to a place where they could use that money effectively?'	Participant 6 – Local government
Paid phone line as a barrier	'It's a charged phone number…again when you're in, when you're talking about dealing with, you know some of the most disadvantaged and the most vulnerable erm people aren't able to spend you know a really long time on the phone which actually you know there's quite a lot of evidence that phone calls end up being quite long on a number that is not free. So, you use all your credit essentially just to get the point where you can speak to someone to try and apply for Healthy Start. So that is a real barrier.'	Participant 1 – Local government

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Poor awareness (Recipient)	'When Healthy Start was paper based, we used to keep a stack of information and application forms at food bank distribution sessions. If a customer/family coming into food bank appeared to have children in the relevant age range, we would ask did they know about Healthy Start vouchers. The large majority did not know about it, those that did not took the form to apply.'	Participant 3 – Local charity
Poor awareness (Staff/promoters)	'What I found before I delivered the training was that when I spoke to erm, you know partners about Healthy Start, they would say things like "oh well I've heard of Healthy Start, but I don't know much about it" and I just thought that wasn't good enough.'	Participant 7 – Local government

Table 5: Example quotes for existing barriers sub-theme.

New barriers

The online application has removed the barrier of the paper form for some, but interviewees reported that it has raised the new problem of digital poverty. To sign up, recipients need a device to access the internet, as well as Wi-Fi or mobile data, presenting a cost barrier. Needing to email if the application has complications also presents a digital barrier as not all have access to a device or email account.

The cost-of-living crisis has significantly impacted HS recipients. The credit value has not increased in line with food prices, and interviewees frequently raised how this has impacted food security. Also discussed was how the monetary value was not enough to cover formula feeds resulting in families watering down formula, posing a significant risk to the nutrition of young babies.

A final area discussed was the missed opportunities of the online switch. Local HS coordinators conveyed that families frequently raised being unable to use the card online as a drawback. The ability to use the card online would be highly beneficial in allowing interaction with local food producers and allowing families living in food deserts to order an online food delivery. Coordinators reported a significant lack of funding for physical promotional materials, and without paper forms they have lost their conversation prompt with families – although these can additionally be printed.

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Code	Quote	Participant
Digital poverty	'So actually, some of the people that are eligible for Healthy Start are the people that are most disadvantaged and most vulnerable. So you're essentially relying on people being able to access like a smartphone or the internet and we just know that that isn't always the case.'	Participant 1 – Local government
Impact of cost-of-living crisis	'Another issue is obviously food prices and inflation that has rocketed. We know that in the last 12 months there's almost this 17 per cent increase in food prices, and that's just the average, and the value of the voucher hasn't actually gone up.'	Participant 4 – National charity
Impact of cost-of-living crisis	'It was reported that there were some families in Cornwall that weren't able to formula feed because they couldn't afford the milk. And erm unfortunately they were watering down their formula feeds and/or giving them cow's milk or alternative milk which obviously they're not getting the nutrition that they need which could erm go on to give them erm problems in the future.'	Participant 7 – Local government
Online switch missed opportunities	'The downside though is that the card cannot be used online and that is another big big barrier for people. Like people really want to be able to use the cards online.'	Participant 1 – Local government
Online switch missed opportunities	'When it went to online, we did not have the paper form – this meant that a discussion prompt was lost… So, HS discussions have gone from being a usual practice to hardly ever coming up.'	Participant 3 – Local charity

Table 6: Example quotes for new barriers sub-theme.

Theme two – Importance of local teams

The second theme identified during the interviews was the importance of local teams, both for promoting HS and in helping sign-up. The theme was split into the benefit of local teams, and how teams need more support to reach additional recipients. Local teams clearly know their areas and how to target promotion; they play a key role in the HS scheme and are an asset to their community. Local innovation in creating schemes to increase uptake of HS was evident across the South West; some of the main ideas are presented in Table 7.

- Working in cooperation with local food producers to increase access to cheap fresh fruit and vegetables.

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• Targetted communications to raise awareness of Healthy Start. • Collaborating with food banks and community larders to allow Healthy Start inclusion. • Early intervention lifestyle advice at pregnancy scans – including Healthy Start promotion. • Local Facebook awareness pages. • Awareness sessions in community spaces. • Digital access help at libraries and children's centres. • Leaflets and posters for physical promotion. • Healthy Start awareness training for invested stakeholders.

Table 7: Summary of key ideas local teams have employed to increase awareness of Healthy Start.

Also noted was the crucial role that local teams play in helping registration, particularly in removing digital barriers. Health visitor teams regularly spend time during visits helping recipients apply using their laptops, benefitting families without internet access. Local HS coordinators have set up digital help in local libraries and children's centres where recipients can go if they need internet access.

Local teams repeatedly raised how they needed more support to further their work. Health visitors reported having reduced time to discuss HS with families. Local teams lack funding to print the digital HS posters and leaflets, something they wanted changing. This was echoed by those in national HS positions who spoke of the importance of local teams, but the need for more resources. They advocated a uniform nationwide government promotion of HS, but then giving power to local teams to target advertising based on local needs.

Local and national teams called for up-to-date uptake data for HS in their areas. They use it to assess where uptake is low and then target promotion. Because of the lack of data, teams have been unable to evaluate the effectiveness of implemented interventions. Key quotes for theme two are presented in Table 8.

Code	Quote	Participant
Local innovation	'Like do we need to think about having communications in different languages or different formats. Do we already have community assets that can, you know, physically be in the community that can help support people and, er, and or are there a complete lack of assets in that area. It just kinda helps us to get a broader oversight erm and think a	Participant 1 – Local government

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	bit in a bit more depth about what might be going on and what we can do that is kinda most effective.'	
Local teams supporting applicants	'Yeah, we all have Wi-Fi linked computers so while we're there it wouldn't be unusual for us to link on and fill it in with them there and then.'	Participant 5 – Health professional
Local teams need more support	'You need to have that kinda national oversight and it needs to be kind of equilateral, but then at the local level, there is a massive role to play by local teams because they know their communities well, they can kinda do this responsive promotion and campaigning work. Because it is very much based on what people know and in disseminating promotional approaches.'	Participant 2 – National charity
Local teams need more support	'The promotional materials aren't printed by Healthy Start anymore. It would be amazing if they could provide some printed materials.'	Participant 7 – Local government
Local teams need uptake data	'Getting uptake data has been a real issue and that has had a huge impact on the local public health teams who do a lot of the work in promoting it at a local level.'	Participant 4 – National charity

Table 8: Key quotes for theme two – Importance of local teams.

Theme three – Suggested improvements

The final theme identified was suggested improvements for HS. A summary of these suggested improvements is presented in Table 9 with the key suggestions analysed below.

National-level changes	Local level changes
• Ability to use the card online • Raised monetary value in line with food price inflation • Better and more regular uptake data • Switch to an opt-out system • Increased role played by supermarkets • Free phoneline when using the helpline • Wider eligibility criteria	• Empowerment of and investment in local teams • Increased promotion of the scheme • Better communication of the scheme to local stakeholders and recipients

Table 9: Suggested improvements for the Healthy Start scheme.

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Better promotion of HS is needed. National-level leads wanted a central government coordinated promotion that would be equal across the country, like the Change4Life campaign. They suggested integration with Change4Life, Start4Life and the Red Book to guarantee this. More power and resources for local teams would allow tailoring of promotion based on needs of their population. Local teams echoed this, asking for funding to print out and disseminate leaflets and posters they had created, and uptake data to target areas in most need.

There is currently an age gap between four and five where children do not get access to HS but also are not yet receiving free school meals. Both local and national teams advocated for the widening of eligibility to five so those children do not miss out. Also suggested was raising the qualification threshold, with it being suggested that all children in families on Universal Credit (UC) are given access. An opt-out system was supported by all five interviewees when asked, with them suggesting it be coordinated nationally with local teams supporting queries and use of the entitlement. Put forward was the idea that when a family is qualified as on UC and with children under five, they are automatically registered and sent a HS card.

Utilising supermarkets was the final suggestion. This formed three key areas: an increase in promotion of the scheme in-store, improved staff training on HS and wider use of card top-up schemes and vegetable offers. Key quotes for suggested improvements are shown in Table 10.

Code	Quote	Participant
Need physical promotion	'I think there needs to be much better integrated into other channels for reaching this target group of kinda early years childhood, you know Change4Life, Start4Life, Red Book.'	Participant 4 – National charity
Need physical promotion	'Cornwall had better rates and it was because they had an erm lifestyle adviser at the 20 week scan…for babies when mums were pregnant and they were having those conversations. They were having smoking cessation conversations and Healthy Start conversations at that scan.'	Participant 5 – Health professional
Needs physical promotion	'We get downloadables, but we don't get anything that you can order in terms of printing leaflets. So, you have to pay to get them printed…you have to pay for any kind of social media advertising…and that has to	Participant 6 – Local government

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	come out of our budget and budgets are extremely stretched.’	
Need wider eligibility criteria	‘Er age limit. I think it’s ridiculous there’s this gap between age four and five where kids receive no support until they enter school, so that needs to be rectified.’	Participant 2 – National charity
Opt-out	‘To say that they want, you know, they’re aiming for 75 per cent. That’s not good enough. We should be aiming for 100 per cent. You know, every…if they sent a letter out, you know when people get their benefit letter, if they put a link…you know to automatically set someone up on it or have an opt-out system.’	Participant 6 – Local government
Role for supermar kets to play	‘General signposting to promote the scheme to customers, taking away any kinda complication or stigma or shame at the till, and thinking about where they can add value. So, you know whether it’s now adding certain kinda vegetables on promotion, or like a monetary top-up voucher would be really great.’	Participant 2 – National charity

Table 10: Key quotes for suggested improvements for the Healthy Start scheme.

Discussion

Using qualitative research and thematic analysis of professional’s opinions on HS, this study has answered our research questions on the current state of HS in the South West of England. The online switch has modernised HS and helped recipients by simplifying applications. Removing the health professionals’ signature has streamlined applications. The multi-language form benefits those who were previously inhibited from registration by a language barrier. Despite this, new problems have arisen. Digital poverty has been highlighted by the switch. Low income is a key risk factor for digital poverty; only 60 per cent of households with an income of less than £12,000 per year have internet access, showing how vulnerable HS recipients are to digital poverty (The Learning Foundation, 2022). Consideration of families with no internet access would improve uptake, whether that be a paper form or through increased funding to local authorities to improve digital access. Removing the cost of the paid helpline will also remove the financial barrier for any who are encountering problems online.

Finally, the ability to use the HS cards online would be of great benefit to families in the South West and beyond. Living further from a supermarket increases the odds of being obese (Burgoine

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et al., 2017). One in ten deprived areas in the UK are classified as food deserts, impacting 1.2 million people (Kelloggs, 2018). The ability to use the card online would improve access to fresh fruit and vegetables and combat this inequality.

The next area of investigation was how to improve uptake and experience. This study explores the barriers that stakeholders reported with HS whose removal would help to increase uptake and then explores stakeholders' thoughts on HS improvement. Key among these was the current gap between ages four to five where children receive no support for a healthy diet. A January 2023 Food Foundation survey found 21.6 per cent of households with children reported food insecurity in the past month, a doubling since January 2022 (Goudie, 2023). Childhood food poverty negatively impacts development both physically and mentally, impacting educational attainment (Moore and Evans, 2020). This costs the UK Treasury £6 billion per year in knock on effects, with £29 billion spent yearly on diseases linked to poverty (Bramley *et al.*, 2016). Increasing the HS age to five would ensure those children did not miss out on a nutritional safety net, and changing the eligibility criteria to include all children in families on UC would increase the catchment and help reduce childhood food poverty.

The supermarket chain Sainsburys recently piloted an uplift of the credit value by £2; it gave an average increase of 13 fruit and vegetable portions per weekly shop (IGD – Health, 2022). This suggests that a further inflation-tracking rise in the value of HS from the government would further benefit eligible families and improve their diets, therefore reducing food insecurity. A wider HS eligibility criteria with more recipients would likely encourage other supermarkets to introduce incentives as they compete to attract customers. The increased advertising with this would also further raise HS awareness and improve uptake.

The final area of investigation was the change to an opt-out system. As discussed in the analysis section, all stakeholders supported the change. It should become automatic for any family who is eligible for HS to be notified and regarded for the scheme. It could be simplified to include all families receiving UC and with children under the age of five to be enrolled in HS. This would significantly improve uptake as it is likely that very few families would opt out, ensuring the HS budget is utilised and childhood food poverty is reduced. The current narrow eligibility criteria may explain the wide variation seen in local authority uptake rates month-by-month displayed in Table 1. This suggested simpler eligibility criteria would reduce families fluctuating in and out of HS eligibility, helping to remove confusion for recipients and HS staff.

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Cost-effectiveness evaluations for HS are lacking. Research on the similar Women, Infant and Children (WIC) programme run by the US Government shows it is cost effective at improving fruit and vegetable purchasing, and in reducing birth complications related to undernourishment (Di Noia *et al.*, 2021; Nianogo *et al.*, 2019). The similarity of the UK and US programmes' aims and structures make it reasonable to infer that HS is cost effective. Expansion of HS would reduce childhood food poverty for more children, empowering them to achieve better attainment at school and reduce the occurrence of preventable disease. The cost of funding the expansion would likely be offset by these benefits.

The themes identified during this study and suggested improvements from local stakeholders present new evidence to guide development of HS locally. The results may also reflect a similar picture seen in other rural regions of the UK. One limitation of the study is that no children's centres were recruited to the study. They were identified as a key link to understand parents' views of HS and the barriers causing low uptake. It would have been good to speak with the remaining centres and understand how widespread closures have reduced the chance to meet parents and discuss HS. A good picture of the barriers was built up through the interviews with other stakeholders. However, this study could have been improved by including the views of parents either by directly interviewing them, or by talking to children's centre staff. Due to their contact with low-income families and the growth of food bank use in the UK from the cost-of-living crisis, food charities were invited to join. However, only one joined. The perspective of that charity gave excellent insight into the changes their food bank had noticed with HS moving online. It would have been beneficial to see if other local charities had noticed similar changes.

A limit of ten participants was set but only seven were recruited, thus there is the potential that information was missed by not meeting data saturation. Improved recruitment could have bolstered and added more confidence to the conclusions of this study. This study also did not include vitamins in the analysis. Despite being run separately, the vitamins and food both fall under the HS umbrella, thus a larger study with more resources should also include the vitamins in analysis. Both schemes struggle with uptake and there may be lessons to learn from each other.

This was a small-scale study ran in the South West of England, therefore there is the potential that the views of stakeholders in the region may be different to those elsewhere, and the results found may not be generalisable to other regions of the UK. To combat this, further research should investigate stakeholder views in other regions of the UK, comparing rural to rural, and to see if there is a difference between rural and urban locations. Additional research should look to fully

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understand parent perspectives of HS as they interact with the scheme day-to-day. As key stakeholders, they are the ones whose insight should be used to guide HS development. Finally, research should assess the cost effectiveness of HS and whether an expansion of the eligibility criteria would be beneficial by reducing childhood food insecurity and its associated outcomes.

Conclusion

This study reveals fresh insight into HS in the South West of England. HS has the potential to reduce childhood food insecurity and the associated negative outcomes. Despite the efforts of local staff, the scheme is currently restrained by low uptake. Local teams would benefit from increased funding, and a national advertising campaign would help to raise awareness. The move to online has removed previous barriers, but more investment is needed to help families experiencing digital poverty. Moving the scheme to an opt-out system where families are automatically registered was supported by local stakeholders, with a proposed raising of the eligibility criteria to families on UC with any children under the age of five.

Acknowledgements

I would like to express my gratitude to my dissertation project supervisor Dr Kerry Ann Brown for her guidance and direction. Her enthusiasm for the topic sparked my interest at the beginning of the year and helped me to identify a research area. Her subsequent help both over email and at our in-person meetings has been of great benefit to me. The feedback given on my first draft helped shape the report into its current form. I have learnt a lot from her during this project that I will take into my future career.

I also want to thank Daisy my fiancée without whom I would not have got this far. Her constant support during the project has inspired me and kept me going. Our walks and weekend adventures in Devon helped me to relax, and I am immensely grateful for her repeated reading of my report drafts.

I similarly want to thank all my family and friends for being there for me throughout the year to support and guide me. I thank the participants who gave up their time to talk to me. Their passion for Healthy Start and its potential filled me with inspiration to write this report with the aim of helping those in need of food support. I give my thanks to the support teams in the University of Exeter College of Sport and Health Sciences for their assistance with ethics and data management.

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Finally, I would like to thank Dr Christina Vogel and Millie Barrett from the Centre for Food Policy at the City University of London for allowing me to attend an interview for their research project, and for the subsequent use of the recording in the analysis for this study. They went out of their way to help me in this way and for that I am very grateful.

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Appendices

Appendix A – Participant information sheet

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Participant Information Sheet

Title of Project: The current state of the Healthy Start food voucher scheme in the South West. A qualitative analysis with the stakeholders.

Researcher name: Josh Harris

Invitation and brief summary:

This study is looking to investigate the current state of the NHS' Healthy Start food voucher scheme here in the South West. Uptake data shows that only around 60 per cent of those entitled in Exeter are signed up to the scheme; similar rates are seen across the region and nationwide. This study will look to investigate how the scheme is functioning in the South West and how it can be further developed to help more people access it. Thank you for your interest in the project, please take the time to consider this information carefully and discuss further with family or friends if you wish. Please feel free to ask myself (the researcher) any questions.

Purpose of the research:

As stated, this research aims to address the current state of the Healthy Start food voucher scheme here in the South West of England. We will be conducting interviews with the scheme's key stakeholders in both Devon and Cornwall. We aim to focus on three topic areas:

1. The recent switch from paper to online
2. How the scheme could be developed to improve uptake
3. The potential for switching the scheme to opt out

We will analyse the comments from all participants with the aim to suggest future improvements for the scheme to those involved locally.

Why have I been approached?

You have been approached for this study because the researchers have identified you as a key local stakeholder in the healthy start scheme. This may be because you work for a local council, for a food/hunger or children's charity, at a children's centre or food bank. We will have contacted you through information found online, or from details given by contacts working in the area. We are looking to recruit ten participants involved in the Healthy Start programme across Devon and Cornwall.

What would taking part involve?

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If you agree to take part the researcher will organise a time with you that works to conduct the interview. These will be held online via Zoom at the agreed time and will last for a maximum of 45 minutes. These interviews will be recorded to allow the researchers to transcribe the interview for analysis. The interview process is fully confidential, and answers will be anonymised when we transcribe the recordings. Permission will be sought from you before any reference is made in the paper towards your employer or charity. The interview will focus on the three key topics:

1. The recent switch from paper to online
2. How the scheme could be developed to allow more people to access it
3. The potential for switching the scheme to opt out

There is the potential for a follow-up interview to be requested by the researcher if their analysis of original interviews reveals a need for further questioning. If you would like, the interviewer can contact you after transcript analysis to check they have interpreted your answers as you intended.

What are the possible benefits of taking part?

This research aims to have a wider benefit to society by assessing the current state of the Healthy Start food scheme here in the South West, and if possible, drawing up recommendations for development of the scheme.

What are the possible disadvantages and risks of taking part?

Participation in the study is voluntary and you will not be reimbursed for your time, this means there is the potential this may impact on your working time or social time. To avoid this, we will work with you to schedule the interviews at a time that is best for you. The main risks are addressed below:

- Recording the interviews – You may want your responses kept secret. The interview will be confidential and will be anonymised
- Storage of the recordings – There is a risk of the recordings being stolen or hacked. They will be stored following University of Exeter and GDPR guidance in an online password protected OneDrive business account
- Topics discussed may be sensitive – The topics we discuss may be emotive and upsetting to you. If you become upset, we can stop the interview whenever you want and can signpost you towards any support required
- Risk to personal reputation – You may not want your answers and views shared with your employer or charity. Upon transcription all responses will be anonymised, and we will seek your permission before mentioning the name of your employer/charity in our analysis
- Disclosure of sensitive information about someone – You may disclose sensitive information about a vulnerable person or child you have come into contact with – While the process is confidential, we have the duty to inform you that if concerns are raised about a vulnerable person, then we must raise this with the appropriate authorities.

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

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You are able to withdraw from the study at any point of your choosing without prejudice and do not have to give a reason. If you would like your data to be removed, then interview recordings will be deleted alongside any personal information. If your removal occurs at a point after transcription of the interview, then the researchers will use the original recordings to identify your transcript from the anonymised transcripts. If you say anything during the interview that you later want removing from the transcription, then it can be erased at your request.

How will my information be kept confidential?

The University of Exeter processes personal data for the purposes of carrying out research in the public interest. The University will endeavour to be transparent about its processing of your personal data and this information sheet should provide a clear explanation of this. If you do have any queries about the University's processing of your personal data that cannot be resolved by the research team, further information may be obtained from the University's Data Protection Officer by emailing informationgovernance@exeter.ac.uk or at http://www.exeter.ac.uk/ig/

As described above the interviews will be recorded and then stored following University of Exeter and GDPR guidance in a password protected OneDrive business account. No personal, identifiable or data about employment will be published in the write up, and during analysis transcripts will be anonymised with an ID number. Recordings and anonymised transcripts will be stored for a maximum of ten years. All results of the study will be shared with you on the studies completion.

The process is confidential, and this will only be broken if you disclose either a risk yourself or to another person or vulnerable individual. In this case your information will only be shared with the appropriate people and with the aim of protecting the individual concerned.

Will I receive any payment for taking part?

Participation in this study is voluntary and no payment will be given for taking part. As we are working over Zoom there will be no travel involved so you will not be impacted by that. The researchers will work with you to organise a time for the interview that causes minimal disturbance to you. In return for participation, you will also receive the results of the study for your use.

What will happen to the results of this study?

Once the study is complete the result, dissertation report and poster will be shared with you. You are welcome to distribute the report and poster with your employer, charity or any other invested

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party. There is also a possibility the researchers will publish a journal article with the results, again if this happens it will be shared with you.

Who is organising and funding this study?

The sponsor for this study is the University of Exeter.

Who has reviewed this study?

This project has been reviewed by the Research Ethics Committee at the University of Exeter (Reference Number 529569)

Further information and contact details

If you wish to contact any of the researchers, please contact:
Josh Harris – jh1090@exeter.ac.uk

If you have any concerns or complaints, feel free to reach out to the below contacts:
Dr Kerry Ann Brown – Supervisor – k.a.brown@exeter.ac.uk

Gail Seymour, Research Ethics and Governance Manager
g.m.seymour@exeter.ac.uk, 01392 726621

Or the Research Ethics and Governance Mailbox cgr-reg@exeter.ac.uk

Thank you for your interest in this project.

Appendix B – Topic guide used for interview structure

Topic guide

Introduction:

- Introduce myself and give background
- Get to know them, build rapport etc
- Check they have read PIS, ask if they have any questions or queries
- Obtain verbal consent to continue (plus have signed consent)

Q1 – Could you please explain your role in the Healthy Start scheme and how you interact with it?

- Gets participants background and clearly defines their role

Q2 – How long have you been involved with the scheme?

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- Understand their depth of experience with the scheme

Q3 – Please describe how you currently view the state of the Healthy Start food scheme here in the South West

Q4 – Why do you think Healthy Start historically has poor uptake levels?

Q5 – The Healthy Start food scheme has recently moved from the old paper system to a new online based application with pre-paid cards. How has this change been?

- Be prepared for them not knowing about the change, if they are unaware then their view on the change likely to be unhelpful anyway
- Be prepared to move into talking about other changes, including the increase in value

Q6 – How does the scheme achieve its aims of reducing food insecurity and improving nutrition for people in the South West and is it successful in this?

- Closed question, but builds into Q8

Q7 – Following on, how do you think the scheme could be further developed in the South West to increase uptake and improve experience

Q8 – Organ donation in England has recently moved from an opt-in system, to opt out. Would it work for Healthy Start to be changed into an opt-out system?

Q9 – If it was to be opt-out, how do you think this would best be organised?

Conclusion:

- Thank you, that's all the questions
- Chance for me to ask/clarify anything else they mention or talk about points raised
- Do you have anything else you would like to add?
- Or any questions for me?
- Explain what happens next – Finish other interviews, transcribe and link-anonymise transcripts, check with them before using identifiable information, write up project
- Check I have correct contact details for them, are they like to change. Leave me email and ask them to let me know if they do
- Will be in touch one project is finished with the findings
- Is there anyone else you recommend I should contact?
- Thank you for taking part.

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Glossary

Economically disadvantaged People who lack financial resources and access to basic daily living needs such as housing, healthcare, education and nutritious food.

https://doi.org/10.31273/reinvention.v18i1.1597, ISSN 1755-7429, c 2025, contact reinventionjournal@warwick.ac.uk. Published by the Institute for Advanced Teaching and Learning, University of Warwick. This is an open access article under the CC-BY licence (https://creativecommons.org/licenses/by/4.0/)

NHS Better health programme A public health campaign launched by the **NHS** to encourage positive lifestyle change such as losing weight, quitting smoking, getting active and improving mental health.

Change4Life A public health campaign aiming to help families eat well and be more active through provision of resources and recipes.

Start4Life Linked to Change4Life, this focuses on pregnant women and parents with advice on breastfeeding and healthy development of young children.

Dietary inequalities Differences in access to healthy, nutritious and affordable food between different population groups.

Welfare food scheme The predecessor to Healthy Start, launched by the UK Government in the 1940s to supplement rations for pregnant and new mothers to improve nutritional intake.

Food deserts Areas where inhabitants have limited access to affordable highly nutritious food due to a lack of nearby affordable grocery stores.

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