Evaluation of the Creative English for Health Programme: Caring for My Family Programme, Greater Manchester, 2023-24

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Abstract

This paper provides an evaluation of the Creative English for Health: Caring for My Family programme which ran in Greater Manchester in 2023 to 2024. The programme aimed to address health inequalities among learners who have limited English language skills to positively influence their skills and attitudes towards managing their own health, that of their family, accessing the NHS appropriately and boosting vaccine acceptance and uptake. The programme not only enhanced spoken English proficiency but also boosted learner confidence. Out of 371 learners, 98.2% reported increased confidence in their English-speaking abilities. Significantly, health literacy indicators saw marked improvements, particularly learners feeling confident in accessing appropriate treatment (+60.4%) and booking, or intending to book, vaccinations (+58.7%). The programme effectively engaged historically isolated groups and therefore was an effective vehicle in addressing local health disparities in Greater Manchester. Its localised approach and leveraging of trust between learners and faith and community organisations contributed significantly to its success, making it a recommended model for future public health interventions which are aimed at vulnerable and/or isolated populations.

Introduction

This document provides an evaluation of the Creative English for Health: Caring for My Family programme which ran in Greater Manchester in 2023/24. The evaluation was commissioned by FaithAction to provide summative evidence base which serves as a check that the Creative English for Health: Caring for My Family programme delivered as per the expectations of the funder whilst also capturing good practice and areas of learning from it which can be used by other programmes and projects.

<u>Creative English for Health: Caring for My Family</u>

In 2023 Greater Manchester Council commissioned FaithAction to run Creative English for Health: Caring for my Family in places of worship, faith-based and community organisations across Greater Manchester. These “hubs” were all local to areas of high-deprivation and populations with high incidences of negative health inequalities and the work aims to help address the health inequalities that people in these areas experience as a result of having English as an additional language.

The Creative English for Health: Caring for My Family programme was designed to help learners take care of their own health and the health of their families by empowering them to better navigate the NHS. The programme is a bespoke iteration of the Creative English programme and was tailored to focus on Covid-19 Vaccinations and risk factors associated with vaccinations by working with people who live in the top 2 deciles for deprivation within Manchester and supporting efforts to prevent Chronic Pulmonary Disease (COPD).

A desired outcome here included improving the uptake of Covid-19 and Flu vaccinations in communities it operated in by improving knowledge and how to access vaccinations. To this end there was a focus on building learner trust in primary care services and reducing vaccine hesitancy, particularly with regard to the COVID-19 and seasonal flu vaccines.

The programme was broken into sessions that learners attended on subject areas including talking to doctors, going for blood tests and understanding, managing and preventing conditions such as heart disease, high blood pressure and diabetes, child respiratory health. There were also sessions on appropriately accessing primary care services such NHS 111, emergency services, pregnancy care, screening checks and GPs.

This programme follows on from a Creative English for Health pilot programme run by FaithAction in Birmingham which ran in 2022/23. Here over 500 learners engaged and more than 88% reporting greater understanding of which NHS services with learners also reporting greater confidence attending appointments and discussing their health in English.

Methodology

The evaluation has used a mixed-methods approach, bringing together a range of data types in order to produce a breadth and depth of findings about the deliverables and impact of Creative English for Health: Caring for My Family in Greater Manchester. The evaluation includes a review of the academic and policy literature related to health literacy, allowing empirical data to be grounded in the latest relevant evidence and academic frameworks.

Learning from previous iterations of the Creative English programme, evaluation and monitoring were built in at inception, with each delivery hub having clear reporting requirements which relate to the data interests of both the funder and FaithAction. This provides a large volume of quantitative data available on the progress of learners in relation to health literacy, progression through the course and confidence to speak English. Additionally, all learners were asked to self-report their demographic data.

All quantitative data used in this report is hub-level data collected by the hubs and the compiled by FaithAction before submission to the evaluation team for analysis. Resources, such as questionnaires, were provided in English with hub support available to learners as needed. Learner data, including language assessments, was collected by hubs at registration and upon programme completion.

As the primary focus of the Caring for My Family iteration of Creative English is health literacy, less focus has been placed on English proficiency in the data that is collected. This was a conscious decision to not overburden learners through data collection. The dataset is primarily based on health literacy the data has been anonymised entirely, collated by FaithAction and passed to the evaluation team for analysis.

The evaluation team have sought to supplement this with qualitative data from two main sources:

1. Semi-structured interviews with Creative English for Health: Caring for My Family hub leads (n=3);
2. Semi-structured interview with a FaithAction team member working directly on the programme (n=1).

The qualitative data collection focused on the perceptions, personal experiences and views of the programme, aiming to complement the quantitative data which focuses on more objective, comparable and measurable progress indicators. Hubs were selected to take part based on convenience sampling (Saunders, M; Lewis, P; Thornhill, A, 2012). This is an established approach of non-probability sampling which is commonly deployed to avoid any selection bias.

Data from across these methods has been synthesised, using thematic analysis around the programme's overarching aims. Findings are, where applicable, triangulated between datasets,

meaning that quantitative data and interview data are brought together to support or discuss key points throughout.

As with all research, there are limitations to the approach taken. Whilst the scope of the evaluation ensures data is collected from a wide range of sources and matches breadth with depth, the scale of the qualitative data collection is small. Despite the limited scale on the qualitative side, researchers found a good degree of saturation in the findings from the data, meaning that very similar themes and ideas were raised across interviews and, towards the end, no new themes were raised and findings here did largely align with the quantitative data. The findings in the qualitative data were also similar to the findings of previous evaluations of Creative English and Creative English for Health and this adds an extra layer of robustness. This is not to say that the views and experiences of all individuals are represented in this limited dataset but that there can be a good degree of confidence in the validity of findings and broad themes in this report.

Literature Review

The Creative English for Health programme is rooted in established academic and policy literature and practice. FaithAction commissioned a full literature review around the relationships between literacy and health literacy with an additional focus on how intersectionalities (such as ethnicity, deprivation or religion) can affect health outcomes. The review also included definitions and frameworks of health literacy before covering health literacy as a whole-system concept and its relationship with health inequalities. The key themes which are pertinent to Creative English for Health: Caring for My Family are included here in abridged form.

Literacy and Health Literacy

Literacy, as a foundational concept, encompasses the capacity to comprehend, articulate, and interpret information through reading, writing, speaking, and listening, thus enabling effective communication and comprehension of the surrounding environment (Kickbusch, 2001). In a 2011 survey commissioned by the UK government, 14.9% of adults in England were shown to possess literacy levels at or below Entry Level 3, akin to those expected of children aged nine to 11 (The Skills for Life Survey, 2011). Subsequent research in 2015 indicated a slight increase, with 16.4% exhibiting "very poor literacy skills" (OECD, 2015), with this being linked to significant impacts on their societal engagement, particularly within healthcare contexts.

This links to the concept of health literacy. A recent synthesis by Liu et al. (2020) identified three overarching dimensions: knowledge, information processing, and ability-based aspects, echoing Nuttbeam's (2008) tripartite model of functional, interactive, and critical health literacy. Notably, both frameworks underscore the intertwined nature of literacy skills— encompassing reading, writing, oral proficiency, and numeracy—with the foundational tenets of health literacy. Consequently, individuals with lower educational attainment or non-fluency in the predominant language of healthcare systems often exhibit diminished health literacy.

Health Literacy as a Whole System Construct

Contemporary research into health literacy has also redefined the concept, moving away from viewing it solely as an individual's skill. Scholars now depict it as a more holistic, whole system construct. For instance, Salter et al. (2014) found that participants in focus groups perceived health literacy as a product of patient-healthcare system interaction, highlighting the importance of effective communication. They regarded any deficits in health literacy as systemic flaws, influenced by factors such as inconsistent personnel and service fragmentation. Samerski's (2019) ethnographic

study and Edwards et al.'s (2012) research further underscore the social dimension of health literacy, emphasising the role of support networks in navigating health information. These findings suggest that health literacy is not merely an individual's possession but a collective endeavour involving healthcare providers, family, and peers.

Levels of Health Literacy

Quantitative measures of health literacy have, however, traditionally centred on its individual dimensions. For instance, the European Health Literacy Survey (HLS-EU) defines health literacy as encompassing "knowledge, motivation, and competences to access, understand, appraise, and apply health information for making informed decisions regarding healthcare, disease prevention, and health enhancement across the lifespan" (2018).

Surveys conducted in Australia, Canada, New Zealand, and the USA have indicated that, at individual levels, up to half of the populace may encounter significant challenges in comprehending health-related information and executing associated numeracy tasks (Barber et al., 2009). In 2015, HLS-EU research across Austria, Bulgaria, Germany, Greece, Ireland, the Netherlands, Poland, and Spain revealed that 47% of respondents exhibited inadequate or problematic health literacy levels (Sørensen et al., 2015). Notably, considerable disparities among EU nations were observed, with just 2% of Dutch citizens exhibiting inadequate health literacy compared with 27% in Bulgaria (ibid).

A 2018 survey involving 2,309 UK adults discovered that 19.4% experienced some degree of difficulty comprehending written health information, while 23.2% encountered challenges discussing health concerns with healthcare providers (Simpson, Knowles & O'Cathain, 2020).

Variations in Health Literacy

These national surveys consistently demonstrate a social gradient in health literacy, aligning with broader indicators of social and economic disadvantage (Mantwill, Monestel-Umaña & Schulz, 2015). Common variables such as education levels, spoken language, and age frequently correlate with diminished health literacy within populations (Bo, Friis, Osborne & Maindal, 2014). For instance, in the HLS-EU study (Sørensen et al., 2015), individuals with 'very low' social status (such as the least educated, those facing financial challenges, and those aged over 76) exhibited the highest proportions of limited health literacy.

Similarly, research in the USA identified lower health literacy among the elderly, ethnic minorities, those with incomplete education, those with English as a second language, and individuals impacted by deprivation (Kutner et al., 2006). An Australian study echoed this and showed lower health literacy scores among migrants who spoke a language other than English at home (Beauchamp et al., 2015). Lower education levels, multiple chronic conditions, and lack of private health insurance were also linked to lower levels of health literacy.

In the UK, research demonstrates that the least health-literate groups as those from the most deprived social stratum, individuals with health conditions or disabilities, and those with lower education levels (Simpson, Knowles & O'Cathain, 2020). Ethnic minority respondents were less proficient in understanding health information compared to White respondents and migrants consistently exhibit lower health literacy levels compared to native populations with this being, largely, attributed to language barriers (Ward, Kristiansen & Sørensen, 2019). Within migrant communities across the EU, inadequate health literacy, along with language and cultural hurdles, contribute to suboptimal maternity care, treatment adherence, chronic disease management, and a lower awareness of health risks (Lauria et al., 2013; Cooper et al., 2012).

Relationships between Health Literacy, Health Outcomes and Health Inequalities

Multiple studies have affirmed a correlation between lower levels of health literacy and adverse health outcomes. Baker et al. (2002) demonstrated an association between diminished health literacy scores and heightened rates of avoidable hospitalisations, while Miller (2009) observed a decrease in individuals' capacity to manage their health effectively. Similarly, Bostock and Steptoe (2012) documented higher mortality rates and increased healthcare costs among individuals with lower health literacy. Importantly too, health literacy is seen as an independent predictor of health outcomes, even after adjusting for socioeconomic status (Berkman, 2011; Bostock & Steptoe, 2012).

Stormacq et al. (2019) proposed health literacy as a mediator in the relationship between socioeconomic status and various health indicators, behaviours, and healthcare utilization. Specifically, health literacy has been shown to be a factor in the health disparities associated with educational attainment and race. Bennett et al. (2009) found that in the US ethnic minority background individuals were more likely to report poorer health and exhibit lower rates of preventive healthcare services compared to their White counterparts

Regression analyses conducted by Bennet et al. (2009) underscored the mediating role of health literacy in the relationship between race, educational attainment, and health outcomes. Although the precise causal mechanisms remain unclear, interventions targeting health literacy may mitigate disparities in health outcomes related to education and race.

Finally, health literacy has been identified as a mediating factor in various health-related behaviours and outcomes, such as paediatrician appointment attendance (Yin et al., 2009) and adherence to diabetes medication (Osborn et al., 2011). Pelikan et al. (2018) and Stormacq et al. (2020) advocate for enhancing health literacy as a strategic, cost-effective and pragmatic intervention to address health disparities which likely stem from socioeconomic factors.

Interventions to Improve Health Literacy

Health literacy is thus recognised as being closely linked to individual contexts, influenced by personal experiences, social networks, and cultural backgrounds. This contextual specificity implies that individuals may possess greater understanding of health issues that directly affect their immediate social circles, such as family and friends, compared to those beyond their personal encounters. Moreover, individuals are often more adept at navigating healthcare systems with which they are familiar, a familiarity typically rooted in upbringing and exposure. This may explain why those new to a country or system struggle relative to those with systems literacy. Thus, efforts to enhance health literacy must necessitate improvements in accessibility and navigability of health services, alongside healthcare providers' cultivation of cultural competence and proficiency in communicating health information across diverse audiences.

The academic literature presents a spectrum of interventions designed to bolster health literacy, ranging from individual-focused approaches to group interventions, and from online platforms to traditional in-person sessions. These interventions span single-component initiatives, such as informational leaflets, to more complex multi-component programmes comprising diverse elements like training sessions and interactive discussions. Within this landscape, a systematic review conducted across 23 studies in the European Union highlighted three overarching approaches: interventions targeting the enhancement of individuals' health literacy levels, interventions tailored to accommodate varying literacy levels, and general interventions aimed at improving health outcomes while considering patients' literacy or numeracy levels.

Efforts to communicate health information effectively to individuals with lower health literacy have garnered attention within academic literature and with policymakers. Strategies identified in systematic reviews include presenting essential information concisely, utilising visual aids like tables and icon, and incorporating multimedia elements such as videos alongside verbal narratives. However, whilst these strategies demonstrate efficacy in enhancing comprehension, they may fall short in fostering the transferable skills required for interactive and critical health literacy, which are applicable across diverse contexts. In effect, they can be comparable to learning by rote.

Despite significant focus in research, establishing definitive conclusions regarding the effectiveness of specific components within health literacy interventions remains challenging. Issues such as study quality, inconsistent definitions and measurements of health literacy, and divergent study designs contribute to this complexity. Nonetheless, overall data is suggestive that tailored activities, the incorporation of interactive and critical skills, and the adoption of appropriate communication methods hold potential for advancing health literacy initiatives.

Culturally appropriate interventions, characterised by alignment with the target group's cultural values and community involvement, do however appear to exhibit greater value in addressing systemic barriers and promoting community engagement. Strategies for cultural adaptation encompass peripheral, evidential, linguistic, and sociocultural dimensions, alongside active involvement of community members in intervention design and implementation. Tailoring interventions to individual needs and preferences complements cultural appropriateness, while skill development enhances interactive and critical health literacy. This then boosts self-confidence and can facilitate behavioural change. Moreover, community-based settings and participatory approaches emerge in the literature as pivotal elements in health literacy interventions for socioeconomically disadvantaged groups because of the leveraging of familiar environments and culturally relevant messaging to enhance engagement and promote health-related outcomes.

Health Literacy Intervention Model

In articulating pathways for enhancing health literacy, Geboers and colleagues (2018) constructed a model derived from a comprehensive literature review and consultation with 68 health literacy authorities. Their framework centralises the roles of individuals and healthcare practitioners as principal agents in augmenting health literacy. Moreover, it situated these actors within a realistic and holistic context which encompassed familial, peer, and healthcare system dynamics. Drawing from this, enhancements in health literacy are posited to ensue through interventions addressing or combining the following five factors:

1. Community Support: Interventions bolstering individuals' social support structures, including familial, communal, and caregiver networks.
2. Empowerment of Individuals with Limited Health Literacy: Initiatives aimed at skill development and enhancing self-management abilities.
3. Enhancement of Interpersonal Communication between Individuals and Healthcare Providers.
4. Strengthening Health Professionals' Capacity to Identify and Address Health Literacy Concerns.
5. Augmentation of Health System Accessibility: Strategies enhancing service accessibility, quality, and patient safety.

Geboers et al.'s model underscores health literacy as an asset which can be built or developed rather than a mere risk factor necessitating management. Recognising its potential distribution within familial and social networks, health literacy emerges too as a communal asset. This perspective may help explain the efficacy of community-based interventions. In the context of this conceptual framework, Creative English for Health; Caring for My Family is a clear fit Aligning with factors delineated by Geboers et al., the programme addresses key aspects including language proficiency, local healthcare knowledge, and confidence in communicating.

Data and Discussion

This section of the report presents the descriptive demographic information of all learners plus the qualitative and quantitative datasets with analysis alongside them where relevant.

Hubs and Demographics

In total there were 14 hubs involved in delivery to the 371 completed learners. This gives an average of 26.5 learners per hub. However, there were very few hubs that delivered anywhere this average amount as many delivered either significantly over or under this amount. This degree of variance in numbers per hub was not planned at the beginning of delivery and the reasons for it are discussed in detail in the qualitative analysis.

Table 1: Learners by Hub

Hub Name	Leaners Engaged
ADAB- The Mosses	32
Aspire to Inspire	21
CAHN	19
Cede	44
Clarksfield Oasis	30
Communities for All	10
Emmanuel Westly	15
Empowering Education (Bolton)	39
Empowering Education (Rochdale)	36
Fatima Women's Association	38
Neeli Masjid Rodallo	7
Oasis Broakoak	47
Oasis Hub Clarksfield	17
WCWA	16

The vast majority (82.7%) of learners were female with 15.4% being male. This is typical of previous iterations of the Creative English and Creative English for Health programmes and reflects both the target cohort of the programmes as well as the cohorts who are likely to be available to take part in the sessions during weekdays.

Table 2: Learners by Gender

Gender	Number	Percentage
Female	307	82.7
Male	57	15.4
Undisclosed and No response	7	1.9
Total	**371**	**100.0**

The largest single group of learners by religion was Muslim and this accounted for 72.8% of the total learner cohort. This is not to be unexpected given the demographic make-up of the areas in which the programme ran. The next largest groups were Christian and Hindu (11.9% and 8.4% respectively). These groups were somewhat clustered in a smaller subsection of hubs and this suggests that locality or familiarity may play a role in how learners are recruited and participate in the programme.

Table 3: Learners by Religion

Religion	Number	Percentage
Muslim	270	72.8
Christian	44	11.9
Hindu	31	8.4
No religion	16	4.3
Other	7	1.9
No response	3	0.8
Total	**346**	**100.0**

The breakdown of learners by ethnicity is closely correlated with the data in Table 3 showing learners by religion. Here we see that learners from Pakistani backgrounds make up the largest single group by ethnicity with many of these learners also being Muslim. Similarly many of the Indian background learners are Hindu and a high proportion of the African background learners are Christian.

The huge level of diversity that is evident from the data in Table 4 is typical of other iterations of Creative English and Creative English Health but bear testament to the reach of the programme via the hub model and the ability of it to deliver to such varied groups of learners.

Table 4: Learners by Ethnicity

Ethnicity	Number	Percentage
Pakistani	187	50.4
Indian	39	10.5
African	33	8.9
Bangladeshi	28	7.5
Arab	27	7.3
Other	21	5.7
White European	10	2.7
Chinese	6	1.6
Mixed African	5	1.3
White Other	4	1.1
Caribbean	3	0.8
Mixed Asian	3	0.8
No response	3	0.8
White British	2	0.5
Total	**371**	**100.0**

The data in Table 5 shows learners by age and demonstrates a good spread across the adult age groups of learners. The largest single group is that of learners aged 25 to 44 (56.6%) but the vast majority of learners are in age brackets where they are likely to be caregivers or have dependents. This is suggestive that if behavioural change takes place (for instance deciding to cook and eat healthier) that the impact of the programme will go beyond the learner and reach their dependents.

Anecdotally, nearly all learners live in family groups with children and in larger than national average household sizes with multi-generational households being disproportionately over-represented.

Table 5: Learners by Age

Age	Number	Percentage
18-24	28	7.5
25-44	210	56.6
45-64	119	32.1
65+	12	3.2
Not recorded	2	0.5
Total	**371**	**100.0**

Quantitative

This section presents the quantitative learner outcome data for all 371 learners who completed the programme. This was recorded at hub level and collated by FaithAction before being shared with the evaluation team.

In total there were nine outcomes recorded and for the purpose of clarity of analysis, these have been split here into two categories; health service outcomes and vaccination related outcomes.

Health service access

The health service access outcomes detailed here in Table 6 and Figure 1 show that the programme made positive progress in all four outcome areas here. These are a mix of knowledge, attitudinal and behavioural changes, with the most striking changes taking place with regards to learners' knowledge and attitudes.

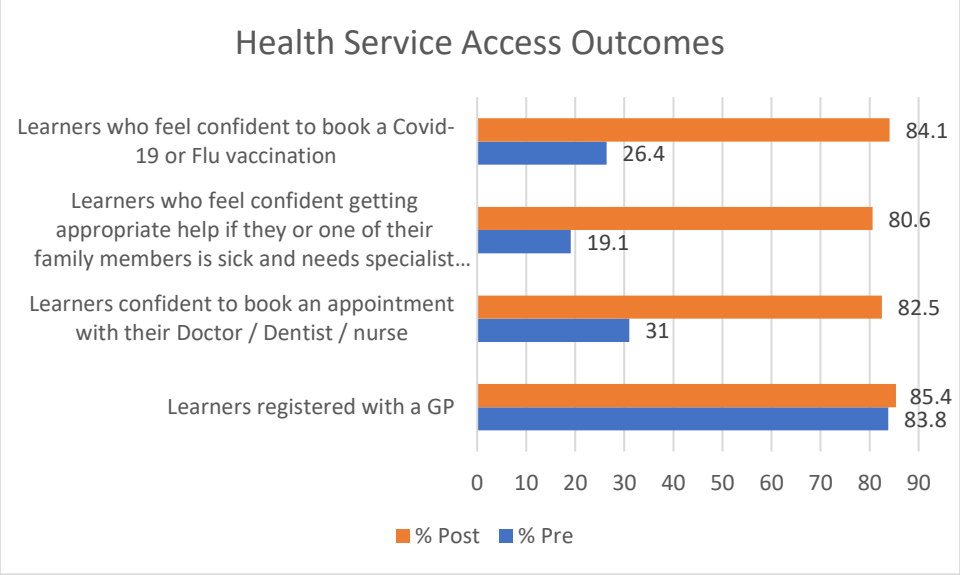
From very low baselines, learners have become significantly more aware of how to access appropriate primary healthcare and more confident in being able to do so if required. That accessing primary healthcare, especially in the event of an emergency, is not a regular occurrence means that these changes are attitudinal and knowledge based rather than behavioural as the majority of learners will not yet have had the opportunity to put their new skills and confidence into practice.

The implications here though are that learners who have completed the programme will now be more able and likely to access early health interventions and to make more appropriate use of primary care services. This, likely, has positive outcomes for the learners, their families and the primary care providers.

Table 6: Health Service Access Outcomes

Measure	% Pre	% Post	% Change
Learners registered with a GP	83.8	85.4	+1.6
Learners confident to book an appointment with their Doctor / Dentist / nurse	31.0	82.5	+51.5
Learners who feel confident getting appropriate help if they or one of their family members is sick and needs specialist treatment (for example NHS 111, urgent care centre, ect)	19.1	80.6	+61.5
Learners who feel confident to book a Covid-19 or Flu vaccination	26.4	84.1	+57.7

Figure 1: Health Service Access Outcomes



More learners being registered with a GP at the end of the programme when compared to the beginning is an example of behavioural change as these registrations have actually taken place. However, that the percentage of learners registered with a GP started at a high level relative to the other outcomes here and that it only increased by a small amount too is an interesting finding with some potential implications.

This data around GP registrations suggests that just being registered with a GP is not enough to infer that there is a degree of health literacy or confidence in using the system on the part of the person registered. Although 83.8% of learners were registered with a GP before the programme, only 31% were confident in booking appointments and, even worse, only 19.1% were confident in seeking out appropriate care. These latter figures all jumped up even though the proportion of learners registered with a GP only saw a small increase. This implies that the programme has the positive impacts on confidence in accessing services, and not the actual act of registration or previous use.

Vaccination related outcomes

All of the outcomes presented in Table 7 and Figure 2 relate to knowledge, attitudinal and behavioural changes experienced by learners who have completed the programme. Again too, the outcomes here are all positive and highly indicative of the programme being impactful and in meeting its funded aims.

That the percentage of learners who understand the benefits of vaccinations has increased from 48.0% pre programme to 85.4% afterwards (+37.4%) is clear evidence of a positive change in learner knowledge. A very large proportion now have the desired knowledge that they did not have before the programme.

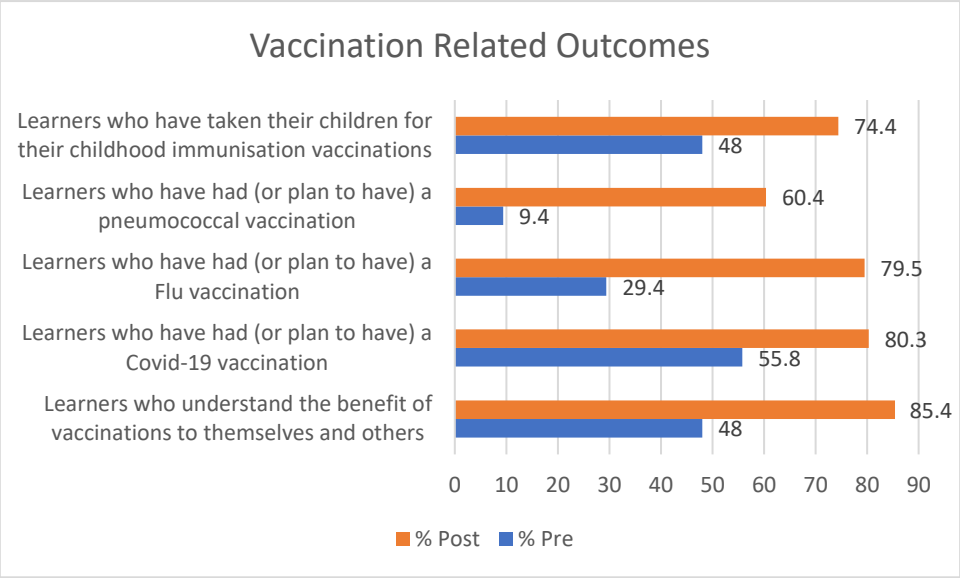
Due to the way in which the data is recorded, it is not possible to unpick the extent to which there has been attitudinal or behavioural change in three of the outcomes. This because the outcomes record that learners have had a vaccination (behavioural) or that they plan to have it (attitudinal). The data is however very clear in showing that learners do see positive outcomes in all three of these measures. The uptakes or planned uptakes around the Flu and pneumococcal vaccinations (+50.1% and +51.0% respectively) are hugely impressive and are likely to manifest over time as positive life and health outcomes for learners, as well as having a beneficial impact via prevention on local primary healthcare services.

There is definite and clear evidence of desired behavioural change taking place with regards to leaners taking their children for their childhood immunisations (+26.4%). This is an actual increase in learners taking their children to be vaccinated and implies similar may have happened with regard to the previous three outcomes.

Table 7: Vaccination Related Outcomes

Measure	% Pre	% Post	% Change
Learners who understand the benefit of vaccinations to themselves and others	48.0	85.4	+37.4
Learners who have had (or plan to have) a Covid-19 vaccination	55.8	80.3	+24.5
Learners who have had (or plan to have) a Flu vaccination	29.4	79.5	+50.1
Learners who have had (or plan to have) a pneumococcal vaccination	9.4	60.4	+51.0
Learners who have taken their children for their childhood immunisation vaccinations	48.0	74.4	+26.4

Figure 2: Vaccination Related Outcomes

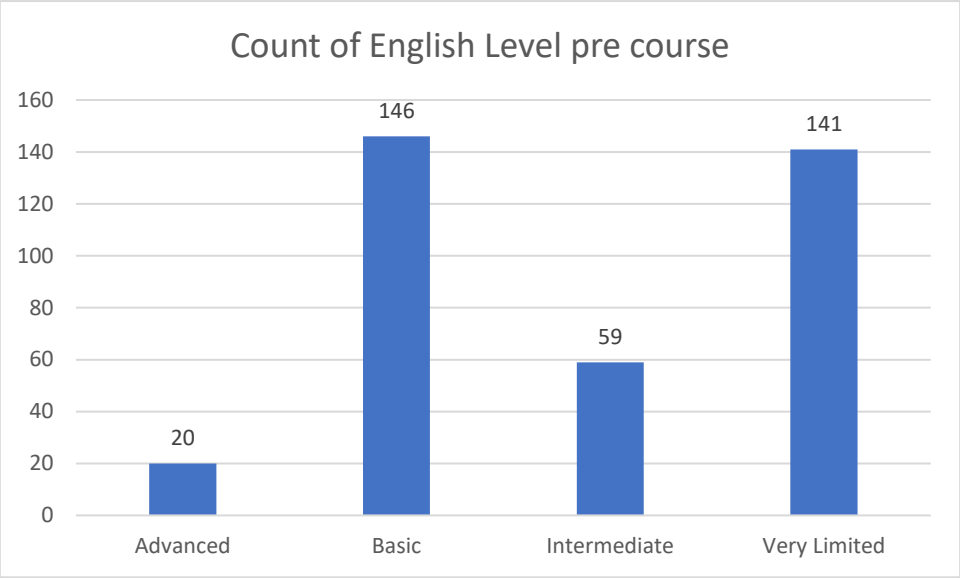


Language Skills and Confidence

The vast majority of learners coming onto the programme have either Very Limited or Basic English language skills (78.4%). This is typical of the learner profile for other iterations of Creative English and Creative English for Health and also entirely inline with the remit of the Caring for My Family programme.

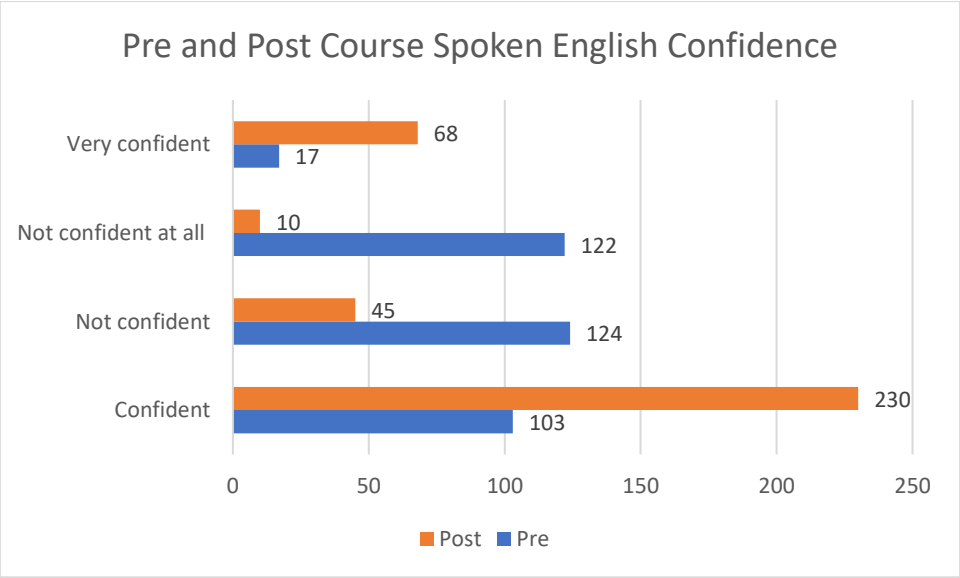
Anecdotally, many of the learners would not be suitable for more formalised, often written, English language provision and so the Creative English programme provides those who do wish to advance with a first step. This should not overlook that participation and progression on the programme with regards to increased spoken English language skills and confidence is both a very important outcome and, for some learners, their desired final outcome. One hub interviewee estimated that around 50% of their learners are likely to not be literate in any language. For these learners, progressing to be able to better and more confidently speak in English is a huge outcome that will have many positive life outcomes associated to it.

Figure 3: Pre-Course English Level



Overall, 98.2% of those learners who responded to the question "After completing this course, are you more confident speaking English?" felt that they were more confident. Again, this is a very significant outcome which will have tangible impacts on the lives of learners beyond the scope and aims of the programme. This high level of confidence increase in learners is also typical of the data seen in other Creative English and Creative English for Health programmes.

Figure 4: Pre and Post Course Spoken English Confidence



There were 5 learners who responded that they were not more confident in speaking English after completing the course and 4 of these began the course at a "Very Limited" of English with low levels of confidence in their spoken English. This does not mean that the programme did not have some

positive impact for these learners but that the majority of those who did not progress had Very Limited language skills and very low confidence is suggestive that there are limits to what can be achieved in 10 sessions with some learners who are starting at the very beginning of their English language journey.

Qualitative

This section presents the key thematic findings from the qualitative data collection. Inline with the Methodology section of this report, all of the interviews were semi-structured and, as much as possible were participant-led conversations around their engagement with, and understanding of, the programme. The data from these was then coded inductively to produce findings which represent the experiences and thoughts of participants. There was a great deal of consistency across all interviewees.

Benefits

All interviewees were effusive about the benefits of the programme and felt that overall they had all seen significant net benefits from it. The beneficiaries here can broadly be split into three groups; learners, hubs and primary health services.

The qualitative data gathered around the positive impacts on learners corroborates the findings of the quantitative data and these benefits were, as a rule, the first thing that all hub interviewees chose to discuss. The same language was used by the hub interviewees too suggesting at a uniformity of positive outcomes:

> *"Confidence, independence and ability. Empowering. All of that empowers people."*
>
> *"People are more confident and doing things for themselves. They feel like they can now and must've always wanted to."*
>
> *"Independence and confidence. They are the first things that come to mind."*

There is also little doubt amongst hub and FaithAction interviewees that there were more beneficiaries from the programme than are recorded in the programme data. The larger than average household size and propensity for learners to live in multigenerational households with a number of dependents means that impacting on the learner's knowledge, attitudes and behaviours will have a positive impact on much larger number of people than just those directly taking part.

Empowering and enabling caregivers and those responsible for the health and habits of others is an effective multiplier of impact and this is doubly valuable when working with relatively isolated population groups.

That the programme was targeting a cohort in need of such an intervention was obvious to all hubs interviewed too. The link that the programme makes between health inequalities and English language skills was clearly understood by all participants and felt to be a correct assumption. Two interviewees reported that this link was something that they already were "subconsciously" aware of but had never seen articulated or evidenced before.

That learners were previously unable to understand or make themselves aware of fairly commonplace public health advice was a recurrent theme:

> *"Language, or lack of it, is definitely a factor in poor health here. How can people eat 5 a day if they don't know what 5 a day is or means?"*

A recurring and key beneficiary group was also those who volunteered in the delivery of the programme. These individuals ranged from those who were confident in their English language skills and wanted to help others in their cohort to those who were looking for a formalised experience to add to their CV, but all were seen by interviewees as being individuals who had benefitted from the programme. In some hubs there were capacity challenges around volunteers progressing into paid employment and them no longer being able to give time to the Creative English for Health. Examples were also given of two volunteers who have since been DBS checked and now volunteer in a local school.

This impact on volunteers was not a deliverable on what is ostensibly a public health programme but shows a high level of added value.

The hubs also saw benefits from the work of the volunteers in terms of their increased capacity to deliver the programme with minimal extra costs, but there were other benefits reported. Two of the hubs interviewed believe that running Creative English for Health: Caring for My Family had opened their building and other services up to new cohorts of people who had either not used their premises before or had only done so fleetingly.

> *"We've got new people coming to other things that we run now. People who weren't accessing before but came to Creative English on word of mouth and are now staying for other things. It is great."*

The hubs also reported that they feel that they have been upskilled and are more capable at delivering training as a result of the support that they received in delivering this programme. This will, it is felt, be a lasting increase in local capacity for the hubs.

Lastly, all hub interviewees felt that it was likely that there would be benefits from the programme for local public health providers. These ranged from money and resource saved through preventative working and vaccinations to less wasted appointments and learners accessing more appropriate care for themselves. A reduced need for translation services was also suggested as a likely benefit though this was caveated by the likelihood that a learner would have previously relied on a family or friend to help them with language barriers.

However, no data was collected from primary care providers and it is not possible here to attribute any definitive outcomes. The data gathered from hubs, alongside the quantitative data on learner outcomes is certainly suggestive of positive benefits in this area though.

<u>The role of the faith and community sectors</u>

The data gathered here gave great emphasis to the significance of faith and community-based elements of programme delivery. This may, in part be a result of selection bias and a small sample but is also entirely consistent with findings from previous Creative English evaluations.

While not explicitly religious, many hubs involved in these programs have affiliations with faith-based organizations, which subtly influence the learners' comfort and confidence levels. The hub interviewees felt that this benefited learners, especially women, who they feel are often discouraged from participating in secular educational settings due to familial or cultural pressures influenced by faith beliefs.

The hubs are also seen as inclusive spaces that bring together local people from diverse backgrounds. For instance, in Christian settings, the religious identity supersedes other cultural or national affiliations, fostering a sense of belonging for participants. Interestingly, the connection with

faith is perceived more through the values of compassion, care, and understanding fostered within these spaces rather than explicit religious practices.

The interview data also, somewhat surprisingly, indicates that the timing of this programme which covered Christmas, Easter, and Ramadan may have enhanced recruitment and retention rates.

Moreover, these hubs serve as vital community resources, addressing issues like health literacy, which may not otherwise be prioritized by learners. The familiarity of learners with these venues, often through word-of-mouth referrals or previous engagements, contributes to the initial trust placed in the program. Participants perceive program facilitators as 'pre-screened' by the community or faith-based leaders, further enhancing trust.

Interviewees did not feel that the primary health care sector, or indeed the statutory sector as whole, had this kind of relationship with the people and communities that the programme was targeted with engaging. This is related, in part, to the language barriers and low levels of confidence that many learners have but is also linked to the physical locations of the hubs compared to many primary health bodies. That learners do not access services and provisions because they lead hyper-localised and spatially segregated lives is a very pragmatic assessment of some of the contributory factors in public health inequalities amongst the target cohort, but also a call for change in how these services and provisions are delivered.

> *"What people don't realise is that many of our learners don't leave the area that they live in. They don't drive and they aren't going to hop on a bus into a city centre. They live, shop and some work within a few minutes of where they live and if there aren't services in that area, then they aren't accessing them. We can work with them because we are here."*

Overall, the data highlights the importance of the coming together of faith, community, and education in this programme. Faith-based settings not only provide a cultural safety net but also facilitate engagement in educational initiatives, particularly in addressing health-related concerns. By leveraging the values and cultural behaviours associated with these spaces, Creative English for Health: Caring for My Family managed to bridge gaps and foster trust among diverse learner groups.

An important, and very positive externality, of the programme was that a notable proportion of learners became volunteers and there was a similar progression for some volunteers into paid employment. The hubs being located in local faith and community spaces was seen as a key driver of this as it gave those looking to advance themselves a space in which to do so.

> *"The volunteers we had volunteered because it was here. Would they have volunteered at a hospital? No, absolutely not."*

The hyper-local use of trusted spaces also gave the programme access to this pool of volunteers and learners who were willing and able to progress becoming volunteers. This is a real asset of the delivery of model and not one that should be overlooked or taken for granted: The programme was able to operate in a cost-effective manner whilst also upskilling and empowering people because it was operated through local faith and community spaces.

<u>Working with FaithAction</u>

The hubs interviewed provided a mix of organisations that had previously worked with FaithAction, and the Creative English programme, and those that had not. For all interviewees it was felt that the FaithAction team and product were professional and very confident in supporting the delivery of Creative English for Health in the hubs.

"They've done this before and they know what they're doing. That gives us confidence in doing what we're doing too."

That FaithAction provided the hubs with a named, single point of contact was felt by the hubs to be very beneficial in helping them to troubleshoot and solve issues. It also gave the hubs confidence that if there was an issue with the programme at all that they would not be alone in solving it.

"Having a name on it was important for us. Just being able to pick up the phone to the same person and they know who you are and why you're calling was really good."

The learning materials and programme content were also praised by the interviewees as giving them all that they needed to deliver. It was also felt that the training and upskilling provided by FaithAction to the hubs would provide a "legacy" of skills and confidence that would last beyond the programme delivery.

The only area in which the working relationship with FaithAction did not always work well for the hubs was with regards to data collection and reporting. This, however, was also attributed to the challenges related to collecting and recording data from cohorts of learners who, by virtue of their involvement in the programme, are likely to have low English language skills and confidence.

<u>Suggestions for future delivery</u>

All of the hubs interviewed would like to run Creative English for Health again and felt that the programme was beneficial to their learners and their own organisation. The localised approach to delivery is something that they would like to see retained as is the open nature of recruitment and who the programme can, within reason, be delivered to. For one hub in particular it was seen as a major positive that it could be delivered to all members of their very diverse local area.

"If you run something for one group and exclude another, then you create new problems. People feel excluded. We didn't have that here. Plus if people have different native tongues then it forces them to speak English to each other."

There were challenges in some hubs around recruitment (see Table 1) and this was attributed, at least partially, by several interviewees to differences in the hubs themselves and the amount of established clientele that they had who were likely to be suitable for the programme. Where hubs had either some track record of working with people who had low levels of English language skills or where they had a large cohort of would-be learners who were already accessing their premises for other activities, recruitment and retention tended to be relatively straightforward. However, where recruitment was dependent on getting large numbers of new people on site, or where it relied on a key individual rather than an institution, recruitment tended to be more difficult.

Conclusion and Recommendations

This evaluation finds that the Creative English for Health: Caring for My Family programme run in Greater Manchester in 2023/24 has achieved the funded aims of helping to address the health inequalities that people in Greater Manchester experience as a result of them having English as an additional language. The programme succeeded by teaching people to better look after their own health and that of their family. It helped them understand how to use and access the NHS better and placed focus on building trust between learners and public health bodies and reducing vaccine hesitancy. Though this was primarily a public health programme, there were also significant positive outputs around spoken English language and confidence for learners.

This attainment is due in large part Creative English for Health: Caring for My Family being a well-designed and run programme that is pitched at the correct level to meet the needs of the cohort, and a programme that draws on over a decade of FaithAction's experience and knowledge of running Creative English and Creative English for Health. The logic of the programme is coherent in meeting the needs of the target group, designed in a way which is supported by a large body of academic and policy literature whilst local hub delivery is supported by a professional and confident team at FaithAction.

Additionally, although the dataset in this evaluation is (by nature of the programme itself) small, all of the findings of this evaluation align closely with those of previous Creative English and Creative English for Health evaluations. This is suggestive of a high validity of the data and findings.

The key quantitative outcomes are that:

- 371 learners have completed the programme. This is against a target of 338 and so represents an overachievement of 33 learners, or around 10%. It is also likely that there is a degree of under-reporting in the dataset used in report as hubs have only recently finished delivery.
- 98.2% of learners feel that, after completing the course they are more confident in speaking English. This particularly important as 67.2% of learners were either "Not confident" or "Not confident at all" in speaking English at the start of their involvement with the programme.
- There were improvements on all 9 health literacy related indicators for learners, with some of these being very significant. For instance 79.5% of learners felt confident in getting appropriate if they or a family member was sick and needed specialist treatment. This is up from just 19.1% at the start of the programme (+60.4%) and 83.2% felt confident booking a Covid-19 or flu vaccination compared to just 24.6% at the start of the programme (+58.7%).

The learners were predominantly of Muslim backgrounds (72.8%) with the bulk of these having Pakistani (50.4%) origins. Those with Indian (10.5%) and African (8.9%) backgrounds comprised the next largest groups. Nearly all learners were born outside of the UK but, anecdotally, many of those in the older age groups engaged have lived in the UK for a number of years with limited English language skills and very low levels of interactions with public health and other statutory services.

That the programme had such positive impact on demographic groups in society that are often isolated and are at disproportionate risk of health inequalities is a major achievement. The programme has worked well in engaging with these learners and groups in Greater Manchester because of the hyper-localised level of programme delivery and the trust that the learners put in their local faith and community organisations. Many of the learners would not access the same programme if it were run outside of their local area or by groups and people that they did not personally know and trust. This is a key finding when considering future, similar interventions. Alongside this, FaithAction as an organisation and a team are experienced at running programmes such as this through the local hub model and are able to empower these trusted local faith and community groups and leaders to deliver in a systematic and professional way.

These factors, again, all align with the previous findings of other Creative English and Creative English for Health programmes and contribute to a wider evidence base for this and similar interventions.

There are, however, some areas of learning for the Creative English and Creative English for Health programmes going forward. Hub performance across Greater Manchester was not equal and it was often the case that those hubs which had established clienteles who were already accessing their premises and services performed better than those which had to recruit more widely and actively.

This can be a consideration in future hub recruitment. Additionally, that delivery run over both the Christmas period and Ramadan was not as disruptive as some hubs had initially believed that it may be, with some arguing retrospectively that delivery over Ramadan in Muslim centres may help to increase attendance and engagement.

Overall, Creative English for Health: Caring for My Family has demonstrated in Greater Manchester that it is an effective public health which reaches people living in the area who are at high risk of suffering health inequalities and who are unlikely to engage with more traditional public health interventions. That it is also shown to be a successful English language intervention which produces outcomes around confidence and spoken language ability that are likely to be linked to improved life and societal outcomes is very real added value.

Based on these findings, this report recommends that:

1. Greater Manchester Council and other similar bodies proactively consider the adaptation and rollout of Creative English for Health in other areas with a similar demographic makeup and prevalence of health inequalities.

2. Greater Manchester Council and associated bodies in the area continue to consider the role that the faith and community organisations can play in helping to address public health inequalities in local populations seen as marginalised or harder to reach. Ongoing engagement here could make effective use of capital already developed through this programme.

3. The conclusion of this evaluation is shared with hubs that participated in delivery as well as all of the local authority and public health body areas in which programme delivery took place.

4. FaithAction continue to refine and adapt delivery of the Creative English programme and the Creative English for Health programme and the recording of participant details and outcomes. Clear examples of this from this iteration include beginning to collect details on participant household size and volunteer pathways.

5. FaithAction review and compile recurrent findings from this and previous Creative English and Creative English for Health programmes. This now represents a significant aggregated dataset and body of evidence.