Evaluation of the Creative English for Health Birmingham Programme 2022-2023

Final Report

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Executive Summary

Creative English is a community-based ESOL programme which is delivered through local places of worship, faith-based and community organisations and uses practical themes such as shopping, talking to teachers, and going to the doctors to equip people with the skills they need to feel empowered and confident to speak English in their everyday life. Since 2014 Creative English has worked with over 15,000 learners in the UK. Creative English for Health Birmingham is based on the original approach and content of Creative English but is adapted to meet local need. This programme has been delivered by FaithAction and funded by Birmingham City Council.

From 2021 onwards, respiratory issues amongst children born during the COVID-19 outbreak have been a pressing public health issue in Birmingham with data showing that there is a higher likelihood of people under 18 being admitted to hospital with respiratory health issues in the areas where a larger percentage of the population have low levels of English. Creative English for Health Birmingham is therefore tailored to promote learning about child and family health matters, accessing support and services, raising awareness, and building confidence for speakers of English as a second language. Key themes in the teaching include making the best use of your GP appointment, using NHS 111, vaccinations, dealing with minor ailments, types of pain, mental health and healthier living.

This evaluation focussed on four clear objectives which were requested by FaithAction and Birmingham City Council. These are:

a) evaluating the delivery of Birmingham Creative English for Health against funded deliverables;
b) capturing best practice and areas of learning to inform the delivery of future, similar, projects and programmes;
c) developing an understanding of how, if at all, health literacy work delivered through established local hubs is able to engage with traditionally “harder to reach” individuals and groups; and
d) providing an evidence base for or against community-based health literacy provision.

Fieldwork and engagement with providers, hubs and learners took place from November 2022 to January 2023. The programme ran until the end of March 2023 and all quantitative data in this report is drawn from the final programme dataset.

This evaluation finds that Creative English for Health in Birmingham has achieved the funded aims of improving health literacy amongst the target cohort. This is in large part due to it being a well-designed and run programme that is pitched at the correct level to meet the needs of the cohort. The logic of the programme is also coherent in meeting the needs of the target group and is designed in a way which is supported by a large body of academic and policy literature.

The contact specified that FaithAction needed to engage with 600 learners across 10 hubs with 450 completing the programme. By programme end over 725 learners had been engaged and registered onto the programme in 11 hubs with 451 completions. This represents an over-achievement.

Learners in the programme have seen improvements in their health literacy and there are a number of key findings which point to successful outcomes in this, the programme’s principal area of focus. The statistical data shows clear, measurable increases in health literacy

awareness, further supported by anecdotal data from interviews and observations. There is very little variance between hubs in this data, with most learners experiencing an improvement of almost one rating category across every field of the health literacy survey. Moreover, the programme shows great promise in supporting learners to make attitudinal and behavioural changes in how, and why, they access health provision.

There are clear indications that the content and new health knowledge and awareness for learners has prompted some people in each hub to make changes to their behaviour. This includes making appointments where they would not have before, attending independently, asking different questions, using more accurate describing language and using NHS services more appropriately. For a 10-week programme in its first iteration to deliver this change is impressive and suggestive of notable impact for learners.

Though not a specific target for the programme, it is notable too that learner outcomes around English language proficiency are also positive. That it performs comparatively well against the original Creative English programme, allows for a clear conclusion that the health focus has not unduly detrimentally affected the efficacy of this tried and tested, nationally-renowned programme. The programme has been a successful experiment in adapting Creative English content to reach other outcomes.

The model of delivering through established faith and community hubs, which offer a level of cultural safety and welcome which learners do not trust to be offered elsewhere, is one that works in engaging people who are otherwise hard to reach or disengaged with statutory services. There is nothing in the data to suggest that this model is not entirely replicable elsewhere and scalable across a greater number of simultaneous cohorts.

This report makes the following recommendations.

1. Birmingham City 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 concerns in populations seen as marginalised or harder to reach. This programme has helped to address a current need but is unlikely to be a lasting panacea - ongoing engagement may be beneficial and would make best use of capital already developed through this programme.

2. Birmingham City Council consider capturing more longitudinal data on the impact of the programme if possible. This evaluation provides a cross-sectional snapshot and evidence that Creative English for Health has been impactful up to this point. It would be of use in the design of future interventions and determining value for money for a dataset to be developed which tests the programme's longer-term impacts and their effects on statutory services over time. A good route for this would be continued engagement through existing hubs and learner routes.

3. Public Health 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.

4. FaithAction continue to refine and adapt delivery of the Creative English programme and the Creative English for Health programme. The team has been excellent at taking on board the feedback of hubs and learners to date. This is an important

mechanism for addressing the dynamic, local needs of people and keeping learners engaged.

5. FaithAction continue to proactively seek funding to continue delivery in other areas across the UK. Public health inequalities are not unique to Birmingham and the model of Creative English for Health is now tested and shown to be effective and replicable.

6. Linked to Recommendation 6, FaithAction should consider using the Creative English programme as a base on which to develop other programmes for vulnerable communities and areas of need. Thematic areas could include mental health and wellbeing or post-pandemic health and educational inequalities.

7. FaithAction ensure that data collected is robust and consistent. This should include internal review of the data collection forms, particularly with regards to indicators around learner confidence and could also include consulting with hubs and learners to ensure that data continues to be collected in an appropriate and standardised way.

Introduction

This document provides an evaluation of the Creative English for Health Birmingham programme and was commissioned by FaithAction with a dual remit. The first is a traditional summative evaluation which serves as a check that the Creative English for Health Birmingham programme has 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.

The second is to build an understanding of the value added by the community-based provision of health literacy programmes. With a faith sector agent leading delivery via established, grassroots local hubs rather than the local authority or secular public bodies, this is an opportunity to explore the role of using trusted local agents to promote health literacy.

Creative English for Health Birmingham

In July 2022, FaithAction were funded by Birmingham City Council to deliver a tailored version of their Creative English programme. Creative English is a community-based ESOL programme which is delivered through local places of worship, faith-based and community organisations and uses practical themes such as shopping, talking to teachers, and going to the doctors to equip people with the skills they need to feel empowered and confident to speak English in their everyday life. Since 2014 Creative English has worked with over 15,000 learners in the UK.

Creative English for Health Birmingham is based on the original approach and content of Creative English but is adapted to meet local need. From 2021 onwards, respiratory issues amongst children born during the COVID-19 outbreak have been a pressing public health issue in Birmingham with data showing that there is a higher likelihood of people under 18 being admitted to hospital with respiratory health issues in the areas where a larger percentage of the population have low levels of English (FaithAction, 2022).

Creative English for Health Birmingham is therefore tailored to promote learning about child and family health matters, accessing support and services, raising awareness, and building confidence for speakers of English as a second language. Key themes in the teaching include making the best use of your GP appointment, using NHS 111, vaccinations, dealing with minor ailments, types of pain, mental health and healthier living.

Evaluation Objectives

This evaluation has four clear objectives which were requested by FaithAction and Birmingham City Council at inception. These are:

A. evaluating the delivery of Birmingham Creative English for Health against funded deliverables;
B. capturing best practice and areas of learning to inform the delivery of future, similar, projects and programmes;
C. developing an understanding of how, if at all, health literacy work delivered through established local hubs is able to engage with traditionally “harder to reach” individuals and groups; and
D. providing an evidence base for or against community-based health literacy provision.

Methodology

Evaluation Methodology

The research has taken a mixed-methods approach to the evaluation, bringing together a range of data types in order to produce a breadth and depth of findings on the programme's progress and impact. Importantly, the evaluation began with a focused review of the academic and policy literature related to health literacy, allowing empirical data to be grounded in the latest evidence and academic frameworks. An abridged version of this is included later in this report.

Evaluation and monitoring have been built into the programme from inception, with each delivery hub having clear reporting requirements which relate to the data interests of both the funder and FaithAction. As a result, there is 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. In addition, all learners were asked to self-report their demographic data where they felt comfortable in doing so.

All quantitative data used in this report was collected at hub level by the hubs and collated by FaithAction before being shared with the evaluation team for analysis. Resources, such as questionnaires were printed in English and hubs offered support to learners where appropriate. Learner data was gathered by the hubs at the time of learner registration and after they have completed the programme. This includes a language assessment undertaken on both occasions.

In comparison to prior Creative English programmes, less focus has been placed on English proficiency in the data; there was a conscious decision to not overburden learners through data collection. The dataset is primarily based on health literacy and, in an example of good practice, questions are taken directly from the established Health Literacy Survey, allowing a good degree of confidence in the instruments used. This 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 three main sources:

1. Semi-structured interviews with Creative English for Health lead contacts and volunteers (n=3);
2. In-depth observation of one Creative English for Health session in an area of Birmingham, including unstructured, informal interviews with volunteers (n=5) and learners (n=4); and
3. Semi-structured interviews with FaithAction team members working directly on the programme (n=4).

The qualitative data collection focused on people's perceptions, personal experiences and views of the programme, aiming to complement the quantitative data which focuses on more objective, comparable and measurable progress indicators. Learners 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.

All qualitative data collection took place in English with informal support offered by the hub and other learners to those who required it. This is the same approach as is taken in the delivery of the programme sessions, which are all also run in English.

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, observation 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 smaller than in previous Creative English evaluations, largely because the programme has been delivered to fewer people over a shorter timeframe and thus the scale of the evaluation matched the more limited scale of the programme. 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. 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.

Programme Methodology

Ward level data on asthma, deprivation and English spoken were cross-referenced to identify the most strategic locations for hubs. To ensure there were a minimum of 60 engagements per hub, the project team recruited hubs that were faith and community organisations with sufficient footfall and reach into the target population to achieve this. In addition, funding to hubs was released according to milestones including phased engagements. This encouraged a proactive approach to promotion and outreach where necessary to achieve the targets.

The HLS-16 questionnaire was completed by all learners who were willing and able to do so at a pre-course registration event or in their first session. The second questionnaire was administered in session 10. The challenges in translating questionnaires, due to the lack of semantic equivalence across languages, are well-documented. Where possible translations of the HLS-16 questionnaire were used that had been verified in existing, published research. This applied to translations in Hindi, Arabic and Kannada. Further written translations were supplied in Punjabi and Ukrainian. For those who were not sufficiently literate in English or in their first language, forms were completed by listening to an aural translation or with support from volunteer interpreter. This inevitably, despite best efforts, will result in some inconsistency in the translation of specific words within the question. The desire to please the questioner is also a risk in oral questionnaires. This however was mitigated against, as far as possible, by getting volunteers to support with this who were not programme leaders.

Session Methodology: Child Respiratory Health

The Creative English for Health Programme has a session particularly focussing on Child Respiratory Health. Relevant vocabulary and opportunities to build confidence communicating in related health settings are repeated and developed across a range of sessions on different health topics to consolidate learning and accelerate learner's confidence in using the relevant health systems appropriately. The consolidation is one of the advantages of embedding issue specific material within a 10-week programme.

This session is typical of the approach to learning taken by the Creative English programme and a full programme outline of all sessions can be found in Appendix 2 of this report.

1. Games to develop health literacy and language

Sessions include a variety of games to help learners understand vocabulary and health concepts in a fun and non-threatening way, which makes content more memorable and creates a relaxed atmosphere which encourages honest exploration of worries.

Example 1:
Paper tubes game
In the respiratory health session, learners make paper tubes and race to blow a feather across an agreed course. This usually results in high energy and lots of laughter.
After everyone has had fun playing the game, they are asked to put both their hands on their tube and squeeze them in, before briefly attempting to play the same game again. This time the feathers won't move much and there may even be some noise similar to wheezing as the air tries to squeeze through the tube.

The facilitator then shows a diagram of the lungs and explains how squeezing the tubes in on the game was similar to what happens in our lungs when he have asthma or a viral respiratory infection. Using one the squeezed tubes from the game as a visual aid, everyone can see that there are areas where fluid can sit, causing phlegm (a word also explained by a photo visual aid) or coughing.

Example 2:

How worried should I be? Child Respiratory Health Symptoms Game

Another objective of this session is to equip parents with an understanding of symptoms of children's respiratory illnesses and whether the appropriate course of action is A&E, NHS111, GP or self-care. Our resource pack includes photocopiable cards for a game in small groups involving acting out symptoms for others to guess and then decide on the appropriate course of action. Linking words and movement both makes it more fun and accessible and improves retention of learning. The group discussion around the activity highlights misunderstandings and anxieties and allows them to be addressed in a relaxed, informal way.

2. Storytelling: Rehearsal for Life, Humour and Improvisation

To equip learners with the confidence to seek the appropriate source of help, they will have an opportunity to practise responding spontaneously to a situation where the knowledge they have acquired earlier in the session is needed. The Creative English blend of narrated acting and improvisation allows for specific symptoms to be embedded in the story.

Example 3: Toddler Rimsha has symptoms of respiratory disease

In this case, the toddler Rimsha is played by a puppet operated by a participant and another participant plays her mum or dad. The facilitator invites the group to add details to the story by asking questions about what the characters are doing which helps to tailor it to the cultural backgrounds of the learners. The toddler is at first mischievous, to again encourage laughter and empathy between parents in the room. When the child develops symptoms of respiratory disease that are ambiguous. The participants are invited to resolve the situation, which requires advice from NHS 111. This gives everyone a common experience to explore and reflect on in the session and links it straight into practical action.

3. Understanding of language and systems

Example 4: Pair work supported by a resource sheet

An objective of this session is that a concerned parent would be confident to use NHS111 for advice if they were not sure of the best course of action for their child. Confidence to ask for an interpreter, if needed, and familiarity with questions that are likely to be asked and possible answers in English are important. Our resource kit contains a photocopiable outline of questions and responses related to the child respiratory concern in the acted section, but with a variety of outcomes to each question. Having looked at the sheet, participants are encouraged to improvise rather than read from the sheet, as this is more effective preparation for real life communication.

4. Child Respiratory Health Case Studies

When addressing child respiratory health, it was important to address the vocabulary and confidence to engage with health services across a range of topics to ensure that lessons learned in session and in practice could be utilised outside of the learning environment. Below are 3 short case studies which illustrate how learning from the programme around child respiratory illness has successfully carried over and resulted in positive changes to participant attitudes and behaviours.

Child Respiratory Health Case Study 1:
M would normally wait for her husband to come back from work and ask him to deal with any medical help needed for her family, as she did not consider her own English to be good enough to do it herself. Last week she phoned the GP and went to the emergency department with her son, dealing with a medical problem in her family independently for the first time. She said: ‘My son was vomiting, coughing, fever, three days so bad. I called my doctor and the doctor said take him to the emergency department. […] The doctor there gave him a spray and now he is ok. I was there for seven hours but because it was [a] weekday, [my] husband [was] working. I was ok talking to the nurses and the doctors and my son is feeling better. I am pleased I did the right thing, calling first the doctor, even though he needed the emergency department. Calling the doctor first gave me confidence, because I was worried for my son, but I knew I am doing the right thing for him – caring. My son is ok now, still coughing little, but he is ok.’

Child Respiratory Health Case Study 2:
R said she always used to panic when her son was ill. She would always go to A&E for help and did not know there were other sources of help and advice. Having completed Creative English for Health, she was able to respond differently. She said: "My child was sick and I [was] scared, but I look at photocopy [traffic lights for self-care, NHS 111 or A & E] and think no – is ok. Breathing is ok. Nappy ok. I monitor and stay home. Now he's better. It helps to know what an emergency looks like. If he get[s] worse, I phone 111. I know I can ask for someone [to] help me. It's hard as [a] parent to do [the] right thing, but this English [class] give me confidence."

Child Respiratory Health Case Study 3:
K's son had a temperature, very runny nose and intermittent breathing difficulties, so she had to make an appointment with the GP for him. She said it was easier to do than before she took part in the English classes as she could tell the doctor her son's symptoms, and how long he had the illness for. Previously, medical words were difficult for K to understand, but in this case she had no difficulty understanding because of the English classes: "This class has given me the opportunity to improve my English speaking and listening skills. The roleplay is helpful to improve English because when I take on a certain role, I can improvise, and this is helpful when I go to the doctors."

Literature Review: Definitions and Dimensions of Health Literacy

To aid the development of this evaluation, a review of academic and policy literature was undertaken, ensuring that the evaluation connected well to the available evidence on health literacy and related concepts. The review introduces definitions and frameworks of health literacy before covering health literacy as a whole-system concept and its relationship with health inequalities. The piece then reviews the literature on health literacy interventions, such as those under evaluation here, and briefly looks at how a published model of such interventions relates to Creative English for Health.

Literacy and Health Literacy

As a starting point, literacy is the ability to read, write, speak and listen in a way that facilitates communication and sense-making of the world. Definitions of literacy also often include having basic numeracy skills (Kickbusch, 2001). A 2011 UK government survey of adult literacy skills found that 14.9% (or 1 in 7) of adults in England have literacy levels at or below Entry Level 3, which is equivalent to the literacy skills expected of a nine to 11-year-old (The Skills for Life Survey, 2011). In 2015, a slightly higher proportion - 16.4% (or 1 in 6) of adults in England – were found to have "very poor literacy skills" (OECD, 2015). This has a significant bearing on these individuals' ability to function and participate effectively in society, including with healthcare services.

The related concept of health literacy was introduced in the 1970s and has been variously defined since then. Over 250 definitions of health literacy have been identified in the academic literature - a systematic review and qualitative synthesis of these by Liu and colleagues (2020) identified three broad dimensions to health literacy, each with sub-themes:

(1) knowledge of health, healthcare and health systems;

a. knowledge about medication, treatments and states of illness
b. knowledge about healthy behaviours, healthy lifestyle, health terms and public health
c. understanding of the basic structure and available services of a health system
d. understanding of fundamental scientific concepts and scientific arguments

(2) processing and using information in various formats in relation to health and healthcare;

a. ability to process and use information to guide health actions – this incorporates literacy, numeracy and oral communication skills in a general sense as well as the distinct abilities around obtaining, understanding, appraising, communicating, synthesising and applying health-related information.

b. self-efficacy in processing and using health information i.e. having confidence in one's own abilities to find and understand health information, and seek help from, ask questions of, and advocate for oneself with healthcare professionals.

c. access to resources and support for processing and using information – this includes access to information infrastructure, guidance and support from healthcare professionals and social networks, and the resources – financial and time – to find and process that information.

(3) ability to maintain health through self-management and working in partnerships with health providers.

a. self-management incorporates self-perception, self-reflection and self-control – it is important for becoming aware of one's need for health information and applying that information accordingly. With respect to managing one's health, this theme also includes goal-setting, and developing and executing strategies to achieve those goals.

b. working in partnership with health providers also requires interpersonal skills – listening, respecting, and communicating effectively with others.

A popular categorisation of health literacy was developed by Nuttbeam (2008) who distinguishes functional, interactive and critical health literacy:

- Functional health literacy refers to the foundational skills of reading, writing and numeracy which are needed to use healthcare services and understand health information.

- Interactive health literacy refers to the more advanced cognitive, literacy skills and social skills which enable someone to "actively participate in everyday situations", deriving information from different forms of communication and applying that understanding in various contexts.

- Critical health literacy is the ability to use those cognitive, literacy and social skills "to critically analyse information" in order "to exert greater control over life events and situations".

Both Liu and colleagues' (2020) and Nuttbeam's (2008) classifications demonstrate that writing and reading skills, oral literacy, and numeracy are inextricable from the most fundamental form of health literacy, showing a clear link between the work of Creative English and the aims of health literacy programming. Only once these skills have been developed can an individual engage more interactively and critically with healthcare providers. Understandably, therefore, individuals with lower levels of educational attainment or who do not speak the majority language of a healthcare system typically show lower levels of health literacy.

Health Literacy as a Whole-System Construct

Recent empirical studies into the meaningfulness of health literacy have given it a different framing. Rather than an individual attribute or skill, these researchers propose health literacy is a 'whole system' construct. For example, patients, carers and professionals who participated in focus groups led by Salter et al. (2014) saw health literacy as a result of interaction between patients and the healthcare system – best supported by good communication in one-to-one consultations: 'they implied that for them personally, any lack of health literacy was a defect in the system, a system that did not give them, or help them, discover and develop the information or skills they need.'. Institutional aspects, like a lack of continuity of personnel within a health service, or fragmentation between different services, were also seen as deleterious to health literacy.

Data from these focus group participants as well as interviewees in Samerski's (2019) ethnographic research point to the need for care and support, not just information, in order to manage their health. Similarly, an empirical study by Edwards et al. on health literacy in people with long-term health conditions identified that 'health literacy was distributed through family and social networks, and participants often drew on the health literacy skills of others to seek, understand and use health information' (2012). This again suggests that people do not experience health literacy as an individual asset or need, but as a social reality, touching on healthcare service design, healthcare professionals, friends and family.

Levels of Health Literacy

Quantitative assessments of health literacy have typically focused on health literacy as an individual attribute. For example, the European health literacy survey (HLS-EU) is built on a definition of health literacy as 'the knowledge, motivation and competences to access, understand, appraise and apply health information in order to make judgments and take decisions in everyday life concerning health care, disease prevention and health promotion to maintain or improve quality of life throughout the course of life' (2018).

Surveys in Australia, Canada, New Zealand, and the USA have suggested that as much as half the population may have substantial difficulties with the reading comprehension and numeracy associated with health-related information and behaviours (Barber et al. 2009). In 2015, the HLS-EU, when conducted in Austria, Bulgaria, Germany, Greece, Ireland, the Netherlands, Poland and Spain (n = 1000 per country, n = 8000 total sample), found 47% of respondents had insufficient or problematic health literacy (the two lower levels in a four-grade hierarchy) (Sørensen et al., 2015). There was, however, significant variation between EU states with only 2% of Dutch people found to have inadequate health literacy, compared to 27% in Bulgaria (ibid). A 2018 survey of a representative sample of 2,309 UK adults found that 19.4% had some level of difficulty reading and understanding written health information

and 23.2% did so when it came to discussing health concerns with health care providers (Simpson, Knowles & O'Cathain, 2020).

Variations in levels of health literacy

National surveys of health literacy have consistently provided evidence of a social gradient in health literacy associated with other indicators of social and economic disadvantage (Mantwill, Monestel-Umaña & Schulz, 2015). Education levels, spoken language and age are commonly recurring variables, accounting for lower levels of health literacy within populations Bo, Friis, Osborne & Maindal, 2014). For example, in the HLS-EU research (Sørensen et al., 2015), the highest proportions of people with limited health literacy were found among those whose social status was defined as 'very low' (73.9%), those with the lowest levels of education (68%), those who had persistent difficulties paying bills (63.4%) and those aged 76 years and above (60.8%).

Similarly, the elderly, ethnic minorities, individuals who did not complete high school, who spoke a language other than English before starting school, and those living in poverty were found to have lower health literacy scores in the USA (Kutner, et al. 2006). A study from Victoria, Australia in 2013–2014 found the lowest health literacy scores among those born overseas and spoke a language other than English at home (Beauchamp et al. 2015). Having a lower level of education, multiple chronic health conditions, and not having private health insurance (used as a proxy indicator for socioeconomic status) were also associated with lower health literacy.

In the aforementioned 2018 research in the UK, those who were least likely to understand health information and be capable of engaging with healthcare providers were those from the most deprived social quintile; those with a health condition or disability; and respondents with lower levels of education (Simpson, Knowles & O'Cathain, 2020). Respondents categorised as BAME were less likely to score highly in the 'understanding health information' domain than White respondents.

Because, to have good health literacy in a specific context, a patient and healthcare professional should ideally be able to communicate in the same language, migrants have been repeatedly found to demonstrate lower levels of health literacy than their indigenous counterparts (Ward, Kristiansen & Sørensen, 2019). In migrant communities across the EU, poor health literacy, language and cultural barriers between patient and healthcare provider have been found to be related to poorer maternity care and maternal health (Lauria, et al. 2013); poorer treatment adherence and self-management of chronic conditions; and lower awareness of chronic disease risk (Cooper et al., 2012).

Relationships between health literacy, health outcomes and health inequalities

Lower health literacy scores have been shown in several studies to be associated with higher avoidable hospitalisation rates (Baker et al., 2002), decreased ability to manage one's own health (Miller 2009), higher mortality rates (Bostock & Steptoe 2012) and increased costs to healthcare systems (Haun, et al., 2015). Health literacy has also been found to independently predict health outcomes (Berkman 2011), even after controlling for socioeconomic position (Bostock & Steptoe 2012). In addition, a review by Stormacq and colleagues (2019) propose that health literacy mediates the association between socioeconomic status and specific health outcomes, health-related behaviours, and access to and use of health services.

Numerous studies have identified health literacy as the mediator in the health inequalities associated with educational attainment and race. For example, in a cross-sectional study of a nationally representative sample of 2,668 US adults aged 65 years and older, Bennett and colleagues (2009) found that Black and Latin origin respondents were more likely to report fair or poor health than White respondents; and Black adults were less likely than White adults to have had an influenza vaccination or dental check-ups. Adults who had not completed high school were 2.4 times more likely to report fair or poor health, and less likely to have received a flu vaccination, mammogram or dental-check-up (Bennett et al., 2009), than those who had graduated beyond high school. When participants' health-related print literacy scores were assessed, White respondents had significantly higher health-related print literacy scores than Black participants, followed by Latin origin participants (ibid). There was also a gradient in health literacy scores by level of education attainment (ibid).

Bennet et al.'s regression analyses found that after controlling for disparities in health literacy, there was a statistically significant reduction in the relationship between race and health status and influenza vaccination, as well as between educational attainment and uptake of all the health services. Although the study did not identify the specific causal mechanism which made health literacy a mediating variable, these findings suggest that interventions focused on improving health literacy may help reduce educational and racial disparities in preventative health measures and health outcomes.

Other studies have found health literacy to mediate the relationship between a parent's level of education and attendance of paediatrician appointments (Yin et al., 2009), and between race and:

- diabetes medication adherence
- blood sugar control
- lower asthma quality of life scores and increased asthma-related emergency department visits
- and levels of prostate-specific-antigen (PSA) in prostate cancer patients (Osborn et al., 2011)

Improving health literacy, therefore, has been suggested by Pelikan and colleagues (2018) and Stormacq et al., (2020) to offer a midstream intervention to address health disparities caused by 'upstream' socioeconomic determinants. In other words, while the ultimate (upstream) causes of health inequalities – like poverty and discrimination – appear intractable to resolve, their impact on certain health outcomes can be mitigated by addressing one of the variables which connects them: health literacy.

Interventions to improve health literacy

Health literacy is to a large extent context-specific – people are likely to be more knowledgeable about health conditions that friends and family have experienced than those which they have not encountered in their personal experience, and more likely to engage confidently with healthcare services they have grown up with than those which are new to them. Accordingly, individuals' health literacy can be improved if health services are more accessible and easier to navigate, and if healthcare providers have increased cultural

competence and an understanding of how to communicate health information at various levels or in different formats (e.g. pictorially).

Various types of interventions used to improve health literacy have been studied in the academic literature – including those aimed at individuals, and those for groups, interventions delivered online and others delivered in-person; single component interventions (e.g. an information leaflet) and multi-component ones (consisting of training sessions, leaflets, chat-groups etc.). A systematic review of 23 studies of such interventions from the EU discerned that they could be (a) aimed at improving (aspects of) the health literacy level of individuals; (b) specifically tailored to different health literacy levels; or (c) general interventions that aimed at improving health outcomes, which described the specific effects for patients with different health literacy or numeracy levels (Visscher, et al., 2018).

Many studies have assessed how health information can be communicated so as to be comprehensible to individuals with low health literacy. A 2011 systematic review of health literacy interventions found that the following strategies were effective at improving participant comprehension: 'presenting essential information by itself or first, presenting information so that the higher number is better, presenting numerical information in tables rather than text, adding icon arrays to numerical information, [and] adding video to verbal narrative' (Sheridan et al., 2011). But these interventions have limited impact as they do not help participants develop transferable skills (i.e. interactive or critical health literacy) which can be employed in different contexts – health-related or otherwise.

Visscher and colleague's (2018) systematic review was unable to draw firm conclusions about the effectiveness of specific components of health literacy interventions on account of the low quality of the studies and the lack of consistency in definitions of, and measurements used for, health literacy, and in study design. They did, however, suggest three factors which appeared to indicate promising results:

1) Activities tailored to the needs of low health literacy participants:

2) Addressing interactive and/or critical skills (instead of knowledge only): and

3) Presenting information in an appropriate way.

Stormacq and colleagues, in their 2020 systematic review of the effects of health literacy interventions on health-related outcomes in socioeconomically disadvantaged adults builds upon Visscher et al.'s comments. They identified "cultural appropriateness, tailoring, skills building, goal setting and active discussions" as "effective intervention operational components":

A culturally appropriate intervention is one which is adapted to the needs, preferences, attitudes, norms and cultural values of the target group (Marín, 1993). They have been found to be more successful than standardised interventions at improving health outcomes by addressing systemic barriers (e.g. financial, geographical, language) and involve community members in developing and implementing the intervention, thereby increasing community engagement (Healey, 2017). Kreuter et al. (2002) describe a range of strategies for making health interventions culturally appropriate:

- Peripheral strategies, such as designing materials with an aesthetic and visual vocabulary which reflects the audience's social and cultural world
- Evidential strategies, such as providing information and data which is specific, and thus relevant, to the target audience, so the relevance is clearly perceived
- Linguistic strategies, e.g. communicating the material in the target audience's spoken language
- Involving 'constituents' – building on the experience and participation of (lay) community members in designing, planning and enacting the intervention
- Sociocultural strategies, i.e. incorporating the values, beliefs, customs etc. of the target audience in the intervention
- Tailoring, like cultural appropriateness, means an intervention is developed and delivered in line with a target audience's needs and preferences – however tailoring typically refers to individualised health messaging whereas cultural appropriateness is oriented towards groups.
- Skill-development is an important part of developing interactive and critical forms of health literacy which involve appraising, evaluating, decision-making, communication and self-management.
- Skill building is partly related to health behaviours through the concept of self-efficacy, the confidence a person has about their capacity to undertake behaviour(s) that may lead to desired outcomes. Self-efficacy is a key concept in several health behaviour change theories, as a proximate and direct predictor of intention and behaviour. Whether a person decides to change their health-related behaviours, how much effort they will put into doing so, what goals they set for themselves, and how long they will persist in the new set of behaviours in the face of obstacles and challenges, depends on self-efficacy – their belief that they will succeed in changing their behaviour and therein improve their health. If an individual has built the skills relevant to initiating and maintaining the behaviour-change, then they are likely to have a higher sense of self-efficacy.
- Individual and/or group discussions, facilitated by a professional or 'layperson' were a common feature of effective health interventions in Stormacq's 2020 review. They allow for individuals to gain clarification, ask questions so they can interpret the health information for their particular context and personal circumstances, and the facilitator can check understanding using techniques like the teach-back method. The teach-back method, whereby a service-user articulates in their own words the information, or demonstrates a technique, just explained by a clinician or educator, has been evidenced to improve patients' level of knowledge and abilities to self-manage a health condition (Talevski, et al. 2020).

Community settings, Stormacq and colleagues suggest, may also be an important factor in health literacy interventions for socioeconomically disadvantaged groups. In a randomised control trial to increase breast cancer screening among African American women, for example, 481 individuals in the EG received the Black Cosmetologists Promoting Health Program delivered in beauty salons. Cosmetologists spoke to their clients about the importance of early breast cancer detection using storytelling and culturally relevant educational materials – at 6 months follow-up, the odds of adhering to mammography screening were 2 times higher in participants in the EG than those in the CG. The trial itself did not identify the factors which made this intervention successful. But Stormacq and colleagues suggest the community-based, participatory approach, whereby the information was delivered in a familiar, local environment by "lay interventionists", and the "culturally appropriate" information as contributing elements.

Health Literacy Intervention Model

To conceptualise how health literacy can be improved, Geboers and colleagues (2018) developed a model based on a literature review and surveying 68 health literacy experts. Their model focuses on the individual and the health professional as the primary actors who, together, can influence health literacy, but it also embeds them in a wider social context, consisting of family, friends, peers and the wider health system.

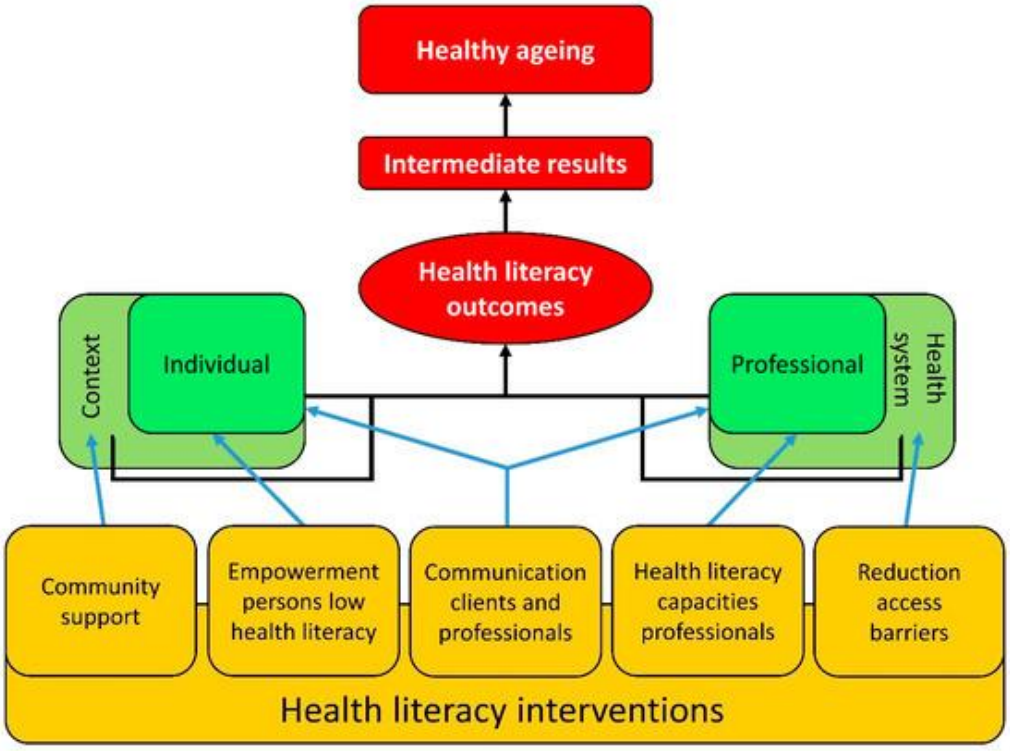

Figure 1: Health Literacy Interventions Model

Based on this model, improvements in health literacy can be achieved through interventions addressing (combinations of) the following five factors:

1. **Community support** - The individual's context through interventions that strengthen their social support systems (e.g., family, friends, caregivers, communities).

2. **Empowerment** of the individual with low health literacy through, for example, skills-building and improving their ability to self-manage their health.

3. Improving **communication** between individuals and health professionals.

4. **Health professionals'** ability to recognise health literacy-related problems and respond appropriately to ensure the patient understands them.

5. Improving **access** to health systems – e.g. improving access, quality of care, or patient safety.

Geboers et al.'s model recognises that health literacy is an asset that can be developed rather than a risk factor that needs to be managed. Since health literacy is likely distributed through family and social networks, we can add that health literacy can be seen as a community asset – which might account for the success of the place-based group interventions described

above. Creative English for Health seeks to improve health literacy among members of migrant communities through such an intervention in Birmingham. Of the factors identified by Geboers et al., it targets factors (1), (2) and (3) by helping participants improve their English language skills, particularly around health-related topics; their knowledge of local health services; and their confidence, social skills and communication skills through group role-play activities.

There are a range of findings from this review which will be referred to throughout this report. In particular, the frameworks which outline different aspects within health literacy go a long way to making the concept less nebulous and more practically-applicable to this evaluation. The discussion on interventions and the model presented above is also useful for showing more precisely where the roles of community support and empowerment sit conceptually in programmes, allowing this novel programme to situate its strengths within existing practice.

The Logic of Creative English for Health Birmingham

Before evaluating the programme, it is important to understand the logic at play within it. Most social action and health programmes attempt to bring about a change via an intervention, and this is true of Creative English for Health Birmingham. Here the coherent logic throughout is that learners having an increased awareness of health-related issues and services, as measured by their health literacy, will improve their health outcomes and reduce the impact of these, and misunderstandings about provision, on local health services. This has been articulated to the evaluation team in interviews with programme stakeholders at all levels throughout and is the clear priority.

The underlying structure and remit of the programme is also clearly linked to models of best practice around community interventions and the use of culturally appropriate venues and content as outlined in the Literature Review section of this report. That Creative English for Health has foundations in tested and credible methodologies is beneficial in terms of both articulating the work and, likely, the outcomes.

The programme is, however, distinct in that English language is a hook that gets people to learn about health literacy. There is a clear demand and need for English skills in the areas in which the programme is run and participants know that they want English skills, but don't necessarily know of or prioritise health literacy.

In this sense the programme uses English language as the vehicle for health literacy learning and a series of counterfactual questions about this approach were used to test the model. These include:

- Would learners have attended if the sessions were run in their mother tongue?
- Would learners have engaged with or read translated literature that promoted health literacy to them?
- Linked to the above: How would this translated literature be picked up in the first place by disengaged people and how literate are they likely to be in any language?
- Is it ethically acceptable to provide people with health information that they are unlikely to be able to use or do anything with?

The findings in this evaluation show that the programme addresses all these questions and presents an inclusive and coherent model of engagement which is appropriate both to the needs of the learners and the requirement of the funder.

An immediately apparent finding in both quantitative and qualitative data is that learners grow in confidence through taking part. This is both in speaking and understanding English but also in being a part of a group or community. For many learners this is a core element of their life outside the home and somewhere that they can express and be themselves and this is something which has been recurrent in previous research and evaluation of other Creative English programmes, especially where they work predominantly with females.

This confidence, along with the knowledge and health literacy, leads to greater self-efficacy from learners in approaching, engaging with and dealing with the primary health sector. Self-efficacy is an individual's belief in their capacity or ability to act in the ways needed to reach a specific goal or goals and is distinct from confidence and self-confidence as it is targeted to one specific outcome. Self-efficacy is a widely used concept in sport science (a common example is of a golfer imagining a shot before taking it), but in relation to Creative English for Health this could involve a learner challenging a doctor over a diagnosis or seeking out further treatment.

This in turn leads to greater empowerment of learners and gives them a sense of control over their own health and choices related to it. Highlighted in interviews was a sense of powerlessness on the behalf of learners. In practical terms this played out through a lack of understanding of the health system with some learners having felt in the past that they should be feeling grateful for any care that they receive or knowing their options around raising issues or requesting second opinions. This meant that they didn’t feel in a position to challenge authority figures (including gatekeepers such as receptionists) or diagnoses and that there was a real sense of health being done, or not done, to people with very little agency on their part.

The data is suggestive that the programme seems to have worked to address this lack of agency and the model of improving English language skills and health literacy in parallel, whilst also building a general self-confidence and more focused increase in self-efficacy around health and health care, is both intuitive and robust.

Programme Data and Findings

The programme was set clear goals at the outset for learner engagement via hubs. Initially it was planned that 10 hubs would run, though by programme end 11 had been engaged. A number of the hubs involved in delivering Creative English for Health Birmingham have worked with FaithAction in delivering Creative English in the past, but there were also some first-time hubs and new areas reached and engaged with. An example of this is that the most recently recruited hub has a strong reach in Eastern European communities of the local area which was a target group identified by Birmingham City Council based on local need.

The programme aimed to secure 600 engagements with 450 completions through 10 hubs by the end of the run. At programme end there had been over 725 engagements and a total of 451 completions from 11 hubs in the city. All participants who have completed the programme will have undertaken a health literacy survey at baseline and endpoint as well as having a language assessment undertaken at the same times. This satisfies a contractual requirement.

The hubs and the number of learners completed at each can be seen in Figure 2 below. That there is a great deal of variance in the total engagements for each can be attributed to a number of factors including how long the hub has been engaged with the programme for and at what stage of their lifecycle with the programme they are at. Some hubs also had higher targets than others to reflect their initial successes in engaging learners.

Hub Name	**Leaners Engaged**
Bangladeshi Women's Association	58
Community Foundation	13
Diamond Community Learning Project	37
Highfield Hall	63
Karis Neighbourhood	23
Nishkam Centre	56
Oasis Hobmoor	54
Polish Ex Pats	11
Saathi	42
Smart Women	34
Springfield Project	60

Figure 2: Hub name and engagements

Additionally, the programme had the following key targets to be delivered:

- Improved confidence talking to professionals, e.g., Teachers, Pharmacists, Dr's receptionist etc.
- Number of participants registered with GP
- Number of participants reporting greater confidence in communicating with GP's
- Number of participants reporting improved health impacts for them and their family members due to participating in the course
- Number of participants who have undertaken a recommended health literacy survey (HLS-EU-16) at baseline and endpoint
- The provision of learning materiel and content to all hubs
- Language assessment undertaken at outset and end of programme with each participant

All quantitative data in this report is drawn from datasets provided to the evaluation team on 04/07/23. This represents a full and final sum of the data collected during the programme. A complete description of the methodology used in data collection is provided earlier in this report.

Data and findings in this section are presented thematically based on the reporting priorities of both Birmingham City Council and FaithAction, as well as relevant emergent areas of interest drawn from the data. Where targets or contractual obligations are directly addressed, these are mentioned in text.

Demographics

FaithAction and the programme hubs collected a large volume of demographic data on leaners. This section provides a summary of this aggregated data and reports it in a way that does not make any learners identifiable. It is possible to interrogate the data further and break down learners by multiple characteristics, however where sample sizes are smaller this does lead to challenges and ethical issues around both identifiability and reliability.

Of these 451 learners, 424 identify as female. This accounts for 94% of the cohort with 4.4% being male and the remaining 1.6% either choosing not to disclose or not responding to the question. It is very clear from this data, and from qualitative data and observations, that the vast majority of learners in the programme identify as female. This was a target group prior to delivery and so represents a positive facet of delivery.

Gender	Number	Percentage
Female	424	94.0
Male	20	4.4
Undisclosed and No response	7	1.6
Total	**451**	**100.0**

Figure 3: Learners by Gender

301 of 451 learners gave their religion as Muslim. This accounts for 66.7% of the total cohort and mirrors the success that previous iterations of the Creative English programme have had in engaging with Muslim populations. The next largest demographic group by faith background was Sikh with 100 learners, or 22.2% of the cohort. A small number of Christian, Hindu, Buddhist learners, as well as some from other and no faith backgrounds, also took part in the programme.

Religion	Number	Percentage
Muslim	301	66.7
Sikh	100	22.2
Christian	34	7.5
No religion	4	0.9
Buddhist	1	0.2
Other	3	0.7
No response	4	0.9
Total	**451**	**100.0**

Figure 4: Learners by Religion

Learners were asked their ethnicity and categorisations taken from the Office of National Statistics were used here. This is good practice and ensures that data is standardised and comparable. Pakistani heritage learners made up the single largest ethnic group in the cohort with 124 in total, or 27.5%. This was followed by 107 of Bangladeshi heritage who comprised 23.7% of the cohort and 60 from Other backgrounds making up 13.3%. Towards the end of the programme there was a targeted hub recruitment effort to engage with more White and/or Eastern European participants and this is reflected in the final statistics.

The idea for the programme was partly sparked as a result of research from NHS Birmingham and Solihull which showed high levels of childhood respiratory disease and low levels of English language proficiency in areas of Birmingham (FaithAction, 2022). The high proportion

of Pakistani and Bangladeshi heritage learners is thus a result of the programme's being targeted at these particular areas of need and is a positive indication that it has successfully reached its intended target groups.

Ethnicity	Number	Percentage
Pakistani	124	27.5
Bangledeshi	107	23.7
Other	60	13.3
Indian	54	12.0
Black African	19	4.2
Arab	14	3.1
White European	14	3.1
African	13	2.9
White other	9	2.0
Mixed Asian	8	1.8
Caribbean	6	1.3
Mixed African	4	0.9
White British	2	0.4
No response	5	1.1
Total	**451**	**100.0**

Figure 5: Learners by Ethnicity

Only 2.2% of learners self-reported as being disabled. This is significantly lower than both the national and local averages and would suggest that either the programme has struggled to reach people with disabilities or that there was some degree of uncertainty or ambiguity in the data collection around this characteristic.

Disability Status	Number	Percentage
No	423	93.8
Yes	10	2.2
No response	18	4.0
Total	**451**	**100.0**

Figure 6: Learners by Disability

With regards to the age of learners at the time of their registration, the largest single group was those aged 25-44 with this group making up 45.7% of the total (206 people). Given the public health concern around young children with respiratory illnesses in the local area, it is a positive outcome for the programme that it engaged with a high proportion of people of typical child rearing age. This is suggestive of greater potential impact. The next largest group was those aged 45-64 and comprised 35.9% of the total, or 162 people.

Age	Number	Percentage
18-24	18	4.0
25-44	206	45.7
45-64	162	35.9
65+	55	12.2
No response	10	2.2
Total	**451**	**100.0**

Figure 7: Learners by Age

Outcomes in Health Literacy

The main ambition of this iteration of the programme has been to improve the health literacy of learners. Central to the programme's logic is that this will lead to better decision making and health outcomes for patients, less misuse of health provision and more efficient primary care delivery in Birmingham. As discussed in the literature review, health literacy is a widely used term with many differing definitions and facets. To measure progress against tried and tested international health literacy indicators, the HLS-EU-16 survey was used by the FaithAction team. This is a short-form version of the HLS-EU-Q47 survey which has been recommended for use with vulnerable populations and those where time and language skills are often limited (Storms H., et al 2017).

To begin with, a key finding from this survey data is that the Creative English for Health Birmingham programme achieved its core aim of improving the health literacy of learners. Across all 16 questions in the survey, the data shows a clear improvement in health literacy by between 0.7 and 1.0 points on average on a 4.0 scale. In real terms an increase for an individual learner of 1.0 would represent a move from 'very difficult' to 'fairly difficult'.

The use of a 4.0 scale for analysis here, as opposed to a 5.0 scale in the HLS-EU-Q47 form was agreed in advance with Birmingham City Council to ensure greater integrity of the data. Where a learner either did not fully complete either a pre or post form, or where they checked "Don't know" or "Prefer not to say", their response to that question was excluded from the pre and post data sets for the purpose of the analysis. This pairing of pre and post responses by learner, and the exclusion of data where one part is missing or inconclusive, is a standard approach in ensuring that data is robust.

The data shows firstly that most learners at the start of the programme found healthcare interactions 'very difficult' or 'fairly difficult', showing a clear relevance of the content to the recruited cohorts. The end-line data shows that almost all learners have progressed to finding these interactions easier relative to their starting point, with on average a move of nearly one whole rating on every question/measure. At present it is not possible to give a breakdown of average improvement by demographic category as the small datasets for some groups could potentially make learners identifiable. This would constitute a breach of research ethics. However, such analysis may be possible with programme end data or through the aggregation of the main demographic classifiers if required.

For a cohort mostly, according to interview data, attending to improve their English language proficiency and likely facing significant barriers to engaging at a basic level with primary health care, this is a significant step forward in a short period of time and tells a positive story in both English proficiency and health literacy.

To ensure the analysis of this quantitative data relates to the latest academic progress on health literacy, the findings from the survey are ordered using the health literacy framework provided by Lui et al. (2020). The 16 questions used by the Creative English for Health hubs, found in the HLS-EU-16 survey, can be broadly divided into three analytical areas, with the caveat that there is some degree of overlap between categories.

Knowledge of health, healthcare and health systems

In this area of the framework, Lui and colleagues demonstrate that health literacy is advanced by a range of aspects related to an individual's knowledge. This includes improving an individual's knowledge about medication, treatments and states of illness, about healthy behaviours, healthy lifestyle, health terms, their understanding of the basic structures and services of a health system and, at a more advanced level, their understanding of fundamental scientific concepts and scientific arguments.

These areas of knowledge clearly overlap with both HLS-EU-16 and the aims and objectives of the programme, particularly with regard to enabling learners to know more about the treatment available to them, areas of concern around their health and that of their families and lastly the way in which primary care in the UK operates. These meet the contractual requirements around improved learner confidence talking to professionals (such as Teachers,

Pharmacists, Dr's receptionist) and also on learner reporting greater confidence in communicating with GPs.

The data, focused primarily on perceptions of a learner's ability, clearly shows that the intervention of the programme makes learners feel that they are more literate in these areas. The survey results show that learners are more confident in searching out information on illnesses of concern and in finding out where to seek appropriate professional help. This directly aligns with the initial concerns of Public Health Birmingham around child respiratory illness not being reported by parents until it became a serious presenting issue, often in a hospital or emergency care setting.

Competency	**Mean learner improvement on 4-point scale**
I can find information on treatments of illnesses that concern me.	+0.9
I can find out where to get professional help when I am ill.	+0.9
I understand my doctor's or pharmacist's instructions on how to take a prescribed medication.	+0.9
I can use information the doctor gives me to make decisions about my illness.	+0.8
I can follow instructions from my doctor or pharmacist	+0.9

Figure 8: Health Literacy Average Change in Knowledge of Health

Building knowledge and understanding in these areas is a clear and expected strength of the programme, given the focus on language and terminology. The qualitative data supports these findings, noting that volunteers are able to see demonstrable change in learners in relation to fundamental health knowledge and talking in English about health.

> *'One of the ladies who comes to the English. I heard her the other day. She was talking to a friend about the different types of pain and she'd remembered it from class and was explaining it all to her. It's clear that she's enjoyed and it's gone in.'*
>
> – Creative English for Health Hub Leader
>
> *'Some of them didn't know parts of the body and different illnesses at all and they all do now.'*
>
> – Creative English for Health Volunteer
>
> *'One lady who used to come to our [play provision]. She's from [Country X]. She had no English. She can now point to parts of the body and name them and she walks into a room now and says hello and how are you.'*
>
> – Creative English for Health Volunteer

It is in these examples which the core programme logic is perhaps most evident and borne out. Most health literacy interventions, as shown in the academic literature, are predominantly focused on increasing understanding of health knowledge. In these examples, though, there is an obvious interplay between gaps in health knowledge and a lack of English language proficiency. Whilst many learners are learning how to speak in English about health for the first time – primarily an exercise in translating from first language to English - some learners did not know foundational terms such as parts of the body in any language. One example provided was a female learner who did not know the composite parts – such as thigh or shin - of the leg in any language. Indeed, at least 3 learners across the hubs interviewed were reportedly close to illiterate in their first language, creating multiple barriers to health literacy in the UK for these learners. These examples bring to life not only the mutual benefit of bringing health literacy and English language learning together but also the low baseline levels of knowledge in both areas with which many learners are entering the programme.

A relevant area of interest here to Birmingham City Council, and a required programme outcome, was that over 90% of learners be registered with GPs. Here the programme has had a minimal effect, but this is due to already high rates of GP registration at the time that learners registered. From a dataset of 451 learners, 427 were already registered with GPs at the time that they joined the programme, and this rose to 433 by the time that learners had completed. 11 learners did not answer the question and the number of learners not registered with a GP was only 7. This is possibly suggestive of a greater number being registered with GPs than had been anticipated by the funder and the provider.

Processing and using information in various formats in relation to health and healthcare

The measures in this thematic area are closely linked to self-efficacy whereby individuals are aware of their health needs and rights and, crucially, feel capable of advocating for themselves with health professionals to ensure that these are addressed and fulfilled. A precursor to this is the ability of an individual to process and use information to guide their actions and an awareness of resources available to them and the means of accessing them. This includes understanding and contextualising advice given by others, including friends, family and the media.

Competency	Mean learner improvement on 4-point scale
I can understand what my doctor says to me.	+0.8
I know when I may need to get a second opinion from another doctor.	+0.7
I can judge if the information on health risks in the media is reliable.	+0.7
I can decide how to protect myself from illness based on information in the media.	+0.8
I understand advice on health from family members and friends.	+0.8
I understand information in the media on how to get healthier.	+0.9

Figure 9: Health Literacy Average Change in Processing and Using Health Information

The outcomes here, as with the previous section, shows a clear improvement across the board.

In many respects this area of outcomes is more advanced than those in the first area, arguably requiring a greater level of self-actualisation on the part of the learner. This feels ambitious for a 10-week programme with a cohort of learners who initially report as lacking the confidence or ability to engage with or challenge health providers, or to tackle misinformation. However, particularly with regard to challenging misinformation, the programme appears to have been an effective space for learners to address concerns and rumours around vaccines, including MMRA and Covid-19, as well as stigma around the menopause and other female health issues.

> *'They don't know about vaccinations as much as they should. They don't know that they're available or needed.'* – Creative English for Health Volunteer
>
> *'Our learners need to hear it from a trusted source, face to face. They tell us the information they see on Facebook or whatever their social media is and it is misinformation. They pick up the wrong idea of vaccines or medical treatment or the NHS and that stops them from getting what they need. This course offers clear advice and tells them how to get help.'*
>
> – Creative English for Health Hub Leader

The data very clearly shows that, as a result of the programme intervention, learners feel better able to both understand and challenge health related information that they either seek out or are given. This is a very important success for the programme, particularly given the low starting point in health literacy of most learners.

Ability to maintain health through self-management and working in partnerships with health providers

Lui et al.'s final thematic area covers individuals' ability and confidence in managing their health and care. This includes elements of self-perception, self-reflection and self-control but also requires the interpersonal communication skills, including speaking and listening, to engage with health providers and the information they provide.

Indicators here such as understanding health warnings around smoking and knowing which everyday behaviour is related to health outcomes can be directly linked to attempts in Birmingham to tackle childhood respiratory illnesses, but it is also clear that the programme attainment here goes beyond this and bleeds into other areas of important preventative care. Again, in all areas of the HLS-EU-16 survey, including those around mental health self-management and self-care, learners have become more literate. This represents an attainment above that initially envisaged for the programme and addresses requirements around participants reporting improved health impacts for them and their family members due to participating in the course.

Indirectly too this dataset shows learners reporting an improvement in their well-being. This was an area of interest to Birmingham City Council at programme inception and appears to be one in which the programme has made a positive impact.

Competency	Mean learner improvement on 4-point scale
I can find information on how to manage mental health problems like stress or depression.	+0.8
I understand health warnings about behaviour such as smoking, low physical activity and drinking too much.	+1.0
I understand why I need health screenings (such as mammograms etc)	+0.9
I know how to find out about activities that are good for my mental well-being.	+0.9
I can judge which everyday behaviour is related to my health.	+0.8

Figure 10: Health Literacy Average Change in Self-Management and Working in Partnership

In addition to the data collected from the HLS-EU-16 survey, the Creative English team also recorded pre and post intervention data on learner confidence in both booking medical appointments and in seeking out specialist care. In both of these datasets, learners report positive attitudinal changes. Where learners are asked how confident they are to book an appointment with a doctor, dentist or nurse in English, a move of +0.7 can be seen. This, again, links closely to the outcome around participants reporting greater confidence in communicating with GPs.

As a broad pattern this is a net positive for the intervention, however a deeper interrogation of the dataset also shows that a number of learners moved from feeling Very Confident to just feeling Confident – a decline of one rating. This could be due to any number of factors, including learners' mood on the day, learners being made aware of their inabilities, the social desirability of wishing to appear confident or a lack of clarity for some in the phrasing of questions. Observations and interviews conducted by the evaluation team did not suggest that learners are undermined by the content or provision, and this would contradict other programme data around increased confidence, but these anomalies could be an area of future exploration and focus for the Creative English team.

Whilst much of the programme focuses on knowledge, language and awareness, there are some data which relate closely to health-related behavioural change. One example which links to the outcome around participants reporting improved health impacts for them and their family members due to participating in the course is that learners reported a +0.7 increase in their confidence in seeking specialist medical care if they or a family member were sick. Specialist care here includes using NHS 111 or urgent care centres. Further, from the qualitative data, there were a range of examples of learners leaving Creative English for Health sessions and taking direct action on their health.

'There are some learners that didn't know what high blood pressure was. So, there's two - they've gone away and spoken to the doctor and found they've both got high blood pressure. From the one class, there's two that went to the doctors as a result of the class.'

– Creative English for Health Hub Leader

This example in particular is a stark demonstration of the potential of the programme, and again relates to the value of bringing health literacy and Creative English together. Not only did these two learners not know what the term in English for blood pressure but they were not aware of the risks of hypertension per se. Whilst this example is far from generalisable, combined with other data on increases in understanding, it shows a clear potential for the programme to spark positive behavioural change from under-served groups.

Finally, there are also a number of examples in the qualitative data related to the agency of learners. As expanded upon in the next section, a number of interviewees noted that some female learners faced barriers to managing their own or their families' health due to a lack of agency at home, partly – reportedly – due to relationship dynamics but also because learners are sometimes the only one in the house without the English language skills and confidence to engage with public services effectively.

'Imagine you couldn't even phone a doctor because you have to wait for your husband's permission. Slowly, slowly we get them to talk English'

– Creative English for Health Volunteer

'Some are so reliant on their husbands. Children are growing up. And the mothers are left at home. Husbands are so controlling. Waiting for husbands to come home so they can phone the doctor. And then the doctors are closed by the time he's home'

– Creative English for Health Volunteer

'Rather than waiting, some of the learners are saying they can now pick up the phone and talk to the doctor and say my name is X and I would like an appointment for my daughter. She has hurt her head.'

– Creative English for Health Hub Leader

Whilst the potential relationship dynamics of learners are far beyond the scope of this evaluation, it is clear from this data that the improvement in both English language confidence and health literacy knowledge has the potential to empower learners to become more independent in managing health and health service engagement. If borne out over time, this is a significant behavioural shift from the programme.

Outcomes in English Language Proficiency

Separate to the strong indications of impact in learners' health literacy, the programme shows clear strengths in advancing language proficiency in both competence and confidence. To some extent, this is to be expected as Creative English in its original form has been tried and tested, with repeated, detailed internal and external evaluation data demonstrating its efficacy in developing the English language competence and confidence of learners at pre-entry level.

One line of enquiry taken in this evaluation, though, is the difference made, if any, by the focus on health literacy: have the changes in content affected the programme's ability to support learners in their English language progression?

Data from across the evaluation shows that the starting English proficiency level of learners, as with most of the original Creative English programmes, is either Very Limited or Basic – in ESOL terms, most learners would be classed as 'pre-entry'. The common experience shown in the qualitative data is that, anecdotally, most learners are new to English language lessons:

> '*Most of the students haven't been to an ESOL class before. New cohort. New learners. They'll move on the ESOL entry one after. They're pre-entry – a few with no English at all.*' – Creative English for Health Hub Leader

The figure below shows the learner's level of English both before and after the programme, as assessed by each respective hub. There is a clear shift in ability from the lowest grading of Very Limited up towards Basic, and again from Basic towards Intermediate. Before the programme, 186 learners were assessed as having Very Limited English skills which moves to being just 87 by the time learners had completed. As a result, the number of learners with Basic levels rises from 225 to 277 and those with Intermediate skills rises from 30 to 62. This is an impressive rate of progress and return on just 10 sessions.

Although there was an increase in the number of learners with Advanced English skills (from 6 to 9) this is not a significant shift and is not one which is the focus of the programme. This does, though, demonstrate both that the engagement of learners has taken place at an appropriate level and that the development of English skills is a good hook for learners, even if it is not the primary focus of the programme or the funder.

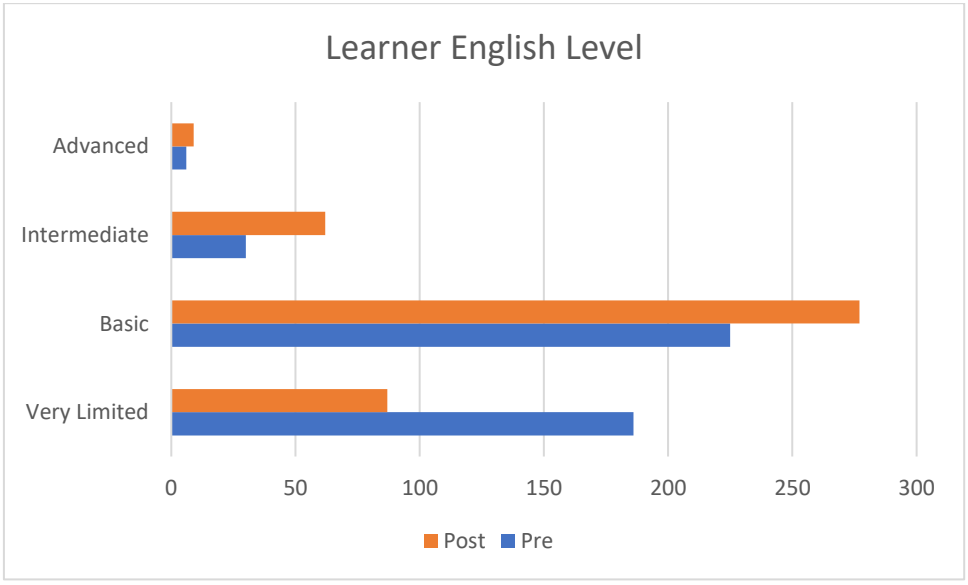

Figure 11: Pre and Post Learner English Level

The hub-assessed data above is in line with learner's perceptions of their own English skills before the programme. Here 73.0% of learners expressed that they were not confident in their English skills, showing the need for the programme amongst these cohorts.

After completion 81.8% of all those completing the programme felt that they had become more confident in speaking English. This is a very high percentage given the short time span of the course and is a credit to the course design, content and delivery. This meets the contractual requirement of language assessment undertaken at outset and end of programme with each participant.

Interviews with FaithAction have also suggested that there may have been issues around the data reported by hubs which may have negatively impacted the figure here too, with the implication that the true percentage may be higher. The particular issue here is related to the layout of the assessment forms. This is an area which FaithAction can focus future attention but this should not detract from the benefits to confidence in speaking English which the vast majority of learners have seen.

The programme's success shown in these results is further supported in the qualitative data collected. There are a range of positive examples of learners showing clear improvements in English language proficiency.

> '*One of the ladies who I know, who has no English and wasn't progressing at all in the other courses she's taken. She's now progressing and starting to speak for the first time in Creative English. Starting to recognise words and ask questions. So that's great. She wasn't speaking at all before.*'
>
> – Creative English for Health Hub Leader

The Creative English programme, in previous iterations, has been evaluated and researched leading to clear, recurrent findings that a strength of the programme is in building the confidence of learners (Coventry University, 2015). This includes FaithAction's working with Barking, Havering and Redbridge University Hospitals to develop and deliver a tailored Creative English programme designed to teach conversational English skills to international hospital staff. Whilst it has been effective in supporting learners to grow technical ability in, for instance, vocabulary and pronunciation, the biggest success and central aim for the programme has been providing the chance for people to speak English in front of others and feel more confident in doing so. The qualitative data shows that this trend has continued with this latest iteration.

> '*Across the board, they really enjoyed it. They just need the space to be able to talk and get confident. It's about the group and engaging with each other and make friends and prompt each. They are shy when they arrive and have a good laugh.*' – Creative English for Health Hub Leader
>
> '*One woman saying that she goes into the pharmacy and understands most of what they say but doesn't have the confidence to speak back and articulate herself, despite knowing most of the words.*' – Observation from Fieldnotes

The observations and interviews with hub representatives provide a range of examples in which people's confidence in speaking in English, health related and not, has grown noticeably during the programme.

Despite the progress, however, those running the programme at a local level felt that there was one main area in which the programme could be improved to better improve English proficiency.

> *'Get it to run a bit longer. People are just getting into it and then it stops.'* – Creative English for Health Volunteer

All those spoken to felt that increasing the number of sessions would significantly enhance the programme's impact for learners. Indeed, two of the hubs involved in the qualitative research reported that they were continuing to support learners to meet informally after the session.

Finally, returning to the question of whether the new focus on health literacy has affected the programme's ability to deliver against its original aims of English proficiency, the general trend in the qualitative data is positive.

> '*I don't think people mind the focus. It could be different focus - shopping. It doesn't matter so much because the health module has been there. It is still people being able to speak and say words in front of other people. They're both good in each aspect.*' – Creative English for Health Hub Volunteer and former Creative English Volunteer

Case Studies beyond Child Respiratory Health

Whilst addressing child respiratory health, it was important to address the vocabulary and confidence to engage with health services across a range of topics to ensure a long-term benefit through putting into practise things learned.

This section includes some other example case studies relating to other indicators on the HLS-16 questionnaire:

Case Study 4: Improved language skills resulting in better communication with health professionals

P became very emotional when she learnt the word 'lungs' in our session. P had been trying to communicate with her GP that she had a problem with her lungs for the last 4 years. Despite using an interpreter, she found that they still hadn't conveyed her symptoms accurately to the doctor. It had been very distressing, as she had not been able to get appropriate treatment. After participating in the Creative English for Health programme, she returned to the doctor. Having explained the problem with her lungs and appropriate investigation, she has a diagnosis of long covid. It has really helped her to finally know what has been causing her to feel so unwell.'

S was prompted after the lesson on diabetes to see her GP, because she was tired and thirsty and knew that other relatives had diabetes. She was able to use the vocabulary she had learnt to make the appointment and explain her symptoms to the doctor. Following a blood test, S was diagnosed with diabetes and is now on medication.

Case Study 5: Social benefits of programme support positive lifestyle change

"Before I joined, I felt very isolated. I was a stay-at-home mom and did not have a social life or many friends. I was also overweight and have diabetes. The healthy workshop lesson has really helped me become more aware of healthy eating habits and the negative side effects

of obesity which has helped me change my lifestyle. Meeting new people and making friends has also been very important for my wellbeing, as I no longer feel isolated."

"I am a single parent who lives alone. I did suffer from depression and isolation. I love attending the Creative English sessions: I have learned so much and I feel great now, made so many friends. From this, I now attend swimming and gym sessions, also I have passed on health information to my friends and family."

Case Study 6: Trusted community advocates as facilitators encourage people to act on health advice

After attending our sessions for screening checks, Miss U checked her breasts and managed to find a lump on her chest. At the moment she is undergoing treatment. She was really grateful that this issue was identified at an early stage as she had been ignoring her breast screening letter. "I am so glad that I have attended these sessions of health Creative English and my teacher made me realise how important these screening tests are. Please carry on these sessions so they can aid other women like me "

"I'd actually received a letter from the Doctor to go for my mammogram but I was putting off booking it because I was scared. Thank you for the reassurance that I now feel following the lesson on Health Checks."

Case Study 7: Combatting misinformation:

"N had suffered from poor mental health for a long period of time. She believed that anti-depressants are harmful and should not be taken. "I [Volunteer facilitator] was able to encourage her to go seek help from the doctor and to express her fears to the doctor. As a result, she started to take anti-depressants and has started counselling. N said: "I feel I can manage my mental health and I can now feel myself getting better, as the fear I had about medication has been clarified. Because of this I am now able to confidently help others like me who believe in rumours. I have joined the counselling sessions. From this, I am able to express myself and put things into perspective."

Case Study 8: Raising awareness of mental as well as physical health

A has a 15yr old daughter who has been struggling with her mental health. She didn't know what to do to help her. As a result of the session on mental health, A feels she can talk to her daughter about seeking help and that she knows what to do. Prior to the session, she hadn't actually realised you could speak to the doctor about mental health. A volunteer facilitator explained: 'Lots of these learners don't realise they can talk to their doctor about their mental health. They think they can only speak to them about physical health, or that the only kind of health is physical health, so that's why we really want to support them to recognise when their mental health is suffering and to know what to do.'

Value added by the faith and community sector

An important aspect of the programme is that it works with a cohort of learners whom statutory bodies, including those in the NHS, traditionally find challenging to engage well with. At first glance there may not be an apparent logic to a faith-based charity running a health literacy programme using English language skills to engage harder to reach learners. However,

understanding this unique logic and then why it appears to provide highly positive results is central to evaluating the programme.

Creative English has a long history of working in diverse communities through local faith and community organisations. At an immediate, practical level, the use of community and faith spaces to deliver the programme enables Creative English for Health to have a physical presence in local areas in which the target populations live. This type of hyper-local, targeted engagement is useful in areas of high spatial segregation, or in instances where cohorts are unlikely to spend much time outside of their immediate neighbourhood.

Providing connections to wider services

Furthermore, by working with and through these faith and community spaces as hubs, FaithAction is effectively able to mobilise embedded local assets and leaders, providing trusted connections to local volunteers and learners. It is telling that a large number of learners – judging from the qualitative data – in the programme have not engaged in English language learning or health literacy programmes elsewhere, including through statutory services such as health, education or housing. Instead they have chosen to attend faith and community centres already known to them. This is an example of bridging capital (Wuthnow 2002) whereby faith-based relationships are leveraged in a way that connects those in more excluded groups into existing social capital (Putnam, 2000). Interviews with hubs corroborated that most learners are only likely to engage with services outside of their immediate vicinity in situations of urgent need such as serious illness or urgent policing support.

> '*The faith sector is engaged with people who aren't engaged in other settings.*'- FaithAction Team Member

Previous research into Creative English has demonstrated that the programme acts as a stepping-stone towards greater engagement with wider community services (Coventry University, 2015). Prior evaluation work has focused on learners engaging in further training or increased employability as success indicators. Similarly for this iteration of the programme, the evaluation data provides initial indications that the programme is supporting learners to increase their future engagement with primary health care systems and providers. This evaluation offers a cross-sectional snapshot towards the end of a short intervention but there is scope for more longitudinal data to be collected in future programmes in order to further test this assumption.

Initial trust through local familiarity

The Creative English for Health hubs which learners see as the face of the programme are also typically venues which learners will have visited or used before or that learners will be aware of through friends or family members. The qualitative data shows that learners are often referred to the programme through word of mouth or habitual use of the hub, allowing an initial level of trust to be conferred upon – for many – an entirely new, unknown learning programme. Those running the programme are likely to be viewed by learners as having been "pre-screened" by the community or faith-based leader who is the face of the hub venue.

> *"We're referred to all the time by social workers and support workers. We are trusted by them and the community."* – Creative English for Health Hub Leader

This aligns closely with documented patterns of behaviour whereby interpersonal trust (in the hub leader, often already known to learners or learners' friends and family) is used to leverage organisational (Creative English for Health and FaithAction) and institutional (public health and wider NHS services) based trust (Bachmann and Inkpen, 2011).

Faith, culture and trust

As well as the familiarity aspect, this research and other Creative English evaluations show a recurrent theme of learners feeling that they would not be as comfortable or confident in engaging with the programme in a wholly secular setting. In this programme, many of the hubs involved are not outwardly or explicitly faith-based but have ties to faith-based organisations, such as being established by a Christian organisation or being linked to a religious school. The link between faith and learner's trust is, then, nuanced and quite difficult to obtain declarative data on – there are lots of variables at play, of which faith is one. It is however clear that the faith-based approach is salient to learners and hubs; this section explores that relationship in order to better pinpoint the ways in which that salience manifests.

As a starting point, all hubs involved in the qualitative research noted that it was common for female learners to share that their family members (in most cases cited, their husbands) would be unlikely to support (the term 'allow' is used in multiple interviews) them taking part in a programme in a more secular environment such as a school or college, partly due to faith and cultural practices at home.

> '*This place here is a trusted place. Husbands feel comfortable for them to come here. They wouldn't feel comfortable to go to a college.*' – Creative English for Health Volunteer

The discussions with learners, volunteers and hub leaders showed that this is due to a range of factors, including gender and perceptions of cultural safety (courses are mainly run and attended by women) and familiarity with the building or people running the hub. For the volunteers interviewed during observations, though, there were often connections made between the faith-based nature of the programme and the hub, the range of faiths practiced by those in the room and a feeling of cultural safety and fitting in.

> *'We're mainly Christian working here. But it's not really a faith-based service. I think the relationship is the biggest part. They know we care and we have their best interest at heart, because we're Christian but also because it is well known and safe.'* – Creative English for Health Hub Leader

As this quote suggests, faith is one part of the picture of trust. From the data available, there appear to be intangible, implicit ways in which the connection with faith ensures that hubs do not conflict with learners' cultural needs and own faith practices. When asked about the faith-based nature of hubs and learning spaces (e.g. 'This is a Christian centre, what does that mean for you?'), learners and volunteers talked about the virtues of listening, compassion, care and understanding of needs, experienced in those spaces rather than about faith practices. Often this sat in contrast in their minds with the perception of what more formal learning in local colleges would offer.

Moreover, this ability to engage with learners through the faith and community sector is far from limited to engaging with learners of the same faith background (e.g. a Gurdwara's community centre engaging with Sikh learners), again suggesting that there is a wider

appreciation of shared values and identity, culture and/or faith relevance at play. There are a range of examples from the hubs involved of faith-based organisations having long track-record and established trust with local people that likely transcends a single faith identity – people appear to trust based on implicit values which transcend faith systems rather than because of specific faiths and beliefs.

The complexity of how faith and identity play out in the programme was bought into sharper focus in an interview with a white, Christian trainer on the Creative English for Health programme who talked of the high level of conversation around difficult subjects that took place, often in an unprompted way, in sessions:

> *'The programme allows for conversations that you wouldn't have with an outsider. But then I am an outsider, aren't I?'* – Creative English for Health Trainer

Here the discussion covered how identity is defined by learners and the multiple layers of identity and superordinate identity that all people carry. Whilst this Hub Leader and the FaithAction team are not Muslims living in Birmingham, they are also not outsiders to the faith sector and are able to access and mobilise faith identity and values in ways which Public Health and other public bodies are likely less able to.

Faith, for most of the hubs involved in this research, was a background factor but an important one which clearly represents a set of values which elicit trust. Clearly, the faith-based nature of many of the hubs does not on its own equal comfort and confidence for learners. It does, from the data available however, provide a link with care, openness, compassion, safety and listening. These values appear to represent and provide cultural safety more than perceptions of statutory provision, or at least they reduce the potential for the learning space to be in conflict with learners' cultural and faith needs.

> *'We celebrate all festivals and honour their culture and faith. That's our strength.'*
>
> – Creative English for Health Volunteer

This approach appears to overcome a crucial barrier which many learners would face if the same programme was delivered by statutory or secular providers: these places offer much greater guarantees that implicit cultural needs and norms will be met. This comes from the relationships between identity, community and faith which play out in these spaces.

Community, informality and overcoming common barriers

Finally, and linked to previous findings, these faith and community settings allow for a more informal and family-friendly approach than would likely be possible (or be perceived by learners as possible) in a health-based location. Important in this is that learners feel confident in coming into the venue but also that they are aware that, in many of these spaces, they are able to bring children or those that they have caring responsibilities for in with them. This removes a tangible barrier to learners. During hub observation it was clear that learners felt comfortable sitting before and after the session to talk to other learners. One learner brought in a homemade cake to share with fellow learners in the break. The volunteers and hub leader went around the class asking about people's wellbeing separate to their roles in Creative English, talking about other concerns of learners related to family or finances. The atmosphere, as seen in many Creative English observations in the past, was informal, relaxed and caring.

That the hubs are also viewed by learners as being the benevolent providers of other community resource is also important for getting learners to engage around matters, such as health literacy, which otherwise are unlikely to be a priority for them without a presenting an urgent need. A strong finding in the interview data is that learners have a pressing range of day-to-day issues and priorities which they must deal with and that they do not have the time or resources to park these in order to learn more about health. This is even the case when there are non-urgent health concerns.

> *'Including health in this programme is really important – the women here see their health as the last thing of importance in their lives. It's the children and husbands first. Their wellbeing isn't a priority for them.'* – Creative English for Health Volunteer

> *'More than systems and health facts – it's about saying it's ok to look after themselves and take control of their own health'* – Creative English for Health Volunteer

By getting learners through the door to deal with other concerns and taking a holistic, whole-person approach, the local providers are able to offer something which larger public bodies are often seen as not providing.

> *'We offer practical help. They know we're there to show love and concern and signposting and practical help.'* – Creative English for Health Hub Leader

Conclusions and Recommendations

This evaluation finds that Creative English for Health in Birmingham has achieved the funded aims of improving health literacy amongst the target cohort. This is in large part due to it being a well-designed and run programme that is pitched at the correct level to meet the needs of the cohort. The logic of the programme is also coherent in meeting the needs of the target group and is designed in a way which is supported by a large body of academic and policy literature.

Learners in the programme have seen improvements in their health literacy and there are a number of key findings which point to successful outcomes in this, the programme's principal area of focus. The statistical data shows clear, measurable increases in health literacy awareness, further supported by anecdotal data from interviews and observations. There is very little variance between hubs in this data, with most learners experiencing an improvement of almost one rating category across every field of the health literacy survey. Moreover, the programme shows great promise in supporting learners to make attitudinal and behavioural changes in how, and why, they access health provision.

There is not enough data available in this cohort or timeframe to support broad statements such as 'most learners changed how they accessed the NHS' but there are clear indications that the content and new health knowledge and awareness for learners has prompted some people in each hub to make changes to their behaviour. This includes making appointments where they would not have before, attending independently, asking different questions, using more accurate describing language and using NHS services more appropriately. For a 10-week programme in its first iteration to deliver this change is impressive and suggestive of notable impact for learners.

The data shows that these health literacy related successes have taken place alongside tangible, positive outcomes for learners related to English language capability and confidence: this is an historic strength of the Creative English programme but still an important achievement here. The Creative English for Health programme is a health literacy programme and is funded as such. However, the findings presented above show that this iteration of the programme also achieves very strong English proficiency outcomes. That it performs comparatively well against the original Creative English programme, allows for a clear conclusion that the health focus has not detrimentally affected the efficacy of this tried and tested, nationally-renowned programme. It perhaps shows the value of the approach, the providers and the ethos in creating impact, over the specific content focus of each iteration.

The programme has been a successful experiment in adapting Creative English content to reach other outcomes. The data here shows that the programme continues to perform excellently in relation to English language proficiency and is still, in many areas, the only funded provision available for those who speak little to no English or are deemed to be pre-entry level to ESOL courses. Creative English's successful adaptation in serving other audiences and performing other functions is a real positive from this test. Health inequalities are not the only inequalities in the UK that are linked to poor English language skills and so the programme has the potential for achieving a wide range of impacts if promoted and funded to do so.

The model of delivering through established faith and community hubs, which offer a level of cultural safety and welcome which learners do not trust to be offered elsewhere, is one that

works in engaging people who are otherwise hard to reach or disengaged with statutory services. There is nothing in the data to suggest that this model is not entirely replicable elsewhere and scalable across a greater number of simultaneous cohorts.

With this in mind, this report makes the following recommendations:

1. Birmingham City 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 concerns in populations seen as marginalised or harder to reach. This programme has helped to address a current need but is unlikely to be a lasting panacea - ongoing engagement may be beneficial and would make best use of capital already developed through this programme.

2. Birmingham City Council consider capturing more longitudinal data on the impact of the programme if possible. This evaluation provides a cross-sectional snapshot and evidence that Creative English for Health has been impactful up to this point. It would be of use in the design of future interventions and determining value for money for a dataset to be developed which tests the programme's longer-term impacts and their effects on statutory services over time. A good route for this would be continued engagement through existing hubs and learner routes.

3. Public Health 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.

4. FaithAction continue to refine and adapt delivery of the Creative English programme and the Creative English for Health programme. The team has been excellent at taking on board the feedback of hubs and learners to date. This is an important mechanism for addressing the dynamic, local needs of people and keeping learners engaged.

5. FaithAction continue to proactively seek funding to continue delivery in other areas across the UK. Public health inequalities are not unique to Birmingham and the model of Creative English for Health is now tested and shown to be effective and replicable.

6. Linked to Recommendation 6, FaithAction should consider using the Creative English programme as a base on which to develop other programmes for vulnerable communities and areas of need. Thematic areas could include mental health and wellbeing or post-pandemic health and educational inequalities.

7. FaithAction ensure that data collected is robust and consistent. This should include internal review of the data collection forms, particularly with regards to indicators around learner confidence and could also include consulting with hubs and learners to ensure that data continues to be collected in an appropriate and standardised way.

Appendices

Appendix 1 – Bibliography

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Appendix 2 – Programme outline

Creative English for Health: Caring for my Family

Creative English for Health is a programme of learning about child and family health matters, accessing support and services, raising awareness, and building confidence for speakers of English as a second language. Each session lasts 2-hours and is supported by the session plan and kit of project resources.

The eight sessions titled here in bold are compulsory and you must cover them over the course of your contract. You must also choose at least 2 of the remaining topics, as relevant to the needs and confidence levels of your group. You may also choose to deliver all the sessions available. There should be a particular focus on child respiratory health and the related skills and confidence parents need to access appropriate care. To complete the programme, learners must attend at least 10 sessions.

1. **Introduction: Talking to Doctors 1**
   - Making an appointment with your GP
   - Describing symptoms of common ailments
   - Diabetes: what are the signs? What are the risks?
   - How to register with a doctor (as required)

2. **Diabetes and Going for a Blood Test: Talking to Doctors 2**
   - Affirm the benefits of going to the doctor even when we are worried about what we may find out
   - Describe different types of pain.
   - Understand what happens when we go for a blood test
   - Understand how to manage or avoid diabetes
   - Recognise the 4T's of diabetes

3. **Going to the Pharmacy**
   - Understand the role of the pharmacy and the range of services available at pharmacies
   - Develop confidence in talking to pharmacists
   - Practice telling your child's school that your child is sick and won't be coming in

4. Attending an Online Doctor's Appointment and Caring for a Child with Eczema
    - Gain confidence in making and attending an online doctor's appointment
    - Develop and/or practise vocabulary relevant to common ailments
    - Learn about how to care for a child with eczema

5. **Child Respiratory Health and Using NHS 111**
    - Understand signs and symptoms of respiratory disease in infants
    - Know when respiratory symptoms need self-care, A&E or NHS 111
    - Build confidence using NHS 111; familiarity with typical questions and being confident to ask for an interpreter when needed

6. **Vaccinations: The Process, Giving Consent for Your Child, and Finding Accurate Health Information**
    - Practise language used during an appointment for a vaccination
    - Feel confident about going for/taking children for vaccinations and understand the consent process in schools
    - Dispel myths and concerns around vaccinations and to identify ways of finding out or clarifying if information is accurate

7. **Wellbeing: Sally Helps Rebecca with Her Mental Health**
    - Recognise some of the key symptoms of depression
    - Support each other in identifying things we can do to increase/maintain our level of general and mental wellbeing
    - Know where to look for support/resources that help us to take care of our wellbeing
    - Practise talking about mental health to a doctor and to support friends who might be struggling

8. **Healthy Eating (with optional content on teenage brain development)**
    - Explore nutrition and what is included in a balanced diet
    - Discuss 'growth spurts' and strategies to support the family in healthy eating
    - Practise discussing an issue with teachers at a child's school
    - (Optional) Explore teenage brain development

9. **Going for Screening Checks**
    - Understand what a mammogram is and what happens when you go for one
    - Understand what different screening checks are and the importance of going for them
    - Feel confident that they know what to expect when they go for a screening check
    - Create a fun and supportive environment where learners can help and encourage each other

10. Calling the Emergency Services and How to do the Recovery Position
    - Build vocabulary around parts of the body, symptoms and making a phone call to the emergency services
    - Recognise situations where it is appropriate to call the emergency services
    - Learn and practise how to do the Recovery Position

11. The Health Impacts of a Damp House

- Identify symptoms of mould-related respiratory illness
- Know what steps you can take to reduce mould in your home
- Understand tenants' rights to repair and how to use Citizens Advice
- Practise speaking to your landlord about household repairs

12. Going to the Hospital for Tests: Outpatients
    - Increase confidence in visiting a hospital for an appointment
    - Understand what happens when you go for an X-Ray
    - Learn the names of hospital departments and vocabulary related to having an X-Ray

13. Going to the Hospital: Inpatients
    - Learn vocabulary around being in hospital and hospital visiting procedures
    - Know what to say to and what to ask a cardiology consultant
    - Recognise how to make heart-healthy choices
    - Understand how to care for yourself or a family member following a heart attack

14. Pregnancy and Going for Antenatal Tests
    - Understanding the importance of attending all of your antenatal appointments, and how to make sure you're accessing the care you need
    - Understand how to communicate with midwives and caregivers in the different stages of your pregnancy
    - Think about giving gifts and congratulating friends on good news