Controlling Migration Fund evaluation

Project-level evaluation report

Lead LA: Kent County Council
Project name: Healthy Communities

August 2022
Department for Levelling Up, Housing and Communities

This document/publication is also available on our website at www.gov.uk/dluhc

If you have any enquiries regarding this document/publication, email Correspondence@communities.gov.uk or write to us at:

Department for Levelling Up, Housing and Communities
Fry Building
2 Marsham Street
London
SW1P 4DF
Telephone: 030 3444 0000

For all our latest news and updates follow us on Twitter: https://twitter.com/dluhc

August 2022

Contents

Executive summary **5**

1 Introduction **8**

The area context 8

The CMF-funded project 9

Project objectives 11

2 Methodology **15**

Overview of evaluation approach 15

Methodological strengths 18

Methodological limitations 18

Analysis and synthesis 19

3 Key findings: Delivery **20**

Introduction 20

Was the project delivered as intended? 20

What worked in delivering the project? 22

What were the challenges to delivering the project? 23

4 Key findings: Outcomes **26**

Progress towards intended outcomes 26

Progress towards longer-term outcomes 35

5 Value for Money **37**

Introduction 37

6 Conclusions and lessons learned 41

What works? 41

For whom? 42

In what circumstances? 43

Could the project be replicated? 43

Could the project be scaled up? 43

Is there evidence of sustainability beyond the lifetime of the project? 43

7. Appendix 1: Methodology and technical note 45

Appendix 2: CMF Theory of Change 55

Appendix 3: Research tools 60

Executive summary

This project-level evaluation report presents the key findings relating to the delivery and outcomes for the *Healthy Communities* project led by Kent County Council in partnership with Kent Community Health Foundation Trust.

Project overview and objectives

Kent County Council received a Controlling Migration Fund grant of £853,106 for the Healthy Communities project. The project aimed to address poor health outcomes among the local Roma population, which were considered to be contributing to increased pressures on health services due to inappropriate use, such as A&E visits for non-emergencies, as well as negative perceptions from residents that the Roma population was increasing pressure on local services. Project activities included creating a specialised team of Health Visitors, School Nurses and individuals from the Roma community through a "Lifestyle Facilitator" role. The team aimed to improve health outcomes among Roma community members (such as addressing lower immunisation rates and increased rates of obesity), by encouraging registrations at General Practitioner (GP) surgeries and increasing immunisation rates. These activities aimed to contribute towards the CMF outcomes listed in table 1.1.

Ipsos MORI undertook an evaluation of the Healthy Communities project between January and December 2019. A theory-based approach was taken to the evaluation, with the aim of reviewing and testing the outputs and outcomes intended through the project activities[1]. Evaluation activities included: a scoping phase to identify outcomes and develop a project logic model; interviews with project and programme leads; analysis of secondary data from interviews and focus groups with delivery staff, stakeholders and migrant residents conducted by an external evaluator; analysis of client feedback surveys administered by project staff; and a review of monitoring information provided by the project.

Progress towards intended outcomes

Progress towards intended CMF-level outcomes that the project expected to contribute to within the evaluation timeframe is summarised in table 1.1 below, followed by a discussion of direction of travel towards longer-term outcomes (expected to be realised in future). Evidence indicates that the project contributed to four outcomes for the local authority and migrant beneficiaries. The contribution towards resident outcomes was more limited, in part due to the lack of direct engagement with this group through project activities, as well as a lack of corresponding evidence on resident perspectives.

[1] Theory-based approaches to evaluation use an explicit theory of change to draw conclusions about whether and how an intervention contributed to observed results. For more information, see: https://www.canada.ca/en/treasury-board-secretariat/services/audit-evaluation/centre-excellence-evaluation/theory-based-approaches-evaluation-concepts-practices.html

Table 1.1: Summary of project CMF outcomes

Intended Outcome	Assessment of progress made by December 2019
Intermediate outcome 1: Increased insight into local migration patterns and community impact	While the data collection tools did not generate as much insight as anticipated, evidence indicates that the local authority still gained valuable knowledge on migrant communities from the project.
Intermediate outcome 2: Increased coordination and cooperation between agencies	There was some evidence that improved communication and data sharing between project partners in the Trust increased coordination and cooperation between agencies.
Intermediate outcome 3: Acquired expertise and structures in place to deal with local issues	Evidence indicates that the "Lifestyle Advisor" role helped to increase expertise about the local Roma community with the Trust.
Intermediate outcome 4: Improved signposting and referral systems	While there was some evidence of increased referrals from Lifestyle Advisors to external services, evidence towards this outcome was limited due to delays to the project activities.
Intermediate outcome 5: Increased understanding and access to public services	Evidence regarding migrant registrations with NHS services provides strong evidence that the project increased understanding and access to public services.
Intermediate outcome 6: Perceived reduction of pressure on public services and private facilitates	The evaluation found minimal evidence to suggest the project contributed towards perceived reduction of pressure on public services, in part due to an absence of wider resident involvement with the project or external communication regarding project outcomes. However, improved health and access to health services among the migrant community may result in improved health outcomes and behaviours in future, thereby reducing pressures on services.
Intermediate outcome 7: Increased opportunities for social mixing	The evaluation found limited evidence to suggest the project contributed towards increased opportunities for social mixing. However, as an indirect benefit from the project, increased use of health services by migrants may increase opportunities for social mixing in future.
Intermediate outcome 8: Improved perceptions/attitudes towards migrant community members in the resident community	The evaluation found minimal evidence to suggest the project contributed towards improved perceptions and attitudes towards the migrant community members in the resident community. As above, this was partly due to a lack of direct engagement with wider residents as part of the project activities.

Based on the contribution of the project towards the intermediate outcomes above, there is evidence to suggest the project will contribute towards building the evidence base for "what works locally". There was some evidence that this was happening already, including learnings around developing effective data collection tools, and successful outreach activities built around delivering in tandem with local third sector organisations. Through

registering beneficiaries with health services, such as General Practitioners, it can be assumed that health outcomes will improve, thereby contributing to the longer-term outcome of improved health and wellbeing. Given the assumption that appropriate use of the NHS will decrease costs, it is also likely that in future the project will contribute towards the longer-term outcome of reducing cost on public services. Given the lack of engagement with the resident community through the project or communication of project outcomes, it is, however, unlikely that the project will contribute to the corresponding longer-term outcomes of increased levels of social mixing and reduced public concern about access to public services.

What works?

- The project worked well in terms of engaging the Roma beneficiary group in designing the project, as well as delivering project activities through local community members who were hired directly by the Trust.
- The project ran into challenges with recruitment; there was a limited supply of Health Visitors and School Nurses, and there were logistical difficulties in engaging Roma community members stemming from low levels of English and a lack of identity documents required to register for services.
- This project addressed these challenges by being flexible in their approach to recruitment and delivery. For example, staff were recruited via job-carving instead of through a new position, and events were delivered in tandem with other local charities instead of solely through the Trust.

For whom

- The Roma community was the main beneficiary group for this project. The project was successfully able to engage these individuals and encourage them to take up NHS services.
- The local authority also benefited from this project by acquiring better knowledge about the local Roma community and feeding this back into the Trust.

In what circumstances?

- This project was the result of persistent efforts on the part of key individuals within the Trust who championed initiatives around diverse communities in Kent.
- Establishment of a cross-cutting and specialised team could be replicated in another local authority; however, the supply of local staff and level of resource required to do this would need to be considered.
- The benefits for beneficiaries, including registering with GPs and being signposted to other services, are likely to be sustained beyond the length of the project.

1 Introduction

The Department for Levelling Up, Housing and Communities (DLUHC) then known as Ministry of Housing, Communities and Local Government commissioned Ipsos MORI alongside the Migration Observatory at the University of Oxford to conduct an independent evaluation of the Controlling Migration Fund (CMF) in May 2018. Launched in November 2016, the Controlling Migration Fund (CMF) aims to help local authorities across England develop and deliver activities to mitigate the perceived negative impacts of recent and unexpected migration on communities in their area. DLUHC provided funding to local authorities to deliver projects that aim to address local service pressures, tailored to their context and needs. While the primary emphasis is on delivering benefits to the established resident population, the fund also seeks to support wider community cohesion and the integration of recent migrants. Interventions can also focus on gaining a greater understanding of the local migration data landscape where there is currently a lack of accurate local data.

Project-level evaluations of 14 CMF-funded projects were conducted as part of the CMF evaluation. The project-level evaluations aim to assess the effectiveness of various project approaches in delivering against their local-level objectives and those of the wider fund. They seek to build an understanding of what works, for whom and in what context to relieve pressure on local services due to recent or unexpected migration. This project-level evaluation report presents the key findings relating to the delivery and outcomes for the ***Healthy Communities*** project led by Kent County Council (KCC) in partnership with the Kent Community Health NHS Foundation Trust (KCHFT).

The area context

Migrant communities throughout the UK often have poorer health outcomes when compared to the rest of the population. This is especially true for migrant Roma communities[2]. However, there is a lack of longitudinal research on migrant Roma health outcomes in general. This is compounded by low levels of self-ascription stemming from stigma around identifying as Roma. Because of this lack of data, identifying the barriers and enablers towards improving these poor health outcomes within this community is difficult.

There are an estimated 4,522 Gypsy and Travellers living in the Kent county area according to the most recent Census in 2011[1]. The term Gypsy and Traveller is a collective term which includes Gypsies, Scottish Gypsy Travellers, Irish Travellers, and the European Roma community[2]. Unfortunately, more recent data and that which specifically details the number of Roma (and migrant Roma) residents, is not collected. Kent experienced an inflow of 9,700 international migrants between 2017 and 2018, the lowest number since 2013.Data on national insurance number allocations for foreign nationals in Kent shows an increase of 220% since 2002[3]. The top country of origin for workers was

[2] Smyth, David (2018) *Roma migration, anti-migrant sentiment and social integration: A case study in South-east England* https://journals.sagepub.com/doi/full/10.1177/0269094218766456
[3] Kent County Council (April 2020) Strategic Commissioning Statistical Bulletin, Migrant Workers in Kent, https://www.kent.gov.uk/__data/assets/pdf_file/0018/73107/Migrant-Workers-in-Kent.pdf

Romania (28% of allocations), while Bulgaria was the second highest (19%). Both are countries with high Roma populations. Kent also has a sizeable Nepalese population, largely due to Gurkha soldiers who served in the British army, and their families, who later settled in the area[4].

KCC applied for CMF funding following a needs assessment undertaken by the Kent Public Health Observatory[5], which found evidence of low childhood immunisation rates; low uptake of Health Visitor checks, development reviews and follow-up; and poor dental care among Roma residents. Further data showed that this could possibly be due to a lack of knowledge and awareness in this community around how to access GPs, family planning, screening programmes, and dentists[6].

There were several existing initiatives within Kent which aimed to address issues among the Roma community in Kent These projects were led by third sector organisations and did not focus on improving health. Notably, the local charity Red Zebra had been working on outreach activities and projects within the Roma community. One project, funded by the National Lottery Community Fund, aimed to create a Roma Development Team for coordinating third sector and integration activities for Roma communities in Kent[7].
KCC had also received CMF funding to support unaccompanied asylum-seeking care (UASC) leavers in Canterbury and Medway. There were also other local projects (at least one CMF funded) working with Roma, however, they are in a different area of the county than this project. Both the UASC project and the other CMF-funded projects are outside of the scope of this evaluation and are not included in this report.

The CMF-funded project

KCC was awarded £853,106 CMF funding to develop and establish the *Healthy Communities* project over a two-year time frame from October 2018 to October 2020. The project aimed to create a new team within the KCHFT who would be responsible for working across localities in Kent with migrant communities, with a particular (but not exclusive) focus on Roma migrant communities. Target beneficiaries were defined by their identification with the Roma community or lack of access to the Health Visiting and School Nursing services. The overall goal was to ensure children are school-ready and families are well supported.

The project further hoped to benefit residents through the cost-savings on local health services gained by registering previously unregistered Roma families with GPs, as well as increasing immunisation rates among this community, which would help to maintain herd immunity[8]. However, while these activities were expected to lead to wider resident benefits, the local authority did not intend to communicate these anticipated positive outcomes to the local community. Instead, project staff planned to organise community cohesion events where wider residents and Roma community members could interact; the

[4] Ibid.
[5] KCC Public Health, (2015), https://www.kpho.org.uk/__data/assets/pdf_file/0019/43804/Gypsy-Roma-and-Traveller-IR-August-FINAL.pdf
[6] Smyth, David (2018) *Roma migration, anti-migrant sentiment and social integration: A case study in South-east England* https://journals.sagepub.com/doi/full/10.1177/0269094218766456
[7] Roma In The Lead: Three year project funded by the National Lottery Community Fund from September 2017 – September 2020.
[8] A form of indirect protection from infectious disease that occurs when a large percentage of a population has become immune to an infection, thereby providing a measure of protection for individuals who are not immune.

aim of these events would be to challenge any negative stereotypes about the Roma community that people might have.

The Healthy Communities team was intended to comprise of two programme Health Visitors, two programme School Nurses, eight "One You Lifestyle Facilitators" recruited from the community, and 12 "community champions". The local charity Red Zebra was actively involved in setting-up the CMF-funded project, mainly by providing advice and contacts for the project throughout recruitment. The planned approach is outlined in more detail below:

- **Programme Health Visitors and School Nurses** would be recruited to four new posts with the project would work together to deliver key public health messages and health services to beneficiaries under the 'Healthy Child Programme'[9], as well as enhanced services such as baby care and mental health support. They would further provide support to other KCHFT Health Visiting and School Nursing staff for more complex cases involving migrant communities (such as children that have not been immunised and are not registered in the GP). They would also have a specific focus on child and adult safeguarding among migrant communities. In addition to the above, it was envisioned that programme staff would be responsible for recruiting and training "staff champions" identified through core services in each of the 12 district authority areas, with one champion per district authority sub-team[10]. Their role would be to act as the link between sub-teams for providing advice and guidance on how to deliver services to Roma and other migrant communities.
- **One You Lifestyle Facilitators and Community Champions:** The project planned to recruit eight One You Lifestyle Facilitators and 12 community champions from migrant and ethnic minority communities to provide support to the Health Visitor's team with caseloads involving Roma and other migrant communities. Lifestyle Facilitators would be responsible for helping clients to change their health-seeking behaviour and improve general health outcomes. They would also attend events such as community meetings and information sessions, and provide health advice within their communities. The approach of using One You Lifestyle Facilitators and community champions was based on previous successful work with Gypsy and Traveller communities in Swale, and with the Nepalese community in Kent which was carried out by KCHFT health trainer service. As these individuals would be recruited from the communities they work in, it was anticipated that they would have a better understanding of their clients' culture and background, which would enable them to build trust more easily compared with other staff. This was further expected to improve trust among the migrant community towards health and social care services and assist clients in accessing the right services earlier by registering them with a General Practitioner (GP) and dentist. The project anticipated that this work would be facilitated by the previous success of engagement work that was undertaken in the Roma community by Red Zebra[11].
-
- **Community events organised by One You Lifestyle Facilitators:** The project planned to organise seven community events to support Roma families and

[9] Universal programme delivered to children aged 0 – 19 by Health Visitors and School Nurses.
[10] For each of the 12 district authority areas: Sevenoaks, Dartford, Gravesham, Tonbridge and Malling, Maidstone, Tunbridge Wells, Swale, Ashford, City of Canterbury, Folkestone and Hythe, Thanet, and Dover
[11] Roma In The Lead: Three year project funded by the National Lottery Community Fund from September 2017 – September 2020.

promote social mixing. Working with the Children's Centres, the One You Lifestyle Facilitators would help organise community cohesion events, where parents would be encouraged to share their personal stories and parenting challenges with other residents. The aim was for communities to build common connections and for Roma families to feel accepted and welcome. In this way, the events aimed to improve community cohesion and break down barriers with the wider resident community.

- **Professional network events:** Two network events per year were planned for Healthy Communities project staff and core-KCHFT staff. The purpose of these events was to share learnings around working with migrant communities and health services through presentations and updates for specific services.

Project objectives

Project objectives were identified following a review of project documentation and a consultation between the Ipsos MORI Relationship Manager and *Healthy Communities* project staff. Following the consultation with project staff, the Ipsos MORI Relationship Manager developed a logic model, which was reviewed and agreed with project staff (see Figure 1.1)[12]. The logic model outlines planned activities and outputs and how these relate to project and CMF fund-level outcomes[13]. How the project aimed to contribute to CMF intermediate outcomes is outlined below, including longer-term CMF outcomes where contribution of the project towards these outcomes was expected or seen within the evaluation timeframe.

Through the planned project activities, the *Healthy Communities* project aimed to contribute towards the following intermediate and longer-term outcomes for the local authority by:

- Recruiting local migrant community members through the Lifestyle Facilitator role; the aim **of these roles was to improve expertise and structures in place to deal with local issues within the local authority**, as well as **increase insight into local migration patterns and community insight** by integrating feedback from community members into the newly established local authority team.
- The creation of a specialised team of Health Visitors, School Nurses, and community representatives aimed to **increase co-ordination and co-operation between agencies** and **improve signposting and referral mechanisms within the local authority.**

Project activities and outputs also aimed to contribute towards the following intermediate outcomes for **migrants[14]**:

- The activities that would be carried out by this the new team were intended to **increase understanding and access to public services** among migrant communities. This was closely linked with three project-level outcomes, which were

[12] A logic model is a diagrammatic representation of a project which depicts the various stages required in a project that are expected to lead to the desired outcomes. The logic model in turn is used to inform the evaluation approach; specifically, what needs to be measured to determine whether outcomes are being met, and how.
[13] CMF fund-level outcomes are outlined in the Theory of Change in Appendix 1.
[14] For all outcomes, the project focused on Roma community members, but did otherwise not differentiate between different nationalities or ethnicities or length of time in the area.

to improve trust in and experience of using local health and connected services, promote better uptake and use of appropriate services, and increase immunisation rates among migrant communities.

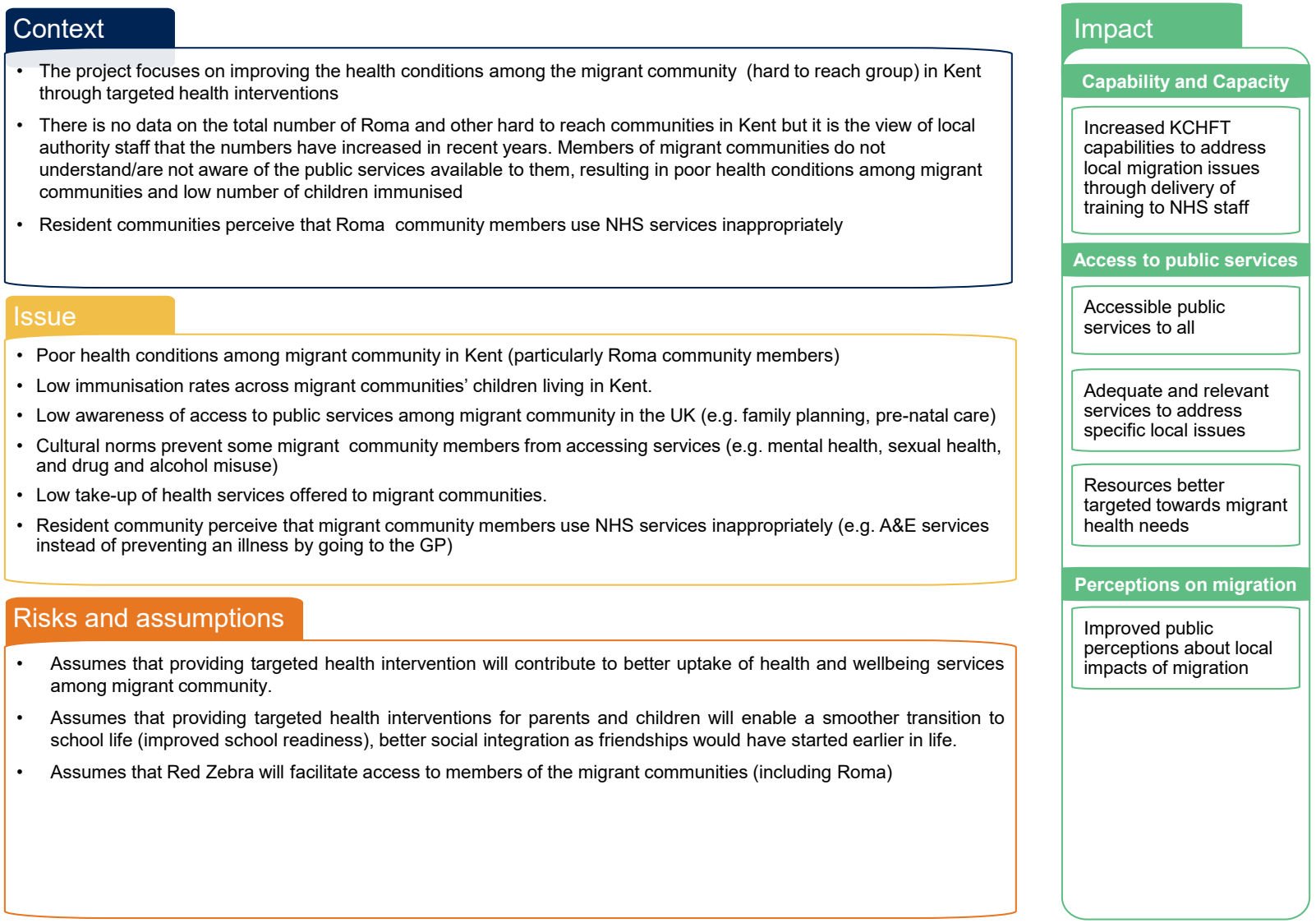
Project activities and outputs also aimed to contribute towards the following CMF intermediate outcomes for longer-term residents:

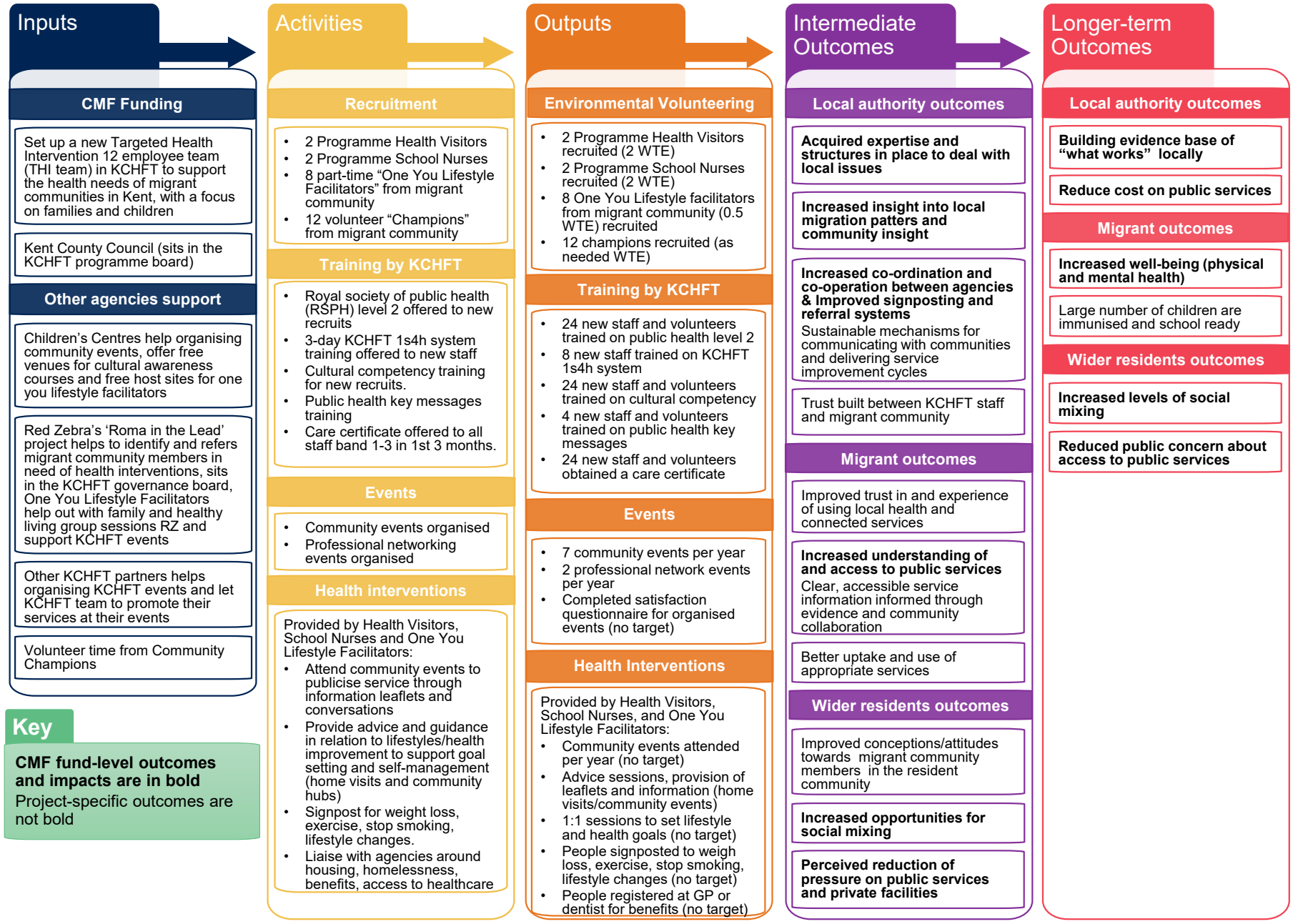
- The planned community and professional events were intended to **increase opportunities for social mixing** among resident and migrant populations, as well as decrease the **perceived reduction on pressure of public services and private facilities** by residents. This was also closely linked with the project-level outcome, which was to improve perceptions/attitudes towards migrant community members among the resident community.

Specific project outputs were expected to feed in to the above outcomes. Broadly, these outputs can be split into those relating to recruitment, training, delivery of community and professional events, referrals from the Roma community, and various health activities to be undertaken by the team. These outputs, as well as the intermediate and longer-term outcomes, are detailed in Figure 1 in the below logic model.[15]

[15] A logic model is a diagrammatic representation of a project which depicts the various stages required in a project that are expected to lead to the desired outcomes. The logic model in turn is used to inform the evaluation approach; specifically, what needs to be measured to determine whether outcomes are being met, and how.

Figure 1.1: Healthy Communities logic model




Inputs
CMF Funding
Set up a new Targeted Health Intervention 12 employee team (THI team) in KCHFT to support the health needs of migrant communities in Kent, with a focus on families and children
Kent County Council (sits in the KCHFT programme board)
Other agencies support
Children's Centres help organising community events, offer free venues for cultural awareness courses and free host sites for one you lifestyle facilitators
Red Zebra's 'Roma in the Lead' project helps to identify and refers migrant community members in need of health interventions, sits in the KCHFT governance board, One You Lifestyle Facilitators help out with family and healthy living group sessions RZ and support KCHFT events
Other KCHFT partners helps organising KCHFT events and let KCHFT team to promote their services at their events
Volunteer time from Community Champions
Key
CMF fund-level outcomes and impacts are in bold
Project-specific outcomes are not bold
Activities
Recruitment
2 Programme Health Visitors
2 Programme School Nurses
8 part-time "One You Lifestyle Facilitators" from migrant community
12 volunteer "Champions" from migrant community
Training by KCHFT
Royal society of public health (RSPH) level 2 offered to new recruits
3-day KCHFT 1s4h system training offered to new staff
Cultural competency training for new recruits.
Public health key messages training
Care certificate offered to all staff band 1-3 in 1st 3 months.
Events
Community events organised
Professional networking events organised
Health interventions
Provided by Health Visitors, School Nurses and One You Lifestyle Facilitators:
Attend community events to publicise service through information leaflets and conversations
Provide advice and guidance in relation to lifestyles/health improvement to support goal setting and self-management (home visits and community hubs)
Signpost for weight loss, exercise, stop smoking, lifestyle changes.
Liaise with agencies around housing, homelessness, benefits, access to healthcare
Outputs
Environmental Volunteering
2 Programme Health Visitors recruited (2 WTE)
2 Programme School Nurses recruited (2 WTE)
8 One You Lifestyle facilitators from migrant community (0.5 WTE) recruited
12 champions recruited (as needed WTE)
Training by KCHFT
24 new staff and volunteers trained on public health level 2
8 new staff trained on KCHFT 1s4h system
24 new staff and volunteers trained on cultural competency
4 new staff and volunteers trained on public health key messages
24 new staff and volunteers obtained a care certificate
Events
7 community events per year
2 professional network events per year
Completed satisfaction questionnaire for organised events (no target)
Health Interventions
Provided by Health Visitors, School Nurses, and One You Lifestyle Facilitators:
Community events attended per year (no target)
Advice sessions, provision of leaflets and information (home visits/community events)
1:1 sessions to set lifestyle and health goals (no target)
People signposted to weigh loss, exercise, stop smoking, lifestyle changes (no target)
People registered at GP or dentist for benefits (no target)
Intermediate Outcomes
Local authority outcomes
Acquired expertise and structures in place to deal with local issues
Increased insight into local migration patters and community insight
Increased co-ordination and co-operation between agencies & Improved signposting and referral systems
Sustainable mechanisms for communicating with communities and delivering service improvement cycles
Trust built between KCHFT staff and migrant community
Migrant outcomes
Improved trust in and experience of using local health and connected services
Increased understanding of and access to public services
Clear, accessible service information informed through evidence and community collaboration
Better uptake and use of appropriate services
Wider residents outcomes
Improved conceptions/attitudes towards migrant community members in the resident community
Increased opportunities for social mixing
Perceived reduction of pressure on public services and private facilities
Longer-term Outcomes
Local authority outcomes
Building evidence base of "what works" locally
Reduce cost on public services
Migrant outcomes
Increased well-being (physical and mental health)
Large number of children are immunised and school ready
Wider residents outcomes
Increased levels of social mixing
Reduced public concern about access to public services

2 Methodology

This section outlines the methodology for the project-level evaluation of the Healthy Communities project.

Overview of evaluation approach

A theory-based approach was taken for the project-level evaluations, which focused on reviewing and testing the outputs and outcomes within the project's logic model[16]. The suitability of different approaches was explored in an evaluation scoping phase. The possibility of implementing experimental evaluation designs, including Randomised Control Trials (RCTs), was explored and deemed not feasible at a fund level due to the broad range of projects that have funded across different regions and local contexts – this would have needed to have been built into the programme design from the outset. The feasibility of identifying local-level control groups was explored during individual project consultations. Identifying a counterfactual with Roma beneficiaries was deemed unsuitable due to anticipated difficulties in engaging Roma populations in other local authorities and the lack of suitable secondary data on Roma health outcomes.

For each project-level evaluation, project-level outcomes were "mapped" onto relevant CMF-fund level outcomes contained in the overall CMF fund-level Theory of Change (see Appendix 2). The evaluation approach was designed in consultation with project staff, including the development of an evaluation framework (contained in Appendix 1). The evaluation activities included both quantitative and qualitative data collection methods, as well as consideration of evidence from secondary sources. Ipsos MORI also worked closely with the external evaluator (University of Kent) to ensure that evaluation tools were aligned to CMF-fund level outcomes as far as possible and that work was not duplicated. This included a review of their logic model and topic guides for the delivery staff and migrant community member focus groups, as well as regular contact and consultations throughout the evaluation.

In order to assess value for money, each of the 14 projects were initially assessed through the lens of an 8-step model (outlined in Appendix 1). The assessment involved a review of the availability and suitability of data collected at each of the 14 project sites. Consequently, each project was triaged to one of three methodological groupings:

1. **Cost benefit analysis (CBA)**: Projects for which data on quantitative and monetizable outcomes was available met the higher threshold for cost benefit analysis.

2. **Cost effectiveness analysis (CEA):** Where quantitative measures for outcome(s) existed, but no data (primary or secondary) is available to monetise the outcomes, cost effectiveness analysis was conducted.

[16] Theory-based approaches to evaluation use an explicit theory of change to draw conclusions about whether and how an intervention contributed to observed results. For more information, see: https://www.canada.ca/en/treasury-board-secretariat/services/audit-evaluation/centre-excellence-evaluation/theory-based-approaches-evaluation-concepts-practices.html

3. **No feasibility for quantitative analysis:** Where there was no quantitative measure of outcomes available to the evaluation, neither cost benefit analysis nor cost effectiveness analysis could be conducted.

Two models were developed: the CBA model calculates costs relative to the monetizable benefits and the CEA model calculates costs relative to the quantifiable outcomes achieved from each of the CMF interventions (without attempting to monetize these outcomes).

As there was no robust control (counterfactual) group against which to assess impact, artificial baselines were constructed. Where possible, input from project leads or secondary data was used to inform the assessment of the counterfactual. In the cases that this was not available, conservative estimates were made. Given the nature of the data used in the construction of the cost benefit and cost effectiveness models, the accuracy of results produced by the models should be interpreted with caution[17].

Further information on the methodological approach, including the evaluation framework, is contained in Appendix 1. Appendix 2 outlines the CMF fund-level Theory of Change. Appendix 3 outlines the qualitative and quantitative research tools.

Quantitative data collection

Client feedback surveys were completed by clients and patients either post-consultation or intervention, and were administered by project staff (Health Visitors, School Nurses, or One You Lifestyle Facilitators). A post-only design was considered most feasible considering the short time available for consultations and to reduce burden on project staff. The Health Visiting and School Nursing questionnaires were designed by the KCHFT Patient Experience team with input from delivery staff and the KCHFT commissioner, while the Lifestyle Facilitator questionnaire was a standardised NHS Friends and Family Test (FFT) questionnaire (outlined in Appendix 3).
As part of the evaluation, Ipsos MORI reviewed existing quantitative research tools to assess how far they aligned to project and CMF-fund level outcomes. The questionnaires were considered to provide evidence towards the following outcomes:

- Increased understanding of and access to public services.
- Improved trust in and experience of using local health and connected services by migrant community members.

A total of 79 surveys were completed and returned to Ipsos MORI by the KCHFT: six from the Health Visitor strand, 40 from the School Nurse strand, and 33 from the Lifestyle Facilitator strand. Project staff explained that the low sample from Health Visiting was due to the low number of one to one case-working consultations and interventions that were undertaken by staff during the period when the evaluation was taking place and was proportionate to the activity they had undertaken at the time.

[17] The Maryland scientific methods scale scores methods for counterfactuals construction on a scale of one to five (with five representing the most robust method). Due to the use of measures of additionally in the construction of the counterfactual, the approach taken for this analysis cannot be attributed a score. Therefore, the accuracy of results produced by the models should be interpreted with a high degree of caution. For more information, see:
https://whatworksgrowth.org/public/files/Methodology/Quick_Scoring_Guide.pdf

Qualitative data collection

In-depth interviews were conducted mid-way through the project to explore experiences of delivery and views on the extent to which outcomes had been achieved (September and October 2019). A mid-way cross-sectional design was chosen to reduce participant burden and due to the timing of the evaluation, which prevented a pre- and post-design. Five telephone interviews were conducted by Ipsos MORI with project staff, including delivery leads, which are outlined in Table 2.1. Participants were identified by the project lead and included all programme leads affiliated with the project.

Table 2.1 Interviews undertaken by Ipsos MORI

Type of interview	Interviews planned	Interviews conducted
Interview with delivery lead	1	1
Interview with programme leads	3	3
Interview with training lead	1	1

The evaluation also included research activities undertaken by the external evaluator, University of Kent, which is outlined in Table 2.2. These activities were planned prior this evaluation, and Ipsos MORI did not undertake additional research activities due to participant overburden. The external evaluator conducted two focus groups with delivery staff (one with Health Visitors and School Nurses, and one with Lifestyle Facilitators), six interviews with local stakeholders (identified by project leads) and with two strategic-level staff members of KCHFT and a delivery partner. The external evaluation also conducted three focus groups with migrant populations living in Kent (two focus groups with Roma participants and one focus group with Nepalese participants). Due to delays in the project the external evaluator recruited migrant community members from the community generally; therefore, some participants in the migrant focus groups did not come into contact with the project. However, the external evaluator explained the project from the outset of the focus groups, and beneficiaries were encouraged to speak either hypothetically or based on their actual experience. Data collection was undertaken between August and November 2019. A thematic summary of these findings was provided to Ipsos MORI to inform the findings of the CMF evaluation.

Table 2.2 Interviews undertaken by the external evaluator

Type of interview	Interviews planned	Interviews conducted	Context
Focus group with delivery staff	3	2	Lower number of delivery staff recruited than expected; Health Visitor and School Nurses combined into one focus group.
Interviews with local stakeholders	8	8	Not applicable.
Focus groups with migrant population	6	3	Additional focus groups delayed by the external evaluator to dates beyond timeframe of the evaluation.

Cost effectiveness analysis

The Healthy Communities project was selected for a CEA, due to the lack of primary or secondary data available to monetize relevant outcomes. Perceptions of project costs and benefits were also explored in qualitative consultations with staff and stakeholders and secondary data from local migrants. The analysis acts to supplement support the quantitative value for money assessment.

Monitoring data and secondary data sources

Monitoring data included in this evaluation includes activity logs from the Healthy Communities team, which were collated by project staff and reviewed by the project lead, as well as Key Performance Indicators (KPIs) collected by the project. Secondary qualitative data collected by the project was also drawn upon by the evaluation, which included Reflection Logs (n = 100) completed by Health Visitors, School Nurses and One You Lifestyle Facilitators quarterly. The Reflection Log was designed by the external evaluator based on their own research from templates found in the literature (see Appendix 3 for templates). These additional materials provided insight into project outputs and perceptions of project delivery among delivery staff.

.

Methodological strengths

- The **breadth and depth of the qualitative data**, including end beneficiaries, project staff of all strands and wider stakeholders, which contributed to a well-rounded analysis of the project's activities and is a key strength of this evaluation.
- **Strong communication between the delivery staff and the evaluation team** allowed for a transparent and honest relationship which further strengthens the credibility of the evaluation itself.
- This evaluation benefited from **a wide range of data sources**, including survey data, Key Performance Indicator (KPI) data, qualitative reflection logs, and interviews with a range of project staff and beneficiaries. Findings from the different data sources generally converged into similar narratives, indicating good reliability.

Methodological limitations

- **Participant self-selection biases**. To ensure the evaluation upheld ethical principles of informed consent, participants could decide for themselves whether they wanted to take part in evaluation activities. However, a wide range of participants were recruited (including beneficiaries, delivery staff, and stakeholders) and all participants who were approached by Ipsos MORI agreed to be interviewed.

- **It is difficult to measure change or judge attribution due to the limit of one assessment date and lack of a counterfactual**. Research activities generally took place at one point in time, midway through the project. This limitation was mitigated by developing the logic model prior to conducting the evaluation, which attributed outcomes to tangible outputs from the project.

- Data suffered from a **lack of objectivity in some instances**, particularly regarding the “Reflection logs” written by project staff. This was mitigated by triangulating the findings with other data sources.

- **Reliance on the external evaluator** may have impacted the reliability of qualitative data. The external evaluator shared thematic summaries, which reduced the level of detail available. This was mitigated through consistent communication with the external evaluator to review findings and raise any concerns with the data made available.

Analysis and synthesis

Secondary data and monitoring data shared by the project was analysed to extract key findings related to achievement of outputs and outcomes, as well as triangulate the primary data that was collected.

Interview notes were systematically inputted into an analysis grid for each research encounter, allowing for more in-depth analysis of findings. There was one grid for each type of audience consulted. The grids follow the structure of the topic guide enabling the identification of relevant quotes for each element of the outcomes and process evaluation. A thematic analysis approach was implemented in order to identify, analyse and interpret patterns of meaning (or "themes") within the qualitative data, which allowed the evaluation to explore similarities and differences in perceptions, views, experiences and behaviours. Once all data had been inputted, evidence for each outcome and key delivery themes was brought together in a second analysis matrix to triangulate the evidence and assess its robustness.

Qualitative approaches explore the nuances and diversity of perceptions, views, experiences and behaviours, the factors which shape or underlie them, and the ideas and situations that can lead to change. In doing so, it provides insight into a range of perceptions, views, experiences and behaviours that, although not statistically representative, it nonetheless offers important insight into overarching themes.

Quotes in this report are verbatim and are used to illustrate and highlight key points and common themes. Quotes that contain personal information have been anonymised.

3 Key findings: Delivery

Introduction

This section reports on the key findings from the evaluation in relation to how the Healthy Communities project was delivered. It begins with an assessment of progress made towards the intended outputs set out in the project logic model. This is followed by a discussion of the success factors and challenges that were found to have an impact on project delivery and the achievement of outputs.

Was the project delivered as intended?

Table 3.1 summarises the target outputs determined at the start of the evaluation process, the actual output at the point of assessment and a determination of whether it was achieved or not11. It should be noted that this evaluation was undertaken mid-way through the project, so findings should be interpreted accordingly. Additionally, several outputs were left with open-ended targets by the project. For the purpose of the evaluation, outputs without a target are categorised as "inconclusive". Out of the 27 outputs, 5 were achieved, on track to be achieved or exceeded, 4 were partially achieved, 3 were not achieved and 15 were inconclusive.

Table 3.1: Achievement of project outputs

Target output	Output achieved	Completion measure[18]
Recruitment		
2 whole time equivalent (WTE) programme Health Visitors	Monitoring information shows that 1.6 WTE Health Visitors (Band 6) and 3 WTE Community Nursery Nurses (Band 4) were recruited	Partially Achieved
2 WTE programme School Nurses	Monitoring information shows that 0.4 WTE School Nurses (Band 6), 1 WTE School Staff Nurse (Band 5), and 0.6 WTE Assistant Practitioner (Band 4) were recruited	Partially Achieved
8 Part-time One You Lifestyle facilitators (0.5 WTE)	Monitoring information shows that 6 One You Lifestyle facilitators were recruited at 4.41 WTE	Achieved
12 champions recruited from the community (0.5 WTE)	No champions were recruited, and this is no longer intended to take place	Not Achieved
Training Sessions		
24 new staff and volunteers trained on supporting behaviour change techniques	Monitoring information shows that 9 new staff had been trained and 2 more are in the process of being trained	Partially Achieved

[18] The completion measure is a subjective assessment by Ipsos MORI based on the extent to which the project has achieved its intended outputs at the time when the evaluation took place – scored as follows: inconclusive; not achieved; partially achieved; on track to be achieved; achieved; exceeded. See Appendix 1 for further details.

8 new staff trained on KCHFT 1s4h system[19]	Monitoring information shows that 6 new staff had been trained and 2 more are in the process of being trained	On track to be achieved
24 new staff and volunteers trained on cultural competency	No training sessions were delivered on cultural competency as 18 current staff had already completed this.	Not Achieved
4 new staff and volunteers trained on public health key messaged training	Monitoring information shows 6 new staff members have been trained	Exceeded
24 new staff and volunteers obtained a care certificate from the KCHFT Health Improvement team	Monitoring information shows that 6 staff members have been trained, 3 are currently being trained, and 1 further application is underway	Partially Achieved
Organisation of community and professional events		
7 community events per year targeted at the resident and migrant community	Monitoring information shows 9 community events were delivered specifically targeted at the Roma community.	Achieved
2 professional network events per year	Monitoring data shows 1 event was delivered	Achieved
Satisfaction questionnaires completed for organised events (no target)	Monitoring data shows 0 satisfaction questionnaires were completed	Not Achieved
Advice and targeted health interventions		
Provided by One You Lifestyle Facilitators: Despite not having set targets, **project and programme leads felt Lifestyle Facilitators were achieving outputs as expected.**		
Community events attended per year (no target)	Attended: 14	Inconclusive (no target)
Brief advice sessions delivered (no target)	Delivered: 6	Inconclusive (no target)
1:1 sessions delivered (no target)	Delivered: 23	Inconclusive (no target)
Clients signposted to weight loss, exercise, stop smoking, lifestyle changes (no target)	Signposted: 24	Inconclusive (no target)
Migrant community members registered at GP and/or dentist practice (no target)	Registered: 27	Inconclusive (no target)
Migrant community members registered for benefits (no target)	Registered: 198	Inconclusive (no target)
Provided by Health Visitors: Despite not having targets, **due to the delays in recruiting Health Visitors, project and programme leads felt Health Visitors were delivering fewer outputs than expected**.		
Group education sessions delivered (no target)	Delivered: 21 sessions[20]	Inconclusive (no target)
1:1 sessions delivered (no target)	Delivered: 26 sessions	Inconclusive (no target)
Development checks undertaken in clinics (no target)	Delivered: 8 sessions	Inconclusive (no target)

[19] IT system used by the One You Lifestyle Facilitator team
[20] The number of participants per session was not recorded.

Community events attended (no target)	Attended: 7 events	Inconclusive (no target)
Provided by School Nurses: Despite not having targets, project and programme leads felt that School Nurses were delivering outputs as expected.		
Lancaster questionnaires carried out (no target)	Delivered: 36	Inconclusive (no target)
Group education sessions delivered (no target)	Delivered: 49 sessions	Inconclusive (no target)
1:1 sessions delivered (no target)	Delivered: 29 sessions	Inconclusive (no target)
Community events attended (no target)	Attended: 39 events	Inconclusive (no target)
Referral of Roma community for support		
Referrals to KCHFT services from partner organisations (no target)	Monitoring information shows that 21 referrals were made to partner organisations	Inconclusive (no target)

What worked in delivering the project?

There were three key elements that were found to facilitate project delivery:

(1) Including end-beneficiaries in the design, development and delivery of the project;
(2) Flexibility in delivering the project;
(3) Combining segregated services into one cross-cutting team.

(1) Including end-beneficiaries in the design, development and delivery of the project was considered by external stakeholders and project staff to have facilitated recruitment of beneficiaries and ensured health interventions were relevant to the needs of migrant communities. Overall, they were positive regarding the decision of the project to engage with migrant communities throughout the different stages of the project. In the design of the project, consultations with the Roma community made the project team aware of the need for a flexible approach to delivering services to migrant beneficiaries (see point 2). They also provided details on local resources within the community, such as Roma focused NGOs, who the project ultimately collaborated with to help deliver events and services. Staff felt this involvement to be highly beneficial, as they were able to leverage the familiarity and trust built by local Roma-focused NGOs with the migrant community to increase attendance at community events. This is in contrast to other events delivered by the school health team which had lower attendance rates; staff expressed that this was because the events were hosted in unfamiliar venues without delivery partners. Lastly, the inclusion of beneficiaries in delivering the project through the Lifestyle Facilitator role was viewed as one of the key success factors in reaching clients and building trust, a point which is further discussed in Chapter 4.

(2) Flexibility in delivering the project was frequently cited by project staff as a key component to overcoming unforeseen barriers and challenges towards achieving outputs. Staff reported that the flexible approach to recruitment and delivery allowed them to address unforeseen challenges to recruitment, effectively train staff, and deliver relevant interventions to beneficiaries.

- Flexibility in recruitment, training, and staff roles were viewed by project and programme leads, as well as delivery staff to be instrumental in effectively achieving

project outputs. For example, unforeseen problems with recruiting project staff and volunteers (detailed in 3.4) was overcome by project staff using "job-carving" to utilise time from existing KCHFT core services staff, as well as hiring staff such as Community Nursery Nurses in the place of Health Visitors. This ensured that the project delivery was not delayed.

- Additionally, because of low English language ability among applicants for the Lifestyle Facilitator role, the project made the decision to budget extra days for their training. This was viewed by delivery staff to be beneficial in that it gave extra time to address any unforeseen time constraints that may have arisen from low understanding of English, particularly as the training was thought by delivery staff to contain complex health jargon.
- Delivery staff reported that they valued the encouragement given to them by project leads to be flexible in delivering their work. They reported that this gave them the time to tailor their approach to with clients which allowed them address persistent structural barriers in receiving KCHFT services, such as low understanding and trust.

"I think this project is necessary as we haven't had the opportunity before to reach out and say, well what is it that you need or what we could do better." Delivery staff, focus group

(3) Combining segregated services into one specialised team was viewed by project staff as a unique enabler towards reaching clients and delivering services. Delivery staff and project and programme leads noted the value of having staff who work with different age groups collaborate on the same team. Staff considered this to be particularly important as many clients were hard to reach or not registered with KCHFT services and by building trust between a client and one health provider, respondents reported that this would cascade to additional services for the client. This finding was supported by interviews with project and programme leads who felt this had "knock-on" effect by contributing to improved identification of problems among beneficiary families registered with the team. For example, one respondent spoke of a household that was identified through the Health Visiting stream that had eight children previously unknown to the trust. Following this encounter, family members were subsequently referred to Social Services and School Health to address additional concerns and problems. This finding was further supported by data from KPIs showing a total of 198 people supported to access other NHS and Social Care Services via contact with the project between May and October 2019. The evidence suggests that this holistic working environment maximised outputs across different services streams encompassed in the Healthy Communities team.

What were the challenges to delivering the project?

There were three main challenges to project delivery:

(1) Delays in recruiting Health Visitors, School Nurses, Lifestyle Facilitators, and Community Champions, which further delayed other aspects of the project;
(2) Lack of visibility of the new team among other services and senior management;
(3) Barriers in accessing the target population.

(1) There were problems related with external resourcing and under estimation of time commitment during the recruitment phase of the project. Interviews with delivery staff and project and programme leads highlighted issues around the recruitment of Health

Visitors, School Nurses, Lifestyle Facilitators, and the community champions. Staff shortages within the NHS made recruitment of Health Visitors and School Nurses challenging; services were under both business-level continuity and retention payments thereby preventing any secondment to other projects. To address this, 'job-carving' from the core KCHFT staff was used, with Health Visitors and School Nurses time split between the Healthy Communities project and the KCHFT core services. This was facilitated by strong relationships between teams and cost-sharing incentives between services. Lower band staff were also recruited in lieu of expected staff; however, this came with certain trade-offs. For example, Community Nursery nurses had to be recruited in place of Health Visitors and were consequently not able to undertake safeguarding responsibilities. Project and programme leads expressed that the recruitment of Lifestyle Facilitators was more time-intensive than initially anticipated. The process was described as *"a lot of legwork"* initially by one internal stakeholder; this included informal outreach work to assess the local skill-set, recruitment events in target areas which included mock-interviews to assess English levels, and development of materials to help job applicants with applying for the position. Even when applicants were offered the position, they did not always have all the documents that were required to start. For example, one applicant did not have valid ID, and consequently they were asked to apply for a provisional driver's license as proof of address.

"I'm living in Dover for fifteen years and I'm always doing just manual jobs like housekeeping, cleaner or like factory packer or something like that… but I know the people. And now I start this job and it's everything for me." Delivery staff, focus group

None of the community champions were recruited, and, according to one project lead, they were unlikely to be recruited before the end of the project. The project lead responsible for recruitment attributed this to cultural barriers; specifically, the project faced challenges in engaging Roma community members in a volunteering role, as these types of positions are uncommon and not valued among this community. They suggested this barrier could have been overcome if project staff had more time and capacity to negotiate and nurture Roma community members for this role.

(2) Delays in recruiting were thought by project and programme leads to have further delayed the delivery of project outputs. Project and programme leads felt this was particularly true for delivery of Health Visiting services, compared with the services being delivered by Lifestyle Facilitators and School Nurses. This may have been due to the time-intensive nature of the Health Visitor role itself, as it was considered less flexible than Lifestyle Facilitators and required more direct outreach in client households compared with School Nursing. Additionally, the community events which were intended to include both residents and migrants were instead used as recruitment and education days for solely the migrant population. Project leads made this decision because of the increased resourcing that was required for recruitment. This likely impacted the expected outcomes among the resident population and is further discussed in Chapter 4.

(3) The decision to create a new team within the Trust was viewed by project and programme leads to have created a gap in management, as well as a lack of visibility of the team among KCHFT staff. For example, the project encountered numerous logistical issues, which included securing parking, desks and laptops, as well as technical problems with the Lifestyle Facilitator computer system. Staff reported that these problems were difficult to address due to the management structure in place as there was

significant gap between the project lead and more senior management, thereby making it difficult to escalate “minor” but significant problems upwards. This was compounded by a general lack of capacity on the part of project leads to invest time to address these issues, likely stemming from the delays in the project outlined in the previous point.
Delivery staff also reported issues about the perceived purpose of the team by other KCHFT core-services. This may have impacted the number of referrals made inwards by other services, as well as general misunderstandings around what types of problems the team should address. These findings draw attention to the inherent trade-offs between creating a new specialised team (see previous point in section 3.3) as opposed to embedding knowledge and specialities within pre-existing teams and structures.

(4) There was a consensus among project and programme leads that although the project was reaching its intended population, there remained persistent challenges in engaging certain types of beneficiaries. For example, one programme lead highlighted difficulties reaching Roma women who rarely leave the house or interact with their own community outside of the immediate household and were unsure of the community outreach model used by the project would be able to engage this sub-group. Another felt that the scope of the project was not wide enough, particularly in the school health stream which only engaged with schools where there was a high proportion of English as a second language students. The project attempted to address these barriers by producing a breastfeeding YouTube video for Roma women which was advertised through Roma third sector partners, as well as organising open information and education sessions for the Roma population which could be accessed by anyone from the community.

“There will always be people [the project] won’t reach, but that is the very nature of health improvement and trying to engage different communities.” Internal stakeholder, interview

4 Key findings: Outcomes

This section reports on the key findings from the evaluation in relation to progress made by the Healthy Communities project towards its intended outcomes. It begins with an assessment of progress made towards each of the intermediate outcomes set out in the project logic model. Where anticipated during the project timeframe, evidence towards expected longer-term outcomes is also considered. This is followed by discussion of the factors that were found to have contributed to the achievement of project outcomes.

Progress towards intended outcomes

The available evidence suggests that the project contributed towards achieving most of the intended local authority outcomes, as well as acquiring local expertise through the creation of the One-You Lifestyle Facilitator role. The project also contributed towards outcomes for beneficiaries, with increased access to services for migrant beneficiaries, and increased understanding of KCHFT services and feelings of trust towards the local authority. However, the evidence suggests that the project has not contributed towards the intended outcomes for wider/ longer-term residents, as there was only one output directed towards these outcomes, which was unsuccessful.

CMF fund-level local authority outcomes

Intermediate outcome 1: Increased insight into local migration patterns and community impact

The project aimed to achieve this outcome by collecting demographic data on migrant communities via Healthy Communities staff. They also anticipated that recruiting migrant community members as volunteer ‘community champions’ and Lifestyle Facilitators would further provide their own insight and local knowledge on migration patterns to the KCHFT. While the project was unsuccessful in recruiting volunteer community champions (see section 3 above), Lifestyle Facilitators were recruited and undertook this role.

Project staff reported that the data collected by the project did not allow for meaningful interpretation or insight regarding migrant community patterns. Project and programme leads, as well as delivery staff, felt that the standard data-collection tools used by the NHS were insufficient and provided limited insight into local migration patterns. Upon registering a new client, all project staff were required to collect demographic data, including ethnicity. However, project staff reported that the options for ethnicity were insufficient, as the “White European other” category failed to capture the diversity of the Roma and Eastern European community. Additionally, in instances where clients could specify their ethnicity, staff felt that clients did not respond accurately due to their perceived prejudice around associating with certain ethnicities. Some project staff expressed discomfort asking these details about ethnicity and would often skip this question, suggesting they would benefit from additional training and support about the importance of asking this information.

"[If we're not] gathering data on who the people are that we deliver our service to… how can we deliver that service or target it [effectively]?" Delivery staff, focus group

Nonetheless, programme leads reported that the project had enabled staff to gain valuable qualitative intelligence into local migrant communities. This mainly related to the location of Roma communities, as well as identification of Roma support services in Kent. For example, the location of clients and migrant communities were shared anecdotally with the KCHFT Health Visiting team, which allowed them to identify pockets of areas where there were more unregistered children[21] than previously thought. Another programme lead reported that the Healthy Communities Lifestyle Facilitators had helped them to identify migrant-specific support services within communities that KCHFT staff had not been aware of previously.
The evidence outlined above indicates that, despite limitations in the approach, there is some evidence which supports that the project has contributed towards the intermediate outcome of increasing insight into migration patterns and community impact.

Intermediate Outcome 2: Increased coordination and cooperation between agencies

The project intended to increase coordination and cooperation between teams in KCHFT by creating a new Healthy Communities team focusing on health within the migrant community. A named link between the Healthy Communities project and the KCHFT core-services (Health Visiting and School Health) further aimed to strengthen this connection to report back learnings and foster co-operation. This was intended to help identify multiple needs within this population that cut across disciplinary teams. Respondents reported that co-operation and co-ordination increased among teams directly involved with the project; specifically, with the Healthy Communities team and KCHFT services (Health Visiting and School Nursing). A quarterly multi-agency steering committee was set up by the project and comprised of representatives from the Health Communities team, Health Visiting, School Nursing and KCC. While project and programme leads felt these meetings were beneficial in identifying areas of overlap between services, they also thought that it was too soon in the project for this to have impacted service delivery. This was likely due to the delays caused by recruitment outlined in section 3.4.

Project and programme leads cited other channels of communications between Healthy Communities and KCHFT staff, including:

- Sharing of case-study reports outlining areas of best-practice;
- Shadowing between different teams to understand how they operate;
- Team 'away-days' to observe instances where other teams had developed an innovative approach or interesting learning;
- Informal, anecdotal evidence sharing between teams.

Project and programme leads perceived these activities contributed to a co-operative working environment which had a "knock-on" effect by identifying intersecting problems within families (detailed in **Error! Bookmark not defined.**). Furthermore, reflection logs written by delivery staff found shadowing other staff to be useful in contributing to their general knowledge of migrant communities and enabling them to

[21] Children whose birth was not registered with the KCHFT.

better deliver services to their own clients. However, another programme lead was less positive, and felt that their KCHFT core-service had not changed how they engaged with other agencies and organisations as a result of these activities.

While not intended by the project, external stakeholders and delivery staff reported that learnings had been shared on an 'ad hoc' basis at relevant conferences or with external projects. For example, an Early Help team in Margate set up a Black and Minority Ethnic (BME) meeting to strengthen partnerships within this community. Once established, Healthy Communities staff were able to attend these meetings to share additional information. Specifically, when the Margate team planned to run immunisation workshops in Children's Centres, they would contact the Healthy Communities team to provide information from local GP practices and schools to address immunisation concerns. With the caveat that this project did not directly cause the development of these programmes, respondents said that it likely contributed to the growing momentum of activities directed towards migrant communities within Kent. The evidence outlined above suggests that while there was evidence of increased communication within the Healthy Communities project and KCHFT staff, there was less evidence as to whether this had an impact on how services operate.

Intermediate Outcome 3: Acquired expertise and structures in place to deal with local issues

The project aimed to achieve this outcome by creating the Healthy Communities team which would specifically focus on addressing migrant health needs. By creating the Lifestyle Advisor role and recruiting community champions, the local authority further hoped to acquire community expertise into the KCHFT. While they were unable to recruit any community champions, they successfully recruited six Lifestyle Facilitators.

The Healthy Communities team were able to address health seeking attitudes and behaviours among the Roma community which were leading to ill-health and poor wellbeing. An example given by delivery staff was understanding and addressing reasons for missed appointments or Did Not Attends (DNAs) among the migrant community. In cases where Roma clients missed appointments with their GP, they would either be removed from the contact list or referred to other services; for example, missed new-born screenings resulted in the family being referred onto the GP for follow-up. The Healthy Communities team found that some families could not understand these referral letters due to lack of clarity and difficulty with the language used. Additionally, GPs did not always have the most up to date address of the family, and letters were not received at the correct address. Furthermore, families expressed an inherent fear of public services which prevented engagement; delivery staff provided an example of a case where a family was copied into a letter referring them to safeguarding for missing appointments, despite the mother attempting to call to explain that they could not attend services due to their child being sick.
The Healthy Communities team were able to identify barriers around language (letters not being easy to read or only in English), incorrect contact details (particularly since Roma are highly mobile) and fear/mistrust of public authorities. Delivery staff felt they were able to identify these barriers as they were given the space and mandate to focus on understanding and addressing health problems within the migrant community. Delivery staff were reportedly addressing these issues by developing easier to read

letters, increasing engagement with families to note address changes, and building trust through continuous out-reach to reduce feelings of fear towards KCHFT services.

Programme leads and delivery staff felt that Lifestyle Facilitators contributed to this outcome by bringing in language skills and community knowledge of health-seeking behaviour. This included skills related to translation and interpretation, which was used to translate health pamphlets and communicate with clients; this was thought to contribute to clients understanding of health services and improve accessibility. Lifestyle Facilitators' knowledge about migrant health-seeking behaviours further helped to address issues within the community. For example, one programme lead highlighted how knowledge communicated to them by a Lifestyle Facilitator had made them aware of migrant families' preference to be contacted in person as opposed to over the 'phone, as well as the importance of ensuring there is an interpreter present during the meetings.

"I think one of the positives too has been the inclusion of people with lived experience now contributing into those key groups and that needs to continue." Stakeholder, interview

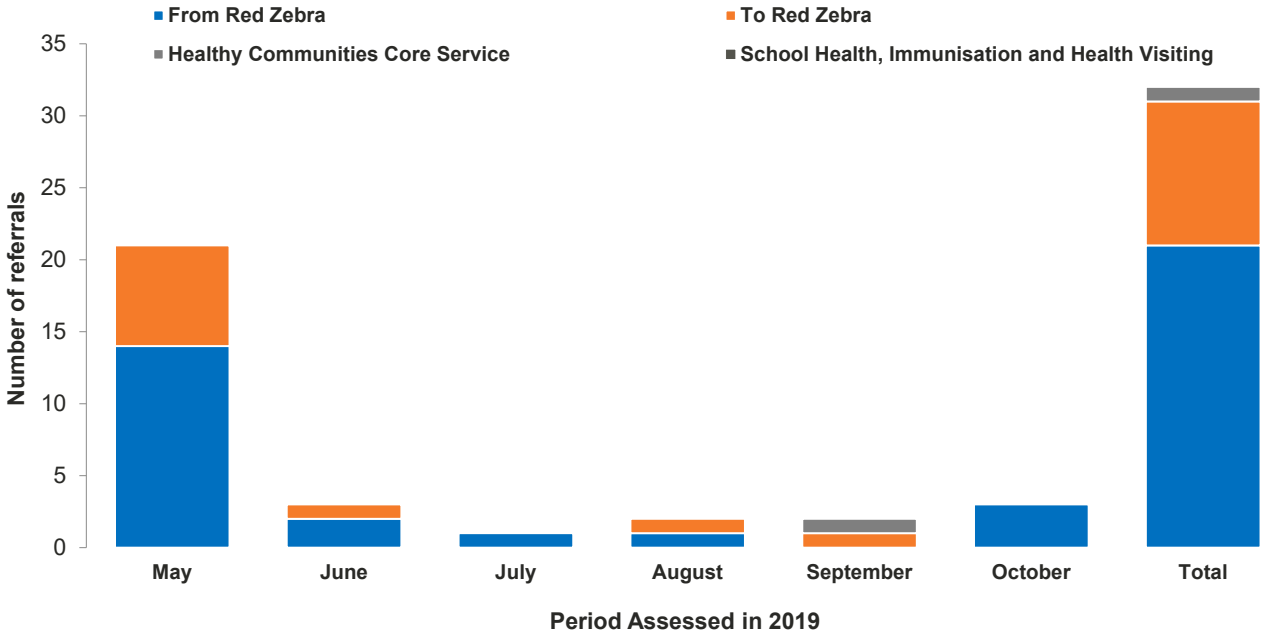
The evidence outlined above from interviews with project and programme leads and external stakeholders suggests that the project is likely to contribute to acquired expertise and structures in place to deal with local issues in the future.

Intermediate outcome 4: Improved signposting and referral systems

The project aimed to improve signposting and referral systems in KCHFT by creating a separate, cross-cutting team which could refer clients to appropriate services as needed.

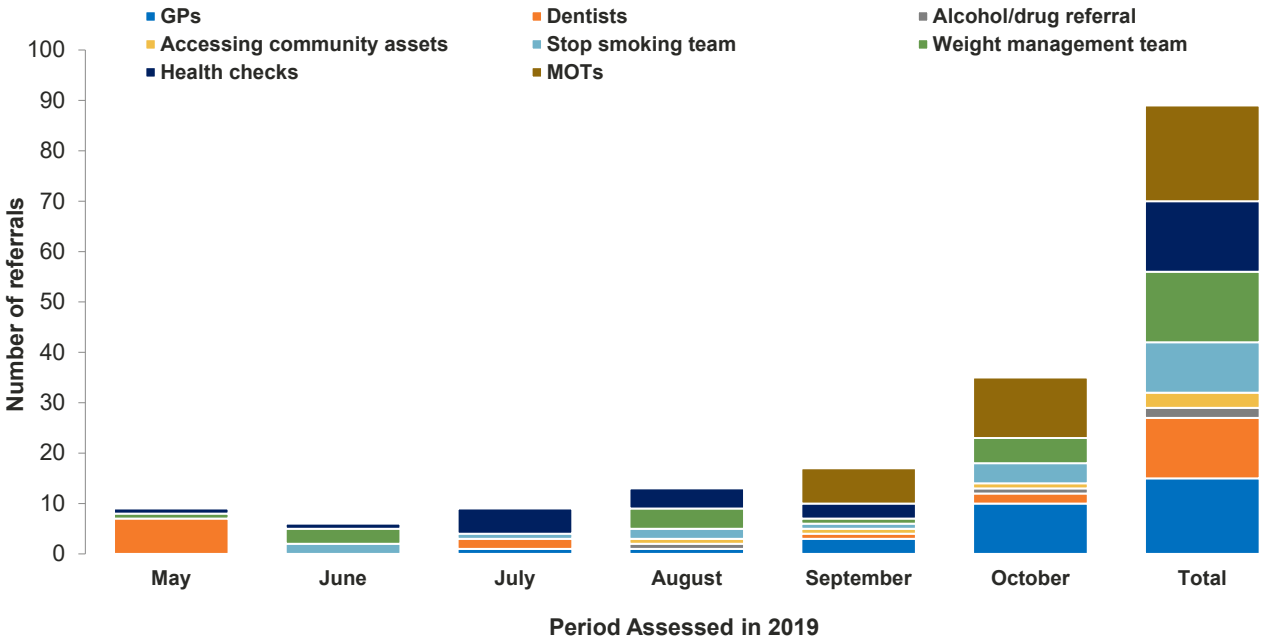
The perceived lack of visibility of the Healthy Communities staff within the KCHFT may have impacted the number of internal referrals. Overall, the majority of internal referrals were between the Lifestyle Facilitators and the charity Red Zebra at the start of the project, with very few within the Healthy Communities core-services, and none to KCHFT School Health, Health Visiting, or immunisation teams (see below Figure 4.1). The initial high number of cross-referrals at the beginning of the project was likely due to offloading of relevant health cases from Red Zebra and vice versa, once the project was established. The low number of referrals between internal partners may have been due to the low visibility of the Healthy Communities core staff; for example, one internal stakeholder stated that this initially resulted in referrals to the project that were for unrelated or inappropriate given their mandate, such as translation of letters. Despite this, the project and programme leads were hopeful that referrals would increase given time and familiarisation of the project across the services.

Figure 4.1 Referrals made by One You Lifestyle Facilitators to the Healthy Communities team



Referrals to external services among unregistered clients increased since the start of the project; this trend is depicted in figure 4.2 below. However, there was a consensus among project and programme leads that it was difficult to say whether this represented a significant improvement, citing the short amount of time between the project set-up and evaluation (resulting from delays outlined previously in section 3.4). Project and programme leads further felt that it was difficult to comment on levels of improvement as it was a new team and they lacked a comparison reference for referrals. Furthermore, due to the lack of data surrounding specific health outcomes within this Roma population, they also felt it was difficult to comment on the extent to which these numbers are effectively targeting health problems. Given these reservations from project and programme leads, this outcome was determined to be inconclusive.

Figure 4.2 Referrals made by Lifestyle Facilitators to external services[22]



As the evidence outlined above demonstrates, findings for this outcome are inconclusive as project and programme leads felt that delays in the project had limited the time required to see any improvements in their signposting and referral systems.

CMF fund-level migrant outcomes

Intermediate Outcome 5: Increasing understanding of and access to public services

The project aimed to achieve this outcome by establishing a specific team dedicated to Roma and other migrant clients. Integrating migrant community members into this team was considered vital to this outcome as the local authority felt they would be better able to communicate information to beneficiaries and enable understanding of services as well as build trust and improve experience of using local health services compared to staff from non-migrant backgrounds. This was expected to ultimately improve uptake and use of appropriate services among migrant community members.

Communication and Understanding of Services

Interviews with migrant focus groups emphasised how having a member of staff who speaks their native language had enabled them to better communicate with and understand services available to them. This finding is supported by evidence from quantitative data (Table 4.1), which shows that migrants understood why they were being seen by School Nursing staff, as well as the information that was given to them. These findings were also consistent with surveys collected by Health Visitors (n = 2; n = 4), with beneficiaries which indicate that they were given information by the Health Visiting team, and that they now knew who to contact for questions and concerns although findings should be interpreted with caution given the very small base sizes This appears to have contributed towards more positive health-behaviours, as

[22] MOT refers to an NHS Health Check, which is aimed at adults aged 40 – 74 to check vascular and circulatory health

evidenced in a focus group with migrants where they outlined changes in their health behaviours which they attributed to the project. Participants explained that while they previously would only seek help once they were sick, they now felt they were more likely to proactively consider preventative healthcare options.

> *"It's the language. It was difficult for us but with the project it's different… we used to only see the doctor if we got sick… but now with this she calls us, we check our blood pressure and talk about it and about being healthy." Migrant resident, Nepali focus group*

Table 4.1 Responses from survey data related to understanding of services

Service Line	Question	Percent/Number Response "Yes"	Sample/ Base
School Health	*Q2.1.2 and Q2.2.2 Do you know why you were seen by the nurse today?*[23]	83%	*N = 40*
	Q2.1.3 and Q2.2.3 Did you understand the nurse?[24]	85%	*N = 40*

A focus group with delivery staff also stressed the importance of communication in increasing understanding of health services. Although not everyone had the language skills, Healthy Communities staff emphasised how the way in which information is presented, and not just the content, is also important, especially regarding its relevance to the migrants' daily lives. This was echoed in interviews with external stakeholders who felt that simply providing information, even translated information, was often not enough of a motivating factor for beneficiaries to apply it to their daily lives. Both delivery staff and external stakeholders expressed the need for an ongoing effort to understand information value and opportunities for presenting information in alternative ways.

Increasing Trust and Improving Experience of Migrants with KCHFT Services

Evidence from migrant focus groups and survey data indicates this project contributed towards improving clients' trust and experience with GP services. During the migrant focus groups, participants expressed a general lack of trust between GPs and their community. "Dr Paracetamol" was mentioned by all three focus groups; which was a reference to participants' frustration with GPs perceived tendency to prescribe paracetamol without explanation. Findings from the external evaluator indicated that this had created negative perceptions within these communities towards GPs, with reports of migrants even returning to their home country to seek healthcare. Participants felt that the inclusion of the Lifestyle Facilitator helped to address these barriers by taking the time to communicate and explain services to them. This finding is supported by evidence from quantitative data (Table 4.2), which shows that clients were positive regarding the different aspects of care they received. Although the sample for surveys collected by Health Visitors were very low (n = 4), responses indicated beneficiaries felt they were treated with respect and would recommend the service as well.

[23] Data merged from two separate surveys asking the same question (worded the same).
[24] Data merged from two separate surveys asking a similar question. Phrased as "Did the nurse talk to you in a way you could understand?" on one survey, and as "Did you understand the nurse?" on the other.

"Sometimes you didn't want to listen, but when the lady [health improvement adviser] explained us in our own language then we felt excited and we started getting motivated" Migrant resident, focus group

Table 4.2 Responses from survey data related to trust and experience

Service Line	Outcome	Question	Percent/ Response "Yes"	Sample/ Base
School Health	Trust	*Q2.1.4 Did the nurse listen to what you had to say?*	7	*N = 7*
	Experience	*Q2.2.1 Would you want your friends and family to have this service if they need it?*	61% Yes 12% No 27% Maybe	*N = 33*
		Q2.2.5 Would you be happy to see the nurse again?	64% Yes 6% No 30% Don't know	*N = 33*
One You Lifestyle Facilitators	Trust	*Q3.1.3 Confidence Ruler (average mark based on trust in the service)*	96%	*N = 34*
	Experience	*Q3.1.2 How likely are you to recommend the service?*	82% Ext. Likely 12% Likely 6% No Response	*N = 34*

Focus groups with delivery staff described their approach to contributing to this outcome. Lifestyle Facilitators felt that because they were a recognisable face from the community, migrant community members were more comfortable approaching them. Once initial contact had been made, they were then able to build trust by communicating with them in their native language. Respondents stressed the importance of communicating on a diversity of topics, and not just health information alone, in building trust. Interviews with project and programme leads further highlighted other components for building trust, including the importance of using the same staff for continuity of care, as well as familiar venues that made people feel comfortable.

"It's easier to come to us because of the trust - they see that we are from the community, so they trust you with their problems" Delivery staff (Lifestyle Facilitator), focus group

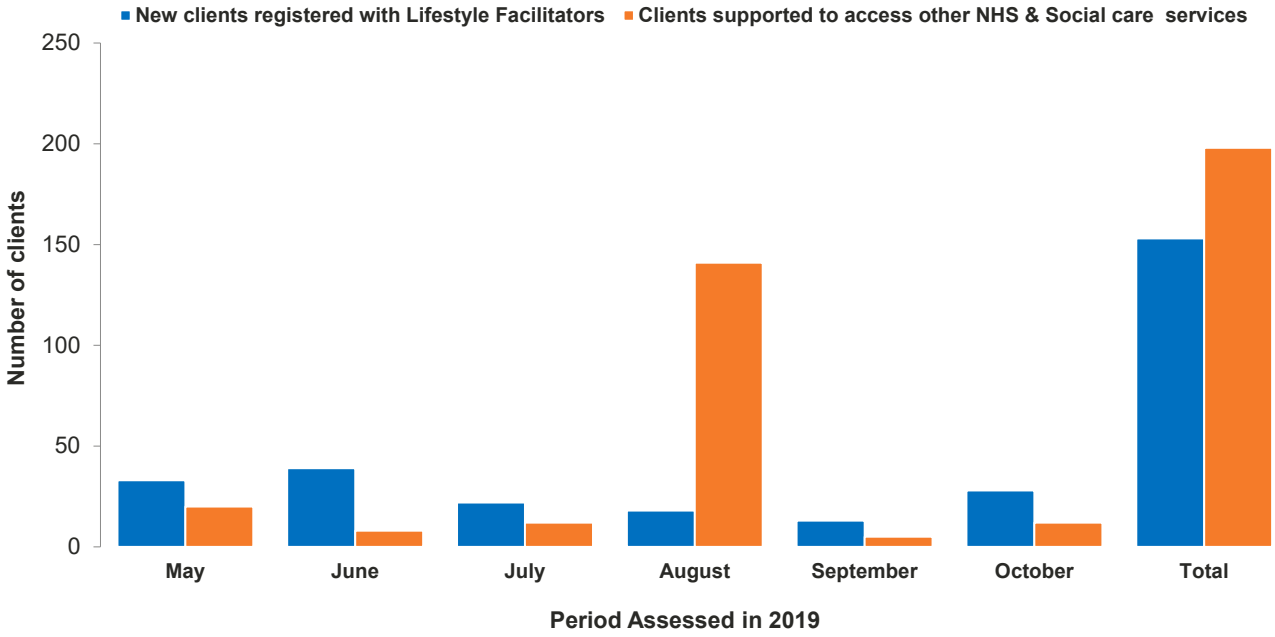
Access to and Uptake of Services

Evidence suggests that this project contributed towards increasing accessibility and uptake of KCHFT services. Interviews with project and programme leads found that there was a general perception that the project was increasing the number of previously unregistered migrants who are signing-up and using services, such as in-house visits and development checks. Findings from a migrant focus group further indicated that participants perceived themselves to be more engaged with services,

with some expressing a desire to progress with other types of support signposted by the project, such as language classes.

Delivery staff felt that increased levels of confidence was a key step towards migrant community members accessing services. However, the exact mechanisms for instilling this sense of confidence was not made clear by respondents. This was thought by delivery staff to be contributing to beneficiaries proactively considering preventative healthcare actions or progressing with language support activities.
These findings were supported by registration numbers depicted in figure 4.3. Notably, these numbers were among clients who were previously unregistered with KCHFT services and became registered to appropriate services by the Healthy Communities team.

Figure 1.2: Clients registered and supported to access other services by Lifestyle Facilitators



The above evidence indicates that the project has contributed towards increasing understanding of and access to services among migrant beneficiaries.

CMF fund-level resident outcomes

The project did not target any of their activities towards non-migrant residents, as the planned mixed community events were instead targeted solely at migrant-community members. As outlined in Chapter 3, this decision was made because of a lack of time and staff capacity due to the delays in recruitment. Additionally, the project did not intend to advertise any findings from the project to the local community for fear of negative repercussions from the resident community stemming from perceptions that more resources are being allocated to migrant community members. For these reasons, the project contributed to none of the resident outcomes and this section only gives a brief summary for each specific outcome, based on interviews with project staff.

Intermediate Outcome 6: Perceived reduction of pressure on public services and private facilities access to public services

The project hoped to achieve this outcome by reducing costs on services caused by inappropriate use by migrant community members. This was expected to increase overall resources for KCHFT services, and therefore improve access to KCHFT services by the resident population. While programme leads felt that staff pressure has likely decreased (for example more complex cases within Health Visitors had been supported by the project), this was not being communicated to residents. Furthermore, project and programme leads felt that residents would not notice this reduced pressure, as Health Visiting and School Nursing services are mandated universal services and should not technically be subject to reduced accessibility.

However, many of the activities carried out by the project will likely achieve an actual reduction in pressure on NHS services, which will ultimately benefit the resident community. For example, efforts to increase immunisation rates among the migrant community by the Healthy Communities team will contribute towards increased herd-immunity and better health-outcomes for wider residents. Additionally, registering Roma community members with GPs will also likely reduce costs through unnecessary A&E visits and complications arising from untreated health conditions.

Intermediate Outcome 7: Increased opportunities for social mixing

The project aimed to achieve this outcome by hosting community events targeted at the migrant and resident community, as well as increasing mainstream use of services such as Children's Centres by the Roma community where they could mix with the resident community. As the community events were only targeted towards the migrant community, this outcome was unlikely to have been achieved. One respondent hypothesised that because migrant families are using public services more (such as the Children's Centres), it was likely that there were increases social mixing; however, this was only implied and there was no additional evidence to support this.

Intermediate Outcome 8: Improved perceptions/attitudes towards migrant community members in the resident community

The project hoped to achieve this outcome by having residents mix with migrants at community events, where they could better understand each other and how all residents contributed to the local community. Additionally, the project changed the name from "Migrant Communities" to "Healthy Communities" so the project would be perceived as more inclusive among residents of the wider community. However, as these events did not take place as planned, it is unlikely that residents were able to interact with migrants in this context. Additionally, as the project was not advertised to local residents, it is also unlikely that the project would contribute to improving attitudes through this pathway. Project and programme leads could not identify any other ways in which residents would be aware of the benefits of the project.

Progress towards longer-term outcomes

. his section gives a short overview of how likely the projects activities will contribute towards longer-term outcomes. This is informed by the directionality of change depicted in the logic model (figure 2.2) and is valid given the assumptions in the logic model are met.

There was strong evidence to suggest that the project had contributed towards the intermediate outcome of acquiring expertise and structures in place to deal with local issues, and partial evidence to suggest that this had in turn increased insight into local migration patterns and community impact. Based on the assumption that this will improve the local authority's knowledge base, this is likely to contribute towards the intended longer-term outcome of **building the evidence base for "what works" locally.** There was some evidence from the evaluation that this was happening, including learnings around developing effective data collection tools, and successful outreach activities built around delivering in tandem with local third sector organisations.
There was strong evidence to suggest that the project had contributed towards registering previously unregistered migrants to a GP, as well as partial evidence to suggest that the project had contributed towards improving increased co-ordination and co-operation between agencies, and minimal evidence to suggest that the project had contributed towards improving signposting and referral mechanisms. Despite this mixed evidence, given the assumption that proper use of the NHS will decrease costs, it is likely that the project will contribute towards the longer-term outcome of **reducing cost on public services.**

There was strong evidence to suggest that the project had contributed towards the intermediate outcome of improving understanding of and access to health services. Therefore, assuming that increased access to health services results in health needs being addressed, the project is likely to contribute towards the intended longer-term outcome of **improved well-being within the migrant community.** There is some qualitative, anecdotal evidence that this is already happening, as some migrant beneficiaries interviewed reported practicing healthy behaviours like proactively seeking GP advice for health complications and registering with the stop smoking team.

There was minimal evidence to suggest that the project had contributed towards either of the intermediate resident outcomes; therefore, it is unlikely that the project will contribute to the corresponding longer-term outcomes of **increased levels of social mixing** and **reduced public concern about access to public services.**

5 Value for Money

Introduction

Cost-effectiveness analysis (CEA) was conducted in order to assess value for money of the CMF funds granted to the Healthy Communities project. The assessment looks at the project's achieved outcomes against the specific costs associated with achieving the outcome in question.

The project was selected for a CEA due to the lack of primary or secondary data available to monetize outcomes. As there was no control (counterfactual) group against which to assess the impact of the project, artificial baselines were constructed (outlined in more detail below). Given the nature of the data used in the construction of the cost benefit and cost effectiveness models, the accuracy of results produced by the models should be interpreted with caution[25].

In addition to the CEA, a secondary data search was made to further inform the value for money assessment in the case where benefits could not be monetized. Perceptions of project costs and benefits were also explored through qualitative consultations with staff, and delivery partners. This analysis acts to supplement and thus support the quantitative value for money assessment. For more information on the methodology, see Chapter 2 and Appendix 1.

This assessment does not take into account non-monetizable benefits of project outcomes (such as increased insight, knowledge and expertise of staff, improved signposting and referral, increased social mixing, or outcomes related to wider resident views and perceptions), which are explored in Chapter 4.

Value for money assessment

Cost effectiveness analysis

For the Healthy Communities project, the outcome of interest was the **number of individuals supported to access NHS and social care services**. This was selected as the outcome for interest because there is a logical and evidenced link between earlier referral to NHS or social care services and increased individual and social wellbeing.

Over the lifetime of the project, 200 referrals were made to NHS or social care services. Evidence from qualitative interviews with staff suggested that, in the absence of the programme, none of these 200 individuals would have been referred through other channels (rather, clinical presentation would have occurred further down the line following a worsening of health status). However, to introduce a degree of conservatism into the calculations, the model assumed that 10% of these individuals

[25] The Maryland scientific methods scale scores methods for counterfactuals construction on a scale of one to five (with five representing the most robust method). Due to the use of measures of additionally in the construction of the counterfactual, the approach taken for this analysis cannot be attributed a score. Therefore, the accuracy of results produced by the models should be interpreted with a high degree of caution. For more information, see: https://whatworksgrowth.org/public/files/Methodology/Quick_Scoring_Guide.pdf

(20 referrals) would have come into contact with NHS or social care services through other means, over the duration of the project. These 20 referrals represent the counterfactual (as it is assumed they would have occurred in the absence of the project) against which the net effect of the intervention can be calculated (e.g. 180 net new referrals).

The costs associated with achieving the 180 net new referrals related to the hiring, training and management of eight One You Lifestyle facilitators. A more detailed breakdown of the isolated and attributed costs involved in generating the 200 referrals can be found in table 5.1 below.

Table 5.1 Healthy Community project cost type and cost value

Cost type	**Cost Value**
Salary and on costs for 8x One You Lifestyle Facilitators	£95,120
One You Lifestyle Facilitators travel cost	£9,600
One You Lifestyle Facilitators equipment cost	£2,000
One You Lifestyle Facilitators total training costs	£5,474
Management and oversight	£22,232
Total cost of referrals	**£134,425**

By dividing the total costs presented above by the net number of new referrals (180) provides **a 'cost per referral' value of £747**.

Given the lack of data available, the evaluation was unable to determine the social benefit associated with each of these 180 new referrals. This would have required sufficiently robust secondary data or, optimally, detailed follow-up data on each patient's future health outcomes.

In light of this assessment, if the benefit to the individual and society at large from an early referral exceeds £747 then the project can be deemed net beneficial to society from a value for money perspective. Additionally, the cost per referral value can be used to assess the value for money of this project relative to all other projects which seek to increase earlier referral to health and social care services. If alternative interventions lead to a cost per referral value greater that £747, we can infer that the Kent project is better value for money at the margin (in terms of its impact on numbers of referrals).

Secondary data assessment

There is evidence that the project contributed to additional outcomes that have the potential to increase the true cost-effectiveness of the project interventions, but were not possible to include in the cost-effectiveness analysis due to a lack of available data on beneficiary outcomes. Analysis of secondary data therefore provides wider context to the CEA presented above.

One project outcome was to increase immunisation rates among Roma community members. While data was not available on the number of individuals who were

registered with GPs that were also immunised, studies have found broad economic impacts from vaccination programmes and they are seen as one of the most cost-effective ways to save lives[26]. For example, as a result of improved health outcomes, vaccinations have been shown to help to increase the cognitive skills and performance of children at school[27], therefore having benefits that accrue over the course of an individual's lifetime in terms of improved employment and health outcomes. A 2018 study by the Department of Health and Social Care found that health protection interventions which include immunisation average a Return on Investment of around £34 for every £1 spent[28].

Furthermore, the project aimed to contribute indirectly to smoking cessation, through referring beneficiaries to relevant services. While data was not available to the evaluation on the number of individuals who reduced or stopped smoking as a result of the interventions, smoking is estimated to incur a societal cost of roughly £1,900 per smoker per year and therefore smoking cessation services have been found to be highly cost effective[29].

Qualitative assessment of project costs and benefits

In order to minimise costs and promote efficient use of funding, project staff sought to share costs with the wider department as far as possible, including splitting the time and travel spent by Health Visitors within the wider departmental budget, and sharing direct costs (such as venues). Project staff felt that this was possible due to strong relationships with senior management. Existing internal NHS processes also meant that all large spending was reviewed by the NHS programme board. This suggests that running a project internally within a larger organisation promotes efficient use of money and financial oversight.

All project staff interviewed agreed the project would not have gone ahead without CMF funding. Staff reported that while wider local authority activities to engage migrant and Roma communities may have taken place, this would not have focused explicitly on health outcomes, nor been able to engage community groups or coordinate activities with the NHS Trust to the same extent. Staff acknowledged that local community and interest groups were engaging the Roma community, but felt this was on a small scale and staff and stakeholders were not aware of any health-focused projects. As a result, project staff felt that without the funding, children not registered with a GP would not have been identified. Migrant community members identified friends, family and social media as their main sources of information about UK health services, as well as personal experience and information shared by children's schools. This suggests that the project was not duplicating existing work in the area and there are few wider contextual factors that could have influenced outcomes.

---

[26] The Association of the British Pharmaceutical Industry (ABPI), What are the economic and societal impacts of vaccines? Available at: https://www.abpi.org.uk/new-medicines/vaccines/economic-and-social-impact-of-vaccines/
[27] https://www.gavi.org/vaccineswork/value-vaccination
[28] Department of Health and Social Care, 2018, Prevention is better than Cure. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/753688/Prevention_is_better_than_cure_5-11.pdf
[29] Cancer Research UK, The Economic Case for Local Investment in Smoking Cessation. Available at https://www.cancerresearchuk.org/sites/default/files/economic_case_for_local_investment_in_smoking_cessation_printed_version.pdf

Stakeholders who took part in a focus group facilitated by the external evaluation partner referred to a growing number of projects and areas of work with a focus on migrant health outcomes and diverse communities. Stakeholder partners noted that there was a need to maintain the momentum attributed to the Healthy Communities project. This was particularly true in the case of collaborative work with Roma community members. Stakeholders noted wider benefits as a result of the improvements in contact and trust with Roma partners and community members as a result of the project.

6 Conclusions and lessons learned

What works?

The evaluation found that the main components required for this project were:

1) the inclusion of the target population throughout the design and delivery of the project;
2) flexibility in implementing the project; and
3) resources required for the project, particularly regarding staff.

- One successful component of this project **was the engagement of the Roma community by the local authority throughout the design and delivery of the project.** This allowed the local authority to work with other Roma-based NGOs to support in delivering certain aspects of the project, such as recruitment and events.
- Furthermore, **knowledge of the beneficiary group generated from this engagement was also beneficial.** Consultations with migrant populations helped to manage expectations of project staff, while integrating community members into the Healthy Communities team further embedded this knowledge into the project.
- Finally, **the flexibility to adapt to unforeseen circumstances** was also viewed as a key to the success of the project. In some instances, such as recruitment, this refers to flexibility in responding to these circumstances, while in other instances such as training, flexibility was built into the design of the project itself.

Key barriers encountered included a lack of resources in terms of project staff due to a shortage in Health Visitors and School Nurses. This delayed the start of the project and, in the case of community champions, resulted in the activity being discontinued.

- While the general shortage in Health Visitors and School Nurses was contextual to wider issues in the NHS, it **highlights the inherent drawbacks of establishing a new team using this delivery model.** Embedding knowledge within the pre-existing teams and structures may have functioned as a viable alternate model.
- There are additional learnings regarding Lifestyle Facilitators, in that **additional time and effort should be inputted into any recruitment phase among applicants with low levels of English or minimal prior experience.**
- Finally, because the recruitment of community champions did not occur due to the Roma communities' negative perceptions of volunteer positions, this once again **emphasised the important of community knowledge in establishing these types of projects.**

One of the main drivers which contributed towards successful outcomes was integrating end-beneficiaries into the project through the creation of the Lifestyle Facilitator role.

- By acquiring their unique expertise into the local authority, Lifestyle Facilitators were able to identify and reach out to communities and individuals that the Trust was not able to reach before.
- Lifestyle Facilitators were further able to sustain this outreach by developing a relationship with their clients, facilitated by their familiarity and language skills. This ultimately allowed them to build trust with their clients, which in turn enabled clients to register with KCHFT services and be signposted onto other health services such as GPs, dentistry, and lifestyle interventions (such as weight loss and quitting smoking).

Establishing a new team within the KCHFT appears to have had both pros and cons in contributing towards local authority outcomes. Some aspects of this model were successful, specifically in facilitating information sharing between Healthy Communities team and KCHFT staff, as well as creating structures to address health inequalities among the Roma migrant population. However, the initial lack of visibility of the team also likely contributed to a slow start in increasing referrals and signposting to services outside of the Healthy Communities team. Future projects should consider both the advantages and disadvantages in creating a separate team, especially regarding their contribution towards achieving specific outcomes.

The project was unsuccessful in contributing to the resident outcomes, with evidence suggesting that this was due to the delays caused by recruitment. However, it is questionable whether a specialised health team directed at migrant communities was an effective way to address resident concerns. This is for two main reasons, the first being that the main activities of the project were not directed at residents in any capacity, and the second being that residents are unlikely to know about the project and its benefits because of its targeted nature. The decision to focus community events solely on the migrant community also impacted the likelihood of achieving the latter point as well. Projects should therefore think more critically of the link between their activities and project outcomes and work closely to ensure that these links are consistently re-evaluated throughout delivery of the project.

For whom?

The key beneficiaries of this project were the migrant communities themselves, and, to a lesser extent, the local authority. By creating a new team targeting the migrant community, the project was effectively able to address specific needs within this population that the local authority was unable to reach before. This was because there was a general lack of knowledge about this community on the part of the local authority, which could only be addressed by engaging and including those community members. By extension, the local authority also benefited from this project by acquiring additional expertise, increasing client access, and improving health outcomes among this population. Wider resident groups did not appear to benefit from this project within the timespan of the evaluation. However, many of the activities undertaken by the project, including building herd immunity and cost-savings through registering beneficiaries with GPs, are likely to benefit wider residents in the long-term.

In what circumstances?

This project arose out of a need within the Roma community which was identified through previous work undertaken by local NGOs and charities, as well as work within the wider trust. There was strong consensus among external stakeholders that this project would not have gone ahead without efforts from key individuals who championed initiatives around diverse communities in Kent. Overall, the development of this project was perceived by external stakeholders to be driven by specific interests of individuals as opposed to an overall strategy of community engagement.

Could the project be replicated?

The model of this project, specifically creating a specialised cross-cutting team, could be replicated in another local authority seeking to address health inequalities among resident migrant populations and other hard to reach groups. However, where a local authority is seeking to recruit skilled workers such as Health Visitors and School Nurses, the availability of suitably skilled and experienced applicants will impact the extent to which the project could be replicated.

Resourcing challenges are less of a barrier to replicating the outreach aspect of the project, which was achieved by recruiting local community members into the KCHFT. Because of the entry-level skills required for this job, there would likely be fewer resourcing problems. This aspect of the project was successful in building trust and increasing accessibility of KCHFT services among the migrant population. Because this component only involved outreach and building trust among migrant communities and not delivering specific services, it could be replicated by other services such as social care.

An additional element that would be beneficial for replicability is strong connections with a third sector organisation specialising in migrant-based services. While not essential, their established presence and knowledge of the community could be helpful for inputting and supporting the project, particularly in recruiting community members to the core-staff team, or in providing familiar venues to host community events.

Could the project be scaled up?

Scalability of this project is dependent on the level of need of the target population. As the exact number of Roma and other migrant communities with health inequalities in the area remains unknown, it is difficult to say whether it would be necessary to scale this project. However, if this project were to be scaled up, it would be challenging due to the shortage of suitably skilled staff. Attempts to scale this type of project would need to be cognisant of these limitations and identify alternative staff resources, either through job-carving or recruiting lower-band staff, to overcome these barriers.

Is there evidence of sustainability beyond the lifetime of the project?

Project and programme leads identified several plans for ensuring the sustainability of the project. They suggested that there was potential to use any underspend to continue the project past the October 2020 deadline. They were additionally looking for funding from the Trust to continue the project in a smaller capacity, with the benefit being that staff have already been recruited and trained. Finally, project and programme leads also indicated that even if the project were to end without further funding, KCHFT would consider hiring Lifestyle Facilitators into one of the Trusts' permanent roles.

7. Appendix 1: Methodology and technical note

Evaluation Methodology

Qualitative evidence

- For research activities undertaken by Ipsos MORI, programme leads were identified through the project lead. Interviews took place over the phone between September and October 2019 and were conducted by Ipsos MORI.
- For research activities undertaken by the University of Kent:
    - All delivery staff in the core team were interviewed in the focus groups which were conducted between July and September 2019.
    - Stakeholders were identified through an internal process in consultation with project and programme leads and were interviewed between August and November 2019.
    - Migrant community members were identified through the partner organisations Red Zebra and were conducted between August and November 2019.

Quantitative evidence

- Health Visiting and School Nursing questionnaires were designed by the KCHFT Patient Experience team with input from delivery staff and the KCHFT commissioner.
- The Lifestyle Facilitator questionnaire was a standardised NHS Friends and Family Test questionnaire.
- Questionnaires were completed by clients and patients either post-consultation or intervention and were administered by project staff.
- Questionnaires used in this evaluation were administered between March and December 2019.

Secondary data and monitoring information

- Monitoring data included in this evaluation included:
    - Activity logs from the Healthy Communities team, which were collated by project staff and reviewed by the project lead.
    - Key Performance Indicators (KPIs) collected by the project.
    - Reflection Logs (n = 100) completed by Health Visitors, School Nurses and One You Lifestyle Facilitators quarterly. The Reflection Log was designed by the external evaluator based on their own research from templates found in the literature

Value for money assessment

In order to assess the feasibility of a cost-benefit analysis (CBA) or cost-effectiveness analysis (CEA) each of the 14 projects were assessed using the 8-step process below.

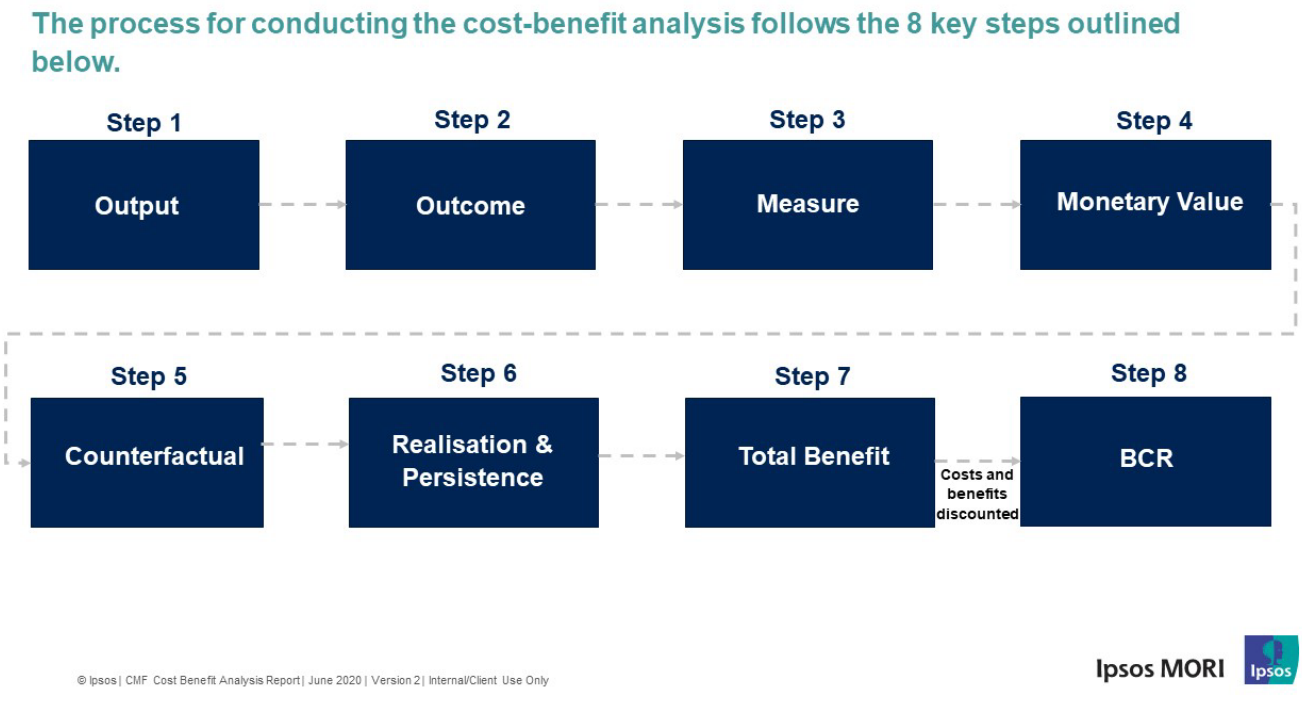
Based on this assessment, each project was triaged to one of three methodological groupings:

1. **Cost benefit analysis (CBA)**: Where data on quantitative and monetizable outcomes was available, a cost-benefit analysis was conducted;

2. **Cost effectiveness analysis (CEA):** Where quantitative measures for outcome(s) existed, but no data (primary or secondary) was available to monetize the outcomes, cost effectiveness analysis was conducted; or

3. **No feasibility for quantitative analysis:** Where there was no quantitative measure of outcomes available to the evaluation, neither cost benefit analysis nor cost effectiveness analysis could be conducted. In this case, a qualitative assessment of project costs and benefits was undertaken based on analysis of staff, stakeholder and beneficiary perceptions from qualitative consultations. Secondary data on potential monetizable benefits was also reviewed.

Eight step model for reviewing project outputs and outcomes



Cost-benefit analysis followed an eight-step process:

1. **Identify the projects outputs** (e.g. number of individuals provided with housing support)

2. **Identify the achieved projects outcomes** and the outcomes which are monetizable

3. **Identify monetary values for each outcome** from existing data sources

4. **Assign a counterfactual case for the outcomes** to estimate the number of outcomes achieved in the absence of the project; derived through primary information collection or secondary data analysis

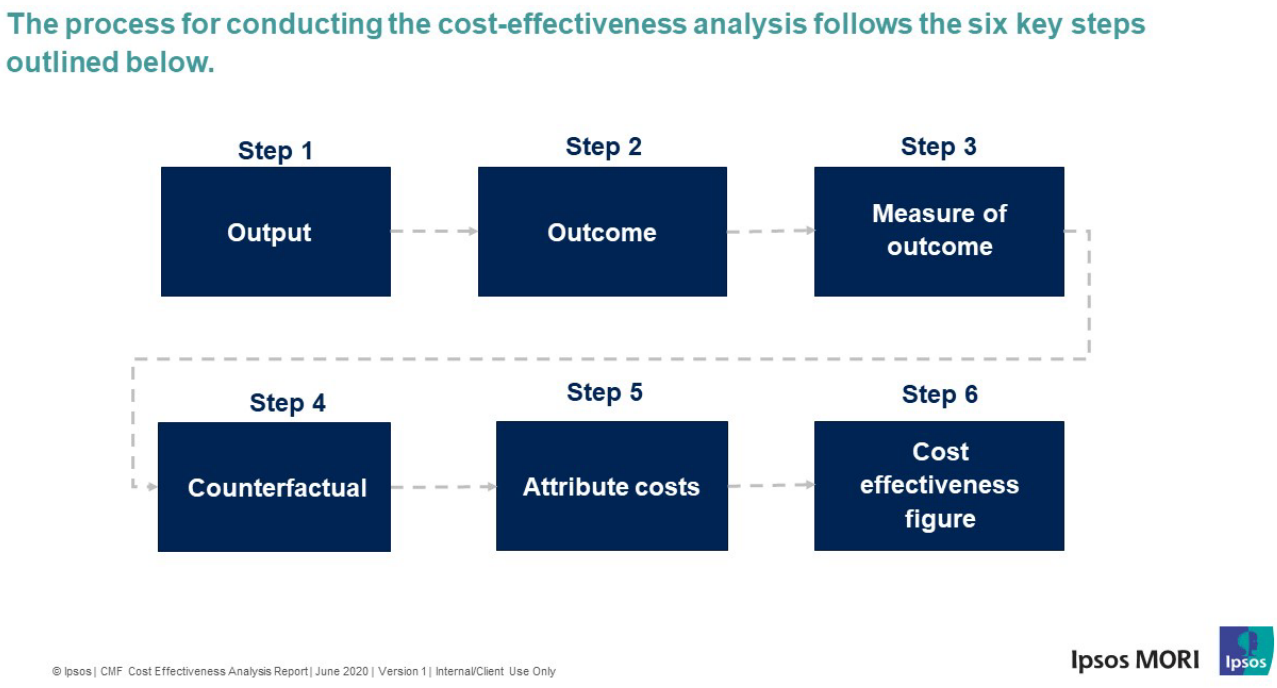
5. **Monetize the outcomes** by multiplying the monetary value of each outcome by the number of additional outcomes achieved

6. **Estimate the persistence of the outcome** (i.e. is this a one-off benefit or ongoing, and how long does the benefit persist for into the future?)

7. **Calculate the total monetary benefits (cost savings)** by summing the total benefit for each outcome (including fiscal savings, public sector efficiency savings and public value benefits), accounting for any duplication of benefits across different categories.

8. **Compared the total estimated monetary benefits to the total costs** of the project, to estimate the estimated Benefit to Cost Ratio (BCR).

Cost effectiveness analysis followed a six-step process, outlined below:



1. Identify the projects outputs

2. Identify the achieved projects outcomes

3. Identify quantifiable values for each outcome

4. **Assign a counterfactual case for the outcomes** to estimate the number of outcomes achieved in the absence of the project. This is derived through primary information collection or secondary data analysis.

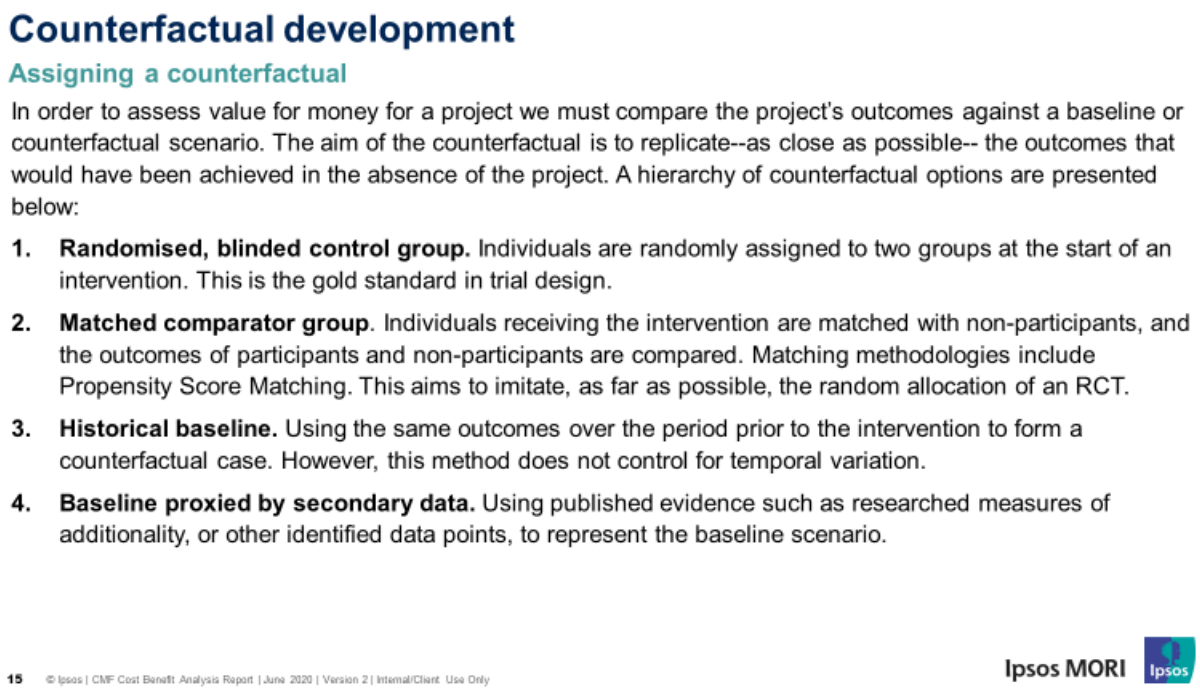
5. **Attribute costs** using a breakdown of the project costs. Costs that are related to the outcomes identified in Step 3 can be isolated and attributed to the relevant outcomes.

6. **Calculate the cost-effectiveness figure** of the project outcome, by dividing the outcome by the cost attributed to it to derive the cost per unit of that outcome.

Two models were developed using Excel. The CBA model calculated costs relative to the monetizable benefits. The CEA model calculated costs relative to the quantifiable outcomes achieved from each of the CMF interventions (without attempting to monetize these outcomes).

As there was no robust control (counterfactual) group against which to assess impact, artificial baselines were constructed. Where possible, input from project leads was used to inform the assessment of the counterfactual and in the cases that this was not available, conservative estimates were made. A hierarchy of counterfactual options are outlined below. Given the nature of the data used in the construction of the cost benefit and cost effectiveness models, the accuracy of results produced by the models should be interpreted with a high degree of caution.

Counterfactual development: hierarchy of counterfactual options



Counterfactual development

Assigning a counterfactual

In order to assess value for money for a project we must compare the project's outcomes against a baseline or counterfactual scenario. The aim of the counterfactual is to replicate--as close as possible-- the outcomes that would have been achieved in the absence of the project. A hierarchy of counterfactual options are presented below:

1. **Randomised, blinded control group.** Individuals are randomly assigned to two groups at the start of an intervention. This is the gold standard in trial design.
2. **Matched comparator group**. Individuals receiving the intervention are matched with non-participants, and the outcomes of participants and non-participants are compared. Matching methodologies include Propensity Score Matching. This aims to imitate, as far as possible, the random allocation of an RCT.
3. **Historical baseline.** Using the same outcomes over the period prior to the intervention to form a counterfactual case. However, this method does not control for temporal variation.
4. **Baseline proxied by secondary data.** Using published evidence such as researched measures of additionality, or other identified data points, to represent the baseline scenario.

Analysis / synthesis of findings

Secondary data and monitoring data shared by the project was analysed to extract key findings related to achievement of outputs and outcomes.

Interview notes were systematically inputted into an analysis grid for each research encounter, allowing for more in-depth analysis of findings. There was one grid for each type of audience consulted. The grids follow the structure of the topic guide enabling the identification of relevant quotes for each element of the outcomes and process evaluation. A thematic analysis approach was implemented in order to identify, analyse and interpret patterns of meaning (or "themes") within the qualitative data, which allowed the evaluation to explore similarities and differences in perceptions, views, experiences and behaviours. Once all data had been inputted, evidence for each outcome and key delivery themes was brought together in a second analysis matrix to triangulate the evidence and assess its robustness.

Qualitative approaches explore the nuances and diversity of perceptions, views, experiences and behaviours, the factors which shape or underlie them, and the ideas and situations that can lead to change. In doing so, it provides insight into a range of perceptions, views, experiences and behaviours that, although not statistically representative, it nonetheless offers important insight into overarching themes.

Outputs achievements

Ipsos MORI undertook an assessment of the project's success in achieving its intended outputs based on consideration of the evaluation evidence generated. There are five measures that this assessment can take and that have been consistently applied throughout the individual project evaluations. These measures are based on the definitions below.

Table 7.1: Definitions of achievement measures

Achievement measure	Definition
Not achieved	The evidence indicates that the output has not been achieved
Partially achieved	There is some evidence to infer some of the output may have been achieved.
Partially achieved (on track)	The output has not been achieved at the time of the evaluation, however there is evidence to suggest that the output will be achieved within the time frame of the project.
Achieved	There is evidence to conclude that the output has been achieved.
Exceeded	This refers to output where monitoring information shows projects exceed their target outputs.
Inconclusive	There is not sufficient evidence to provide a robust assessment of progress towards project outputs.

Project-level evaluation framework

Output / Outcome / Impact (from logic model)	Who will measure it?	When will it be measured?	Target	Data source						
				MI	Community FGs	Community partner interviews	Resident surveys	Management/ coordination lead interviews	Programme lead interviews	Staff FGs
Outputs										
Number of new staff recruited	*KCHFT*	*Post-recruitment*	*4 one you lifestyle facilitators* *2 Health visitors* *2 School nurses* *1 Project manager* *1 Health trainer coordinator* *1 admin*	*Project records*						
Number of community champions	*KCHFT*	*Post-recruitment*	*12 in total*	*Project records*						
Training sessions delivered	*KCHFT*	*Post-training*	*24 staff and volunteers trained on behaviour change techniques* *24 staff and volunteers trained on cultural competency* *24 staff and volunteers obtain care certificate* *8 new staff trained on KCHFT*	*Project records*						

			1s4h system 4 new staff and volunteers trained on public health key messages training							
Number of community events per year	KCHFT	End of Project	4 (two per year)	Project Records						
Numbers of professional events held	KCHFT	End of Project	4 (two per year)	Project records						
										One You Lifestyle Faciltator Targets
Number of community events attended by One You Lifestyle Facilitators	KCHFT	Quarterly	Not specified	Event attendance records						
Number of brief advice sessions	KCHFT	Quarterly	Not specified	One You Lifestyle records						
Number of 1-1 sessions to set lifestyle and health goals	KCHFT	Quarterly	Not specified	One You Lifestyle records						
Number of signposts to weight loss, exercise, smoking cessation, lifestyle changes	KCHFT	Quarterly	Not Specified	One You Lifestyle records						
Number of migrant community members registered at GP and/or dentist practice	KCHFT	End of project	Not specified	GP/Dentist records						
Number of migrant communiteis registered for benefits	KCHFT	End of project	Not specified	LA records						
										Health Visitor Targets
Number of group education sessions delivered	KCHFT	Quarterly	Not specified	Health Vistior records						
Number of 1-1 session delivered on activities related to growth, physical and emotional development and learning	KCHFT	Quarterly	Not specified	Health Visitor records						
Number of development checks	KCHFT	Quarterly	Not specified	Health Visitor records						

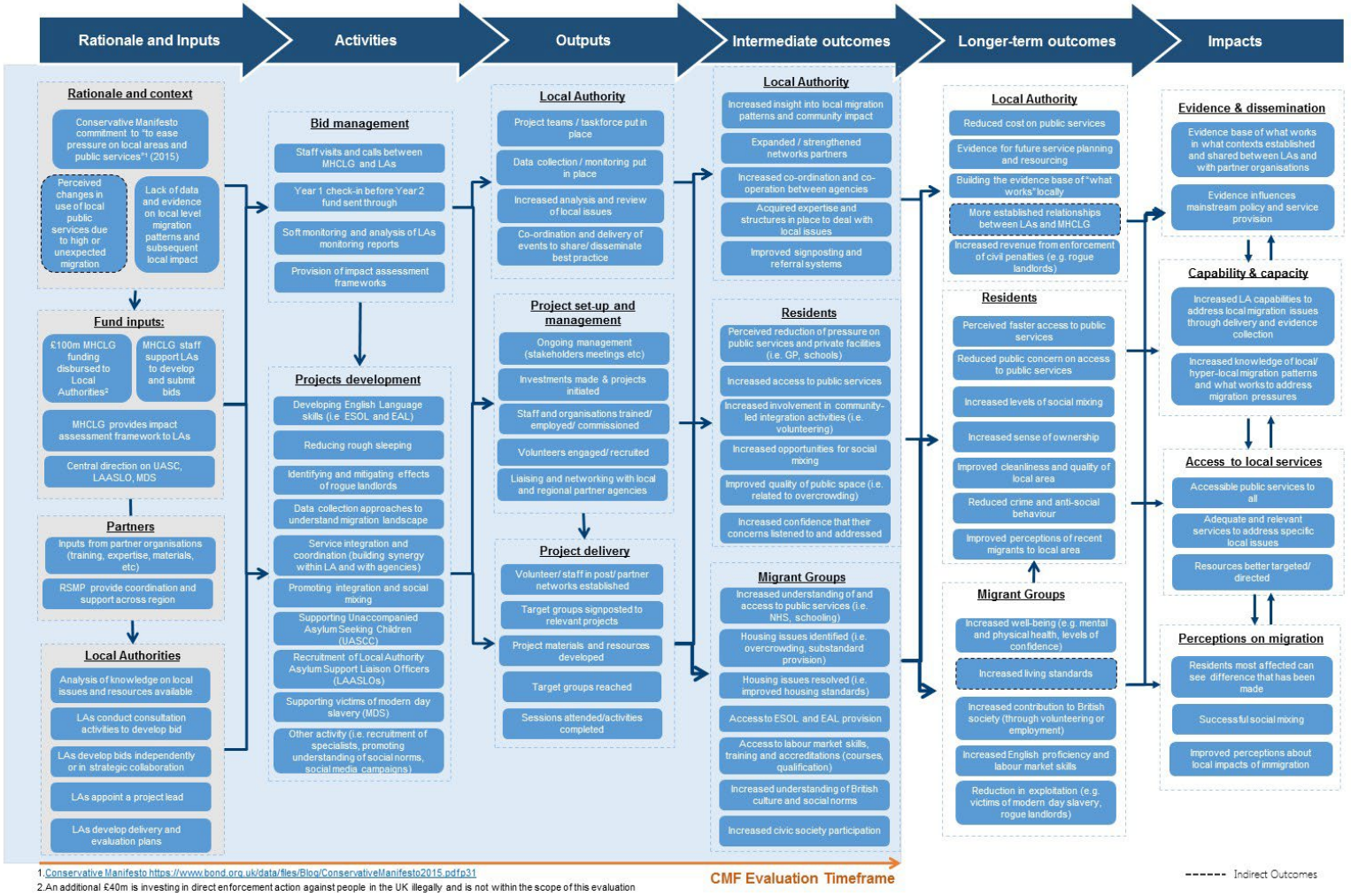
Number of community events attended per year	*KCHFT*	*Yearly*	*Not specified*	*Community Event records*						
										School Nurse Targets
Number of Lancaster questionnaires carried out	*KCHFT*	*Quarterly*	*Not specified*	*School Nurse records*						
Number of group education sessions delivering mental well-being activities	*KCHFT*	*Quarterly*	*Not specified*	*School Nurse records*						
Number of 1-1 sessions	*KCHFT*	*Quarterly*	*Not specified*	*School Nurse records*						
Number of community events attended per year	*KCHFT*	*Yearly*	*Not Specified*	*Event records*						
INTERMEDIATE OUTCOMES	Who will measure it?	When will it be measured ?	Target	MI	Community FGs	Community partner interviews	Resident surveys	Management/ coordination lead interviews	Programme lead interviews	Staff FG
				Local Authority/ KCHFT						
Acquired expertise and structures in place to deal with local issues	Ipsos MORI/Kent University	Ongoing	n/a					*X*	X	X
Increased insight into local migration patterns and community insight	Ipsos MORI/Kent University	Ongoing	n/a					*X*	*X*	*X*
Sustainable mechanisms for communicating with communities and delivering continuous service improvement cycles (**Increased co-ordination and co-operation between agencies & Improved signposting and referral systems)**	Ipsos MORI/Kent University	Ongoing	n/a			*X*		*X*	*X*	*X*

Trust built between KCHFT staff and local migrant community	Ipsos MORI/Kent Unviersity	Ongoing	n/a		X				X	X
Migrants										
Improved trust in and experience of using local health and connected services by migrantcommunity members	Kent University	Ongoing	n/a		X	X				
Clear, accessible service information informed through evidence and community collaboration **(increased understanding of and access to public services)**	Kent University	Ongoing	n/a		X	X				
Better uptake and use of appropriate services	KCHFT/Kent University/Ipsos MORI	Ongoing	All ages	Number of cases seen by HVs and SNs Number of referrals to NHS by Red Zebra Key Indicators – number of referrals to other services				X	X	X
Residents										
Improved conceptions/attitudes towards migrant community members in the resident community	KCHFT	Post-event					X			

Increased opportunities for social mixing	KCHFT	Post-event		Number of community events			*X*			
Perceived reduction of pressure on public services and private facilities	KCHFT/Kent University	Post-event				*X*	*X*			

Appendix 2: CMF Theory of Change

Controlling Migration Fund Overall fund-level Theory of Change



1. Conservative Manifesto https://www.bond.org.uk/data/files/Blog/ConservativeManifesto2015.pdf p31
2. An additional £40m is investing in direct enforcement action against people in the UK illegally and is not within the scope of this evaluation

Overall CMF logic model

Rationale is linked to activities and these are linked to outputs, outcomes and impacts.

Rationale

Context:

- There was a Conservative Manifesto Commitment to ease pressures on local areas and public services; There was a public perception that there were changes in the use of local public services due to high or unexpected migration; Local of data and evidence on local level migration patterns and subsequent local impacts.

Fund inputs:

- £100 million from MHCLG disbursed to Local Authorities; MHCLG staff support LAs to develop and submit bids; MHCLG provides impact assessment framework to LAs; Central direction on UASC, LAASLOs

Partners:

- Inputs from partner organisations (training, expertise and materials etc); RSMP provides coordination and support across the region.

Local Authorities:

- Analysis of knowledge on local issues and resources available; LAs conduct consultation activities to develop bid; LAs develop bid independently, or on strategic collaboration; LAs appoint a project lead; LAS develop delivery and evaluation plans.

Activities:

Bid management:

- Staff visits and calls between MHCLG and LAs; Year 1 check-ins before year 2 fund sent through; Monitoring and analysis of LAs monitoring reports; Provision of impact assessment frameworks

Project development:

- Developing English language skills (ESOL and EAL); Reducing rough sleeping; Identifying and mitigating the effects of rogue landlords; Data collection approaches to understand migration; Service integration and coordinating (building synergy within LA and with agencies); Promoting integration and social mixing; Supporting Unaccompanied Asylum Seeking Children; Recruiting local authority asylum support liaison officers; Supporting victims of modern day slavery; Other activities (recruitment of specialists, promoting social norms and social media campaigns)

Outputs

Local Authority:

- Project teams/ taskforces; data collection/ monitoring information; increased analysis and review of local issues; coordination and delivery of events to share and disseminate best practice

Project set up and management:

- Ongoing management; investments made and projects started; staff trained; volunteers engaged and recruitment; liaising and networking with local and regional agencies

Project delivery:

- Volunteers in post and networks of partners established; target groups sign posed to relevant projects; project materials and resources developed; target groups reached; sessions attended and activities completed.

Intermediate outcomes

Local authority:

- Increased insights into local migration patterns and community impacts; Expanded and strengthened network partners; increased coordination and cooperation between agencies; acquired expertise and structures in place to deal with local issues; improved sign posting and referral systems

Residents:

- Perceptions of reduced pressured on local public services; increased access to public services; increased involvement in community led integration activities; increased opportunities for social mixing; improved quality of public space; increased confidence that concerns are being listened to

Migrant groups:

- Increased understanding of and access to public services; housing ussyes identified; housing issues resolved; access to ESOLand EAL provision; access to labour market, skills and training, and accreditation; increased understanding of British culture and social norms, increased civic participation.

Long term outcomes:

Local Authority:

- Reduced cost of public services; evidence for future service planning and resourcing; building the evidence base of work works locally; increased revenue from enforcement of civil penalties

Residents:

- Perceived faster access to services; reduced public concern on access to public services; increased level of social mixing; increased sense of ownership; improved cleanliness and quality of local areas; reduced crime and anti-social behaviour; improved perceptions of recent migrants to local area.

Migrants groups:

- Increased well-being (mental health) levels of confidence; increased living standards; increased contributions to British Society; Increased English proficiency; Reduction in exploitation

Impacts:

Evidence and dissemination:

- Evidence base of what works in what contexts and shared between LAs and partners; evidence influence mainstream policies an service provision

Capability and capacity:

- Increased LA capabilities to address local migration issues through delivery of evidence collection; Increased knowledge of local hyper local migration patterns and what works to address migration pressures.

Access to local services:

Accessible public services to all; adequate and relevant services to address specific local issues; resources better targeted and directed

Peceptions on migration:

- Residents most affected can see difference that has been made; successful social mixing; improved perceptions of local impact of immigration.

Appendix 3: Research tools

CMF qualitative tools

Table 2.1: Qualitative tools for different participant groups

Participant	Research method	Outcomes measured
Project and programme leads	Interview	All intermediate outcomes (outcomes 1 – 8).
Delivery staff (Health Visitors, School Nurses and One You Lifestyle Facilitators)	Conducted by the external evaluator: focus groups	Topic guides provided by the external evaluator matched intermediate outcomes 2 – 8.
Stakeholders	Conducted by the external evaluator: interviews	Topic guides provided by the external evaluator matched intermediate outcomes 2 – 8.
Migrant communities	Conducted by the external evaluator: focus groups	Topic guides provided by the external evaluator matched intermediate outcomes 1, 2, 4, 5, 6 and 7.

Quantitative tools

Reflective Logs template

Reflective Log - July 19

Structure

What, where, and who—the situation

Think about the situation in detail: What happened exactly and in what order, where were you at the time and who else was involved? What part did you have to play? What was the final outcome?

How did it make you feel—your emotional state

What was running through your head and how did you feel about it? Be honest with yourself: were you afraid, confused, angry or scared? If you can understand how you were feeling at the time it will help you put together why things happened as they did, and help you to recognize similar situations in the future.

Why did it happen—making sense of the situation

Now you have thought about the situation in greater detail, and probably recognized things that would have otherwise gone unnoticed, think about why things happened as they did. How did the situation, yourself, and others interact at the time. Did the situation go well or was there room for improvement?

Could you have done anything differently—critical review and development of insight

With the help of hindsight how would you have managed the situation differently? Think about what factors you could have influenced: is there anything you could have tried that may have improved the situation, or is there anything you did that was particularly important in the situation? It is easy to remember the things that you did not do and it is often the things that you did well that are forgotten.

What will you do differently in the future—how will this change your practice

This is arguably the most important stage in reflecting. You need to pull together everything you have thought of before to learn, change your own practice, and improve3. Do not only think about what you would do differently in that specific situation, but think whether you have thought of any transferable knowledge or skills you can utilize elsewhere. For example: if you reflect on a post procedural complication do not only think of how you would manage this again but also how you would prevent it happening if you performed the procedure yourself! If you are a part of a well-led cardiac arrest do not think only of what you would do next to help, but also how you would lead an arrest in the future, or even how you would lead a team in any other situation!

Re-enforcement—what happens when you put this into practice

Test your reflections: When comparable situations happen again, do things change as you would expect them to? This is a chance to repeat the reflective cycle to refine and develop your understanding.

An example to put this into practice

Bad: I was involved in a patient confrontation; the patient was unhappy with her hospital stay and wanted to be discharged home. Unfortunately she required a package of care and so could not be discharged. I explained this and she returned to her bed. I was happy I had explained everything to her and continued with my other jobs.

Good

Who, what, and why

I was involved in a patient confrontation; an elderly patient was unhappy with hospital stay and wanted to be discharged home. She was under our general surgical team for a head injury and observation after a normal CT head. She had been seen on our ward round and told that she was medically fit for discharge but still awaiting social services: her house had been reviewed and deemed unsafe so she was waiting for banisters to be installed. The issue was raised with me by chance as I was doing other things on the ward. I explained this to her and although she remained annoyed I was able to make her understand what the delay was and she returned to her bedside. She did not seek further clarification that day.

How did it make you feel

At the time I felt rushed and frustrated. I had a lot of other work to be done and this was distracting from that. She had already been told she was waiting for social services in the morning. I understood why this was difficult for her but did not think I would be able to do anything to help.

Why did it happen

The morning ward round was quite rushed and so our explanation was limited to telling her we were waiting for social services. I can understand from her point of view this may have meant very little, and so my explanation of what exactly we were doing may have relieved some frustration. Having been waiting up to this point, it is no surprise she continued to be angry but may have been accepting of this plan.

Could you have done anything differently

I think my explanation was very good, and the patient seemed happy with this, although I did not give a rough idea of how long this would take. It may have been useful to have spoken to the sister in charge to ask for what progress had been made to feed back to the patient. Also I did not ask her whether she was happy with this explanation: I may have been able to satisfy her frustration further by answering a few more questions or even recognize any other issues at home that may need addressing before discharge. Although the information given in the ward round was correct, it was not understandable to the patient. If this had all been quickly clarified in the morning, the patient would have been happy throughout the day and not caused a problem later on.

What will you do differently in the future

I think that the route problem in this situation was our explanation on the morning ward round. Furthermore, I am not sure how long such issues take to be addressed. To avoid a similar situation in the future I will speak to the other health care professionals on the ward to get a round idea of how long occupational interventions such as this and other community interventions take to start. This means when future patients are medically fit I can spend a moment in the morning informing them of what needs to be done and how long it may take. Hopefully this will allow me to address patient concerns early to avoid them becoming an issue when it is too late.

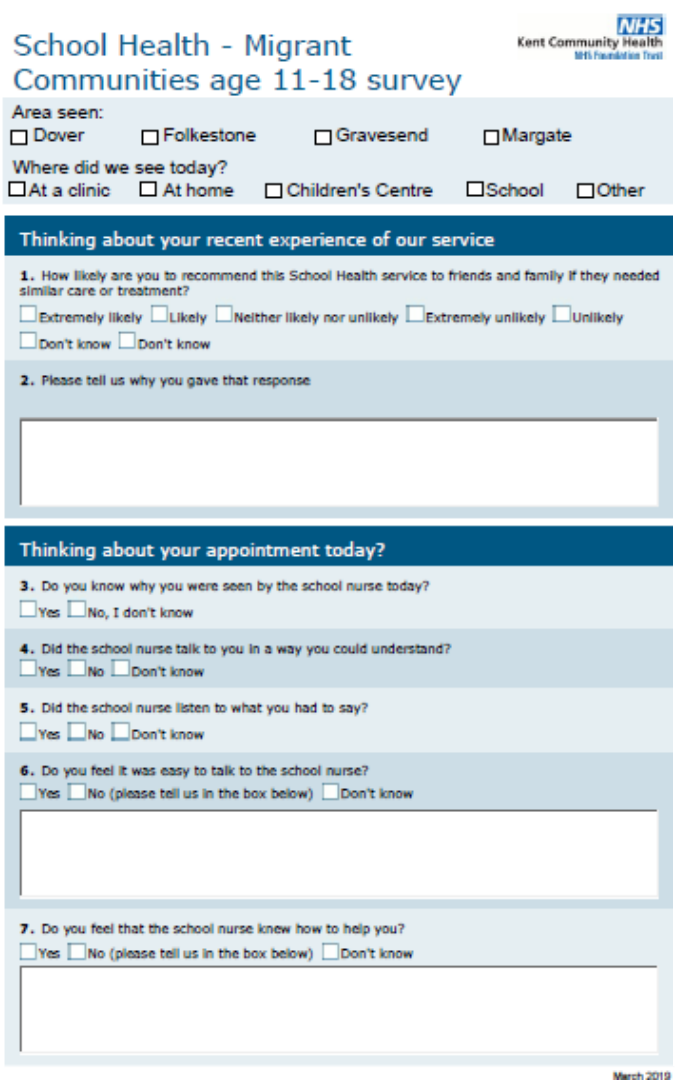
Re-enforcement

I will reflect on how future situations similar to this develop, looking for an improvement in the quality of my patient care.

Koshy, K., Limb, C., Gundogan, B., Whitehurst, K., & Jafree, D. J. (2017). Reflective practice in health care and how to reflect effectively. *International journal of surgery. Oncology*, *2*(6), e20. doi:10.1097/IJ9.0000000000000020

Surveys administered by the Healthy Communities Team

School Health/Health Visitors Survey



School Health - Migrant Communities age 11-18 survey

NHS Kent Community Health NHS Foundation Trust

Area seen:
☐ Dover ☐ Folkestone ☐ Gravesend ☐ Margate

Where did we see today?
☐ At a clinic ☐ At home ☐ Children's Centre ☐ School ☐ Other

Thinking about your recent experience of our service

1. How likely are you to recommend this School Health service to friends and family if they needed similar care or treatment?
☐ Extremely likely ☐ Likely ☐ Neither likely nor unlikely ☐ Extremely unlikely ☐ Unlikely
☐ Don't know ☐ Don't know

2. Please tell us why you gave that response

Thinking about your appointment today?

3. Do you know why you were seen by the school nurse today?
☐ Yes ☐ No, I don't know

4. Did the school nurse talk to you in a way you could understand?
☐ Yes ☐ No ☐ Don't know

5. Did the school nurse listen to what you had to say?
☐ Yes ☐ No ☐ Don't know

6. Do you feel it was easy to talk to the school nurse?
☐ Yes ☐ No (please tell us in the box below) ☐ Don't know

7. Do you feel that the school nurse knew how to help you?
☐ Yes ☐ No (please tell us in the box below) ☐ Don't know

March 2019

Thinking about your appointment today?

8. Was your appointment helpful?
☐ Yes ☐ No (please tell us in the box below) ☐ Don't know

9. If you were given information to read, do you think it will be useful?
☐ Yes ☐ No ☐ I wasn't given any information to read ☐ Don't know

10. Would you be happy to see the school nurse again?
☐ Yes ☐ No (please tell us in the box below) ☐ Don't know

11. Did the school nurse explain what is going to happen next?
☐ Yes ☐ No ☐ Don't know

12. Did you like the place where you were seen?
☐ Yes ☐ No ☐ Don't know

13. If you didn't like the place where you were seen, please tell us why
☐ Too far to go ☐ Not private enough ☐ People know why I'm there
☐ Other (please tell us in the box below)

14. Were you happy with the time of your appointment?
☐ Yes ☐ No ☐ Don't know

15. How did you hear about the School Health service?
☐ Immunisation session ☐ Teacher / school staff ☐ Parent / carer ☐ Other professional
☐ Friend ☐ Don't know / Can't remember ☐ Other (please tell us in the box below)

16. Are you aware of the school nurse mobile phone service?
☐ Yes ☐ No ☐ Don't know

17. Have you used the school nurse mobile phone service?
☐ Yes ☐ No ☐ Don't know

March 2019

Thinking about your appointment today?

18. Is there anything else you want to tell us?
☐ Yes ☐ No

About you

19. How old are you?
☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ 17 ☐ 18 ☐ Prefer not to say

20. Are you male or female?
☐ Male ☐ Female ☐ Prefer not to say

21. Do you have a disability?
☐ Yes ☐ No ☐ Prefer not to say

Please tick this box if you do not wish your comments to be made public ☐

Thank you for completing this survey.

One You Lifestyle Facilitators Survey

NHS
Kent Community Health
NHS Foundation Trust

One You Service survey

Client name	

Thinking about the service received:

1. Overall how would you rate the quality of the service you have received? (please circle one)

Excellent	Very Good	Good	Fair	Poor	Don't know/Can't remember

2. If there are any comments or suggestions you would like to make about the service please let us know here:

NHS
Kent Community Health
NHS Foundation Trust

3. Would you be happy for us to contact you and use your views, ideas and suggestions for the future development of the service?

Yes – please give us your name, telephone number and email address in the space below	No

4. How likely are you to recommend this service to friends and family if they needed similar care or treatment?

Extremely Likely	Likely	Neither likely nor unlikely	Unlikely	Extremely unlikely	Don't know	Comments

5. Please tell us why you gave that response

6. How confident do you feel about maintaining the behaviour changes you have adopted when you leave this service? (1 not confident, 10 extremely confident)

1	2	3	4	5	6	7	8	9	10