ESF-2023-HOMELESS

Deliverable D1.4

Monitoring and Evaluation Plan

EN version

SOLACE-CEE

Solutions for Overcoming Homelessness through Integrated Care in the CEE region

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WP1 - Project management & Coordination

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Table of contents

Abbreviations, acronyms and descriptions

Abbreviation/acronym used in document	**Description**
SOLACE-CEE /Project	Solutions for Overcoming Homelessness through Integrated Care in the CEE region
WP	Work Package
Coordinator	DEDO Foundation
Partner/s	VPR HCSOM (MALTAI) HESED NMP Casa Iona MRI
Team/s	Individual teams described in the plan
Lead Beneficiary of WP	Lead partner responsible for individual WP from List of Deliverables from Grant Agreement
WP Lead/leader	Leader of individual Work Package

1. Introduction

This deliverable contains the core features of the monitoring and evaluation activities envisaged in the project. It discusses

- the functions of the monitoring and evaluation activities;
- the topics in focus of the activities;
- the timeline of the envisaged activities;
- the data collection tools of the activities.

The data collection tool frameworks are also annexed to this deliverable.

2. Functions of the monitoring and evaluation activities

The evaluation activity of the project has twofold functions:

1. to serve as a feedback tool for the progress of the implementation (**progress monitoring**)
2. to serve as a resource of information about the **impact** based on
    a. the planned changes within the participating NGO services and among the targeted staff around the planned services, and
    b. track the process of change towards integrated service delivery, including the methodological improvements (e.g. value shift) and their effects on the clients,
    c. while assessing what responses were delivered to address the needs of the clients.

This way the monitoring and evaluation activities can fully cover (a) monitoring of the project implementation process, (b) internal impact monitoring, (c) evaluating the added value of the project at the level of each partners' package.

3. Topics of the monitoring and evaluation activities

Progress monitoring largely relies on following of the deliverables and the meetings' attendances during the internal cooperation based on the milestones set up in the project time-plan. In addition, formal and informal interviews about the quality and challenges regarding the work packages' progress, and the cooperation within the partnership relating to the project implementation. The responsible partner is a member of various bodies of the consortium, so will distil the lessons with hands-on experience of the various working strands.

Most important milestones to be followed up are as follows (including dates):

ACTIVITY	MILESTONE
1. Management	
a. Report 1	October 2025
b. Report 2	October 2026
2. Piloting Innovations	
a. Inauguration event (documentation and operational plans)	June 2025
3. Launch of the train-the-trainer course	**June 2026**
4. Launch of the calculator	**July 2027**
5. Completion of the Campaign	**autumn 2027**

Data collection tools for process monitoring are to be launched in January 2025, in cooperation with the lead partner to best feed the project management process (see draft in annex). There are two data collection questionnaires: one targeting all partners, the second focusing on the lead partner's insights. These data collection tools are questionnaires with open questions.

The process monitoring questions aim to evaluate the administrative and organizational effectiveness of the consortium's project management. Partners are asked to reflect on the adequacy of their staffing for administrative tasks and the ease with which they fulfil project-related responsibilities, such as time reporting, financial administration, and activity planning. Additionally, the responsiveness of the lead partner to both administrative and content-related queries is assessed, particularly regarding support provided during the initial setup of local activities and staff allocation. Partners are also encouraged to share feedback on the overall cooperation within the consortium.

Specific questions for the lead partner focus on the readiness of project management and administrative staff during the project's initial phase and plans for the next period. They also seek insights into anticipated and unforeseen challenges and their resolution, as well as the delegation of responsibilities among partners and project bodies. Furthermore, the questions explore the effectiveness of communication channels used and the strategies planned for maintaining responsiveness and efficient interaction in future project phases.

Assessing the **impact** of the action will be performed through short online surveys to be sent out to a broad (and non-representative circle) stakeholders in the members' countries, and among the clients (see draft in annex).

The relevant stakeholders comprise organisations and services that are essential for delivering on the specific needs of the clients of the organisations, both in terms of social and health services, e.g. mental health services, social care services, general support services run by municipalities (if relevant), health services' branches that should be responding to the clients' needs but face barriers in accessing the clients and *vice versa*.

The draft initial impact assessment questions for January-February 2025 are designed to integrate with the needs assessment activities and evaluate the anticipated effects of the SOLACE-CEE project on partner organizations and their clients. Partner organizations are asked to share their initial expectations for both their organizations and the target client groups, including the projected size of these groups across different phases of the project. They are also encouraged to evaluate the importance of various challenges, such as staff training, interdisciplinary collaboration, accessibility of care, and the integration of housing with health and social services, using a scale from "not important at all" to "absolutely essential."

Partners are further asked to reflect on desired changes in their operations, including who initiated these shifts and the values of the SOLACE-CEE project they aim to adopt. They are prompted to outline realistic timeframes for addressing identified challenges and to specify barriers to integrated health and social service delivery that lie both within and beyond their organizations' control. External barriers might include client documentation issues, health literacy gaps, funding shortages, and structural barriers in service access, while internal barriers could include limited staff training or inadequate physical spaces. Partners are also invited to indicate the extent to which they anticipate addressing these barriers within the SOLACE-CEE framework.

For clients, the assessment includes qualitative interviews or focus groups to explore the barriers they face in accessing health and social services. Topics include organizational issues, administrative challenges, funding gaps, and personal barriers such as low health literacy or discrimination. Clients are also encouraged to suggest service developments that could better meet their needs, both within and beyond the partner organizations involved in the project.

Expert and stakeholder interviews aim to uncover systemic and organizational barriers to integrated service delivery. These discussions explore key areas like funding flexibility, simplified administrative processes, interdisciplinary teamwork, and the realities of service redesign in local contexts. Stakeholders are also asked to reflect on essential factors such as shared spaces, joint training, integrated case management, and the qualifications and attitudes of support staff, particularly in addressing mental health crises and providing trauma-informed care, and basing their work of Housing First values.

To sum up, the entry data collection for the impact assessment is linked with the *needs assessment*, which at the same time serves describing also the baseline for the local progresses. Moreover, personal questionnaires for staff in the participating services (especially newly hired health related staff) will be designed to assess the program design, expectations and results. Thus, beyond a horizontal module that will be shared across all partners, modular sections of the questionnaires will reflect to a large extent on the core content of the local activities of the services.

The data collection will be carried out in the local languages of the project partners, adjusted to their clientele (translated by local partners), and it will be harmonized and adjusted to the local data collection practices of the partners.

In addition to the quantitative data collection, in each service, prioritised clients will be invited to a focus group to report on their expectations and the potential to redesign / integrate health and social services.

As a follow up, in summer 2027, the questionnaires will be used again to see

- the change in attitudes
- change in usage, along with
- change in health literacy, and
- social and health well-being of clients.

Upon individual discussion with the partners, and if it is feasible to be implemented, client assessment related data can be collected upon entry and exits of the single clients that they involve in their respective services (small panel data instead of cross-sectional data collection of clients in the services at given reference dates).

Qualitative data collection will complement the picture among staff and affiliated services. Since not all providers will have the chance by then to work with the same clients who were interviewed upon the entry data collection, the actual round of clients who have been in contact with the services will be invited to respond to specific questions (based on the first focus groups' rounds lessons).

Data collection tools

Quantitative

- National languages
- Online / Paper based
- Self-filled / With clients / On clients

- Local modules – co-creation with partners according to offered services

- Horizontal modules – to be used in the evaluation of the whole project, too, thus,
  - access
  - well-being
  - attitudes
  - literacy

  need to be part of it

Qualitative

- National languages
- External enumerators
- Internal enumerators / staff

- Interview guidelines
  - Clients
  - Health and social service staff

- Scenario for the focus groups
  - Clients
  - Health and social service staff

Reporting / summary of the local data collection findings will be requested in the course of March-April in a structured outline

Structured reporting on the collected data in English (e.g. local languages machine translated) will be required.

4. Timeline of the monitoring and evaluation activities

The project will work with two **process monitoring** reports.

The first and second process monitoring report will be delivered according to the timeline agreed with the lead partner in order to support the general reporting process of the project. Key monitoring reporting periods are months 11 and 23.

The timeline for the **impact analysis' activities** are as follows:

ACTIVITY	TIMELINE
1. Baseline surveys and qualitative data collection	
a. developing the (online) survey on general picture – qualitative and quantitative data collection tools (task of partners: reading and commenting to the guidelines co-developed with the WP lead)	December 2024-January 2025
b. Implementing survey in the participating countries (task of partners: data collection)	February-March 2025 Client quantitative data collection needs assessment in SK: 100, PL: 10, BG: 40, HU: 250, RO: 15 (afterwards PL:10)
c. Implementing the focus groups and stakeholder interviews in the target services (task of partners: data collection and summarizing the local language interviews and focus groups in English)	March 2025

d. Initial report	*June 2025 – not an official deliverable*
2. End data collection	
a. developing the questionnaires and guidelines for the staff and the clients in the target services	January 2027
b. quantitative data collection in the selected HUBs	March 2027 SK: quantitative data – subjective perception on access to integrated health services in year 3 in the two Hubs
c. qualitative data collection with clients in services	March 2027 Client interviews (personal exit or end of project): qualitative interviews with clients in year 3 in 5 locations (altogether 50 clients), (d) Quantitative data collection among social workers/health staff covering 70% of the clients interviewed upon entry
d. Final Report	July 2027

5. Conclusion

The activities under the monitoring and evaluation plan are co-designed within the partnership in order to best respond to a variety of goals:

- serve a better understanding of the state of the art and the conditions in which the local initiatives are being designed and launched;
- serve clarifying and adjusting to the clients' needs for whom integrated service design will be launched in the local hubs;
- easy and relevant monitoring of the project's processes and progress to be made
- connect the needs assessment as much as possible with the evaluation framework that is tailored to the local service development

6. ANNEXES

Data collection tool frameworks for process monitoring and impact assessment

a. Process Monitoring Questionnaire Framework for the first monitoring round – January 2025

To be responded to by the partners of the consortium to feed the monitoring report prepared by the WP lead (MRI)

1. How many staff do you have to fulfil the administrative tasks of the project?

2. How easy do you find to accomplish in time administrative and organisation tasks relating to the project (e.g. reporting of time use, financial administration, planning of trips, launching activities)?

3. To what extent is the lead partner responsive to the administrative and other content related questions? (e.g. so far you had to accomplish the signature process and set up the local activities' design and allocate your staff to the roles of the project. What support did you need for that and to what extent was this support made available for you?)

4. Please share any further comments you may have about the cooperation.

Additional questions for the lead partner:

1. How has the planned project management and administrative staff been prepared to respond to the tasks arising in the initial phase of the project and what are the plans for the next period?

2. What challenges were anticipated and not anticipated and how have these been resolved?

3. What responsibilities have been shared with partners and organised into bodies of the project?

4. What communication channels have been used and what are the plans for the next phases of the project to maintain responsiveness and have an efficient interaction with the partners and the bodies of the consortium?

b. Initial Impact Assessment Questionnaire Framework – to be combined with the needs assessment activities – January-February 2025

Please note the quantitative data collection tool at client level will be co-created with the partners and adjusted to the partners' data collection practices.

Qualitative questions for the partner organisations

1. Please share your initial expectations about the project in broad terms
   a. for your organisation
   b. for the clients you intend to work with.

2. Please share the anticipated size of the clients' and staff group that will be targeted by the SOLACE-CEE driven development (please feel free to differentiate between given phases within the project, and select planned services if you have an iteration of service extension / integration).

3. Please share how important you find the following challenges. Some of the challenges concern your service and the service(s) you intend to take on board in the networking activities of the project, some further questions concern the policy, financial and administrative environment around your organisation(s).

1 – not important at all
2 – is of little importance
3 – is of average importance
4 – very important
5 – absolutely essential
0 - not relevant for our service

Your organisation / Service 1: ___________________________

Challenges	**1**	**2**	**3**	**4**	**5**	**0**	**Comments**
There is insufficient information/knowledge/practice? of staff on the values of integrated health and service delivery (i.e. HCH principles and TIC framework – see in detail in the next lines)							
Holistic Approach to Care							
Importance of Interdisciplinary Teams							
Accessibility and Low-Barrier Care							
Trauma-Informed and Person-Centred Care							
Integration of Housing with Health and Social Care							
Holistic Approach to Care							
Staff is insufficiently open to adapt to needs of clients (e.g. stick to routines of ongoing case management tasks)							
There is shortage of trained staff to respond to health needs of the clients							
There is shortage of trained staff to respond to social care needs of the clients							
Staff may have difficulties to adapt to delivering additional tasks and use new technical solutions							
The is a shortage of trained staff to respond to mental health and emotional needs of the customers							
Care plans are kept formal and remain less tailored to actual integrated individual care and development needs							
Physical circumstances of service are problematic to (e.g. no space for privacy, no safe space for TIC based service delivery, no							

space for specific types of interactions, dilapidation, etc.)							
There is lack of collaboration with other agencies and services							
Please add any further challenges not listed above:							

4. Please share to what extent there is a desired move from your current operation / activities, and who has formulated the need for a shift.

5. Which are those values of the SOLACE-CEE project that you find most important to adapt in your services? Have any of them been already adapted?

6. Who takes the lead in the change process?

7. Please share the timeframe you think is realistic to achieve change – within or beyond the SOLACE-CEE project framework - regarding the above challenges in your organisation. Please differentiate among challenges if relevant.

8. What are those barriers that genuinely hinder integrated health and social service delivery that are located beyond the competence of your organisation? (i.e. lack of documents of clients, low health literacy of clients, lack of funding, barriers to accessing specific health services for clients like yours, local connection / territorial organisation of services, etc.)

9. To what extent do you anticipate being able to address any of these barriers in the SOLACE-CEE project? (please make a reference to the barriers mentioned above)

10. Please share any further comments you may have.

Qualitative questions to be explored in client interviews / focus group discussions

1. What are those barriers that genuinely hinder you to access the health and social service services that you would need?

(prompt: delivery within and beyond your organisation's competence, i.e. staff, administrative issues, financial issues, lack of competence of clients, low health literacy, lack of funding, barriers to accessing specific health or social services for clients, local connection / territorial organisation of services, discrimination, traumatising experiences, etc.)

2. What are those developments that you think can serve your needs better *within* the organisation and *beyond* the organisation?

Qualitative questions to be explored in expert interviews / focus group discussions with types of stakeholders who should be involved in the implementation of the project and working towards change and with organisations that should be involved in the networking activities of the partners

1. What are those barriers that genuinely hinder integrated health and social service delivery, person centred planning, respect for customer's decisions, and Housing First value-based service design, that are located *beyond* the competence of your organisation? (i.e. lack of competence of clients, low health literacy of clients, lack of funding, barriers to accessing specific health or social services for clients, local connection / territorial organisation of services, etc.)

2. What are those barriers that genuinely hinder integrated health and social service delivery that are located *within* the competence of your organisations?

3. What are the realities of shifting service delivery design in the following areas in your city / country?
    a. Funding of the services: activities can be based on access to pooled funding (e.g. if need be, shifts between social or health related activities funding can be organised for the same person on the long run, continuously)
    b. Administrative: joint and simplified regulations and resource management, straightforward referrals and care responsibilities, local connection and territorial access criteria in the delivery of services
    c. Organizational: services organised in shared space with low barrier access, collaboration across agencies and sectors.
    d. Service Delivery: joint trainings, shared information systems, integrated
    case management, interdisciplinary care teams, flexible care models.
    e. Clinical: joint planning, standardised assessment procedures, shared records, ongoing monitoring and long-term follow-up, regular and needs based support (including family)
    f. Staff / support workers qualifications / training / attitude: esp. training to work with people in mental health crises, psychological and therapeutic qualifications, access to supervision, etc.

7. Relevant documents

D1.1 Management and Contingency Plan - Google Drive

SOLACE-CEE Google drive

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