The Social Psychology of Social Prescribing

A Toolkit

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CONTENTS:

1. About this Toolkit

This toolkit has been developed as a resource for organisations that are involved, or who are considering becoming involved in, Social Prescribing.

This toolkit has been designed to be used in a variety of ways. In each section, we provide an overview of theory and evidence relating to a topic of importance to Social Prescribing. These sections are also related to a specific tool that can be used by those developing, commissioning or running Social Prescribing services. Alternatively, you can access the tools straight away, by going to the document Appendices. The tools are a mixture of signposting to additional resources, and/or lessons learned, and best practice guidance.

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2. What is Social Prescribing?

Social Prescribing (or SP) is a non-clinical model of health service delivery that aims to address the social, emotional, and practical needs of patients, by linking vulnerable and at-risk individuals to local community support (Kimberlee, 2013). Patient's conditions are often exacerbated by loneliness and isolation, sometimes leading to increased healthcare appointment attendance (King's Fund, 2017). This means that patients' wellbeing could improve if we could tackle the key social predictors of ill-health, such as loneliness (Hawkley and Cacioppo, 2010). For this reason, SP has a strong social element: it involves health professionals encouraging patients to join social activities and groups situated in the voluntary and community sector (Kimberlee et al., 2014). In this way, SP bridges the gap between primary healthcare and the community sector, providing patients with opportunities for greater social integration and more personal support that is tailored to individuals' needs (South et al., 2008).

There are several models of SP, but the majority of SP initiatives involve some form of Link Worker (LW) who use their local community knowledge to connect patients to relevant groups. The LW's position can be paid or voluntary, but it generally requires them to have good knowledge of the networks within their community (South, Higgins, Woodall & White, 2008). The LW's role is to meet with the patient to discuss their needs and goals, as well as to direct them to various sources of support provided by local community and voluntary sectors. This community support is delivered in different ways, through a number of different voluntary and community based organisations, but common examples include: social or lunch clubs, befriending groups, walking groups, gardening groups, and arts, cultural and crafts groups.

Social Prescribing has now been mainstreamed across the NHS. Around 60% of UK Clinical Commissioning Groups (CCGs) are estimated to have already commissioned some form of Social Prescribing, with many more initiatives developed and delivered by voluntary sector organisations (DCMS, 2018).

TOOLS FOR THIS SECTION:

Tool 1: Resources List

A list of accessible resources for those interested in finding out more about Social Prescribing, and some of the more recent evidence in the field.

Tool 2: Is Social Prescribing Right for my Intervention

Social prescribing can take many forms and many people are concerned about whether what they are doing is Social Prescribing and/or if it can be adapted to Social Prescribing. This tool can help to clarify the components, aims and actors in an intervention, and to see if these fit an SP approach.

3. Social Psychology and Social Prescribing

Given the primarily ‘social’ nature of Social Prescribing, social psychologists (including the authors of this toolkit) have begun to think about how what we know about groups, social relationships and health and wellbeing, can be used to address some of the challenges facing SP service providers and the populations they serve. So far, SP interventions have been developed without any sense of a theoretical framework. What this means in practice, is that it is quite difficult to know much about how and why these initiatives work, and what the ‘key’ ingredients of a successful SP intervention would look like; and therefore, how these can be made more effective. Social psychologists are helping to close this gap, by providing a vitally important understanding of the relationship SP and health and wellbeing.

We use a theoretical framework called the ‘Social Cure’ (Jetten et al., 2012). This framework, which is based upon work on the importance of social identities in social psychology, makes the argument that our group memberships and our sense of belonging to particular groups (i.e. our social identities) are psychologically very important to us. Such group memberships make us feel that we have sense of community with our group members, and are therefore essential to our self-esteem and how we understand ourselves and others in the world (Sani et al., 2015). These group memberships are so fundamental to our sense of self, that they can direct how we think, what we believe and how we act. They also have the potential to improve our health and well-being, because they provide people with important resources, such as a sense of social connectedness, personal control, and the belief other people will help and support us during times of crisis.

Over the last decade, there is much research to back up these ideas. The groups that we identify with can impact our physical and mental health through the provision of psychological resources such as social support, and the promotion of positive health behaviours (Haslam et al., 2018). These ‘active ingredients’ have been found to be important for people living with complex needs, including those with long-term mental health problems (Cruwys, Haslam, Dingle, Jetten, Hornsey, Chong, & Pei, 2014), older adults (Gleibs, Haslam, Haslam, & Jones, 2011), residents of socially deprived communities (McNamara, Stevenson, & Muldoon, 2013), and those recovering from addiction (Buckingham, Frings, & Albery, 2013; Vangeli & West, 2012). In each case, one or more of the ‘active’ ingredients described above have had a significant impact on positive health outcomes. In summary, there is a strong evidence base that can explain how and why group belonging and social integration is beneficial for individual health and well-being. We think that understanding these underpinning processes, and integrating them into SP interventions, is vital to the delivery of high quality and effective SP.

TOOLS FOR THIS SECTION:

TOOL 3: Recommendations for social psychological factors to consider when developing SP interventions

Tool 4: Example Case Studies

A brief overview of one evaluations of SP schemes in Nottinghamshire that used social psychological principles to understand how and why such programmes might work for individuals with complex social, mental health, and physical health needs (Halder et al., 2018, Kellezi et al 2019, Wakefield et al, under review).

4. Best Practice, Challenges and Solutions in Social Prescribing

There have been a number of recent debates about what should be considered ‘best practice’ in SP interventions to ensure they are of high quality, acceptable and sustainable. This can be particularly difficult to determine, given that SP interventions can be diverse delivery models and have diverse intended outcomes.

The NHS England (2019) recently produced guidelines outlining what ‘good’ SP initiatives should look include:

For individuals: high levels of awareness of the availability and purpose of SP; ease of referral (including self-referral); support for individuals to contact and attend community groups; feelings of belonging and purpose in their group activities; opportunities to contribute to groups.

For the community: awareness of the role of SP in community development; an active role in the design as well as delivery of SP; a greater level of service accessibility and inclusivity for marginalised residents

For the health system: collaborative design and commissioning of SP programmes; clear, easy referral processes and single points of contact for SP; active support for community groups e.g. funding and the involvement of existing voluntary and community groups in delivering SP; integration of SP with other local initiatives.

We have collected evidence, from 180 delegates involved in designing, delivery and/or commissioning SP services across diverse settings, on some their recommendations, challenge and solutions they have found ‘on the ground’. Below, we summarise some of these principles and debates:

	Challenges	*Solutions*
For Patients	Members of the public may not be aware of and have confidence in social prescribing. Some may not feel like they need social prescribing, nor that it will address the complex issues that they are facing. Difficulties in encouraging and supporting those experiencing high levels of social isolation to join group activities. Those who have the most difficulty engaging are also most likely to lose the service as a result of poor attendance at appointments. Concerns about the use of SP for complex cases and/or more vulnerable service users where services often don't have the resources or remit to support those with complex issues, due to limited time, staff or training.	Evidence about SP should also be communicated to patients in an appropriate, accessible format and success stories should be showcased / celebrated in publicly accessible spaces (e.g., GP surgeries). This will help sustain engagement and promote awareness (or even self-referral). Greater confidence could be promoted by ensuring stakeholder involvement in the design and planning of SP services. Consider building relationships with key figures in specific targeted groups to encourage wider community service access and initial engagement. Trust is vital. Without a sense of trust, it is unlikely that clients will engage with the SP process or the social prescription itself. All those involved need to have some element of credibility, be engaged, and appropriately skilled.
For the Voluntary Sector	Difficulties in meeting the demand for SP services, given current resource constraints. Difficulties recruiting and retaining of volunteers, which is an essential component of the delivery and sustainability of SP services going forward. There can be too much bureaucracy, which is detrimental to smaller organisations who lack the resources to comprehensively evidence what they are doing and consequently, lose funding.	Organisations cannot offer everything to everyone, and so some segmentation in terms of offer between different organisations is needed to avoid duplication and overprovision of SP services. SP services must be community-centred, tailored to the needs of the groups and communities that use them. Those in the community should feel a sense of ownership over their community assets. Organisations working at a national level have much to offer in this area, as long as services are delivered locally in accordance with community needs. Volunteer recognition is key, e.g. by turning longer serving volunteers into volunteering 'ambassadors'. Volunteer sharing between organisations can ensure the right person ends up in the right opportunities. Social prescribing groups can provide patients with the opportunity to volunteer. This volunteering supports the

		sustainability of the community groups as a SP resource. It can also positively influence the well-being of the individual, their perceptions of social support, and their sense of connection to other group members, and therefore should be considered a positive outcome of the social prescribing initiative.
For the Health Service	Perceived resistance to SP on the part of some clinicians, requiring significant culture change. GP workloads and time-restricted consultations can mean that those in need of SP are not identified; particularly those who struggle to articulate feelings such as being lonely or isolated). Unrealistic expectations on the part of funders about the outcomes that can be achieved in relatively short timescales (which are often tied to budget cycles). This fuels a feeling of insecurity in both service staff and beneficiaries and can negatively impact on the services' ability to build trust with clients and the local community in which they operate. Quality assurance of SP services can be undermined by a lack of standardised provision, lack of clarity on the training needs of key staff (such as link workers and community connectors), and misunderstanding of the purpose of SP.	Needs buy in from a clinical lead to ensure that SP services would not be used. Referrers and service providers should share a common understanding of SP, its benefits, and its limitations. GPs should not remain the only source of referral. Some organisations involved with SP do not work with medical professionals but nonetheless are in a good position to identify, and help, vulnerable individuals, given their links to local communities and assets. Referrers and service providers should share a common understanding of SP, its benefits, and its limitations. Need to build trust and relationships within and between the different organisations involved in SP, moving from a competitive to collaborative model of working. Funding models are needed that allow a true partnership approach, helping to build relationships that lead to more positive outcomes. This requires a culture shift, moving towards a model that was more flexible and allowed more risk-taking.

5. Evidencing the Effectiveness of Social Prescribing

Most of the evidence for social prescribing's effectiveness comes from evaluation reports which use a range of methodologies and outcomes.

Health and Well-being Outcomes: Using standardised measures of well-being, many studies find moderate or substantial and lasting effects upon patients in relation to reductions in psychological distress, improvements in work and social adjustment, community involvement, improvements in well-being and reductions in social isolation, increases in confidence, confidence in their relationship with the services and increases in ‘patient activation’ level (Kimberlee, 2016). However, some evaluations report more mixed results, with a small proportion of studies reporting negative outcomes on health and well-being indicators.

Healthcare Usage Outcomes: Some evaluations explored how patients’ healthcare use changed while they were engaged with their social prescribing initiative, though the measurement periods before and after treatment commencement varied considerably (6–18 months). The findings from these analyses were quite mixed. Some reported a reduction in primary care appointments, while some did not find any reduction in primary care use. A few found an increase in GP appointments among the intervention group. Likewise, while the majority find a decrease in secondary care and ambulance services, others find an increase in the use of one or both of these services. While there is some consensus that an overall reduction is healthcare usage is likely to result from an effective SP pathway, it must be remembered that increased service usage is not, in itself, a negative outcome. Using the appropriate service (especially secondary care) effectively and efficiently is, in the longer term, likely to improve patient health and well-being, thereby reducing the burden on healthcare services. Often those who are accessing SP interventions have chronic issues, or struggle to access health services so supporting them to seek for help can be beneficial as preventing and treatment strategy.

Economic Outcomes: The evaluation results regarding the economic return from SP initiatives are mixed. Overall it appears that reductions in healthcare costs take time to appear. Some evaluations report an initial rise in healthcare usage as patients become more proactive in managing their own care. Others, especially those employing short follow-up assessment periods, find little change in healthcare usage over the course of the evaluation. Using measures of Quality Adjusted Life Years (estimates of long-term costs of healthcare due to poor quality of life), most evaluations evidence a small change within the first 6-12 months of the intervention (e.g. a return of £0.43 for every £1 spent; Kimberlee, 2016), or £0.50 per £1 spent; Dayson & Bashir, 2014) which, if it continued unabated, would cover the costs of the intervention within a year of its completion. Evaluations that assess economic impacts of larger-scale interventions over longer periods of time typically find more substantial reductions in healthcare usages and sustained improvements to patient health. These programmes can often report a higher return of investment of between £1.90 (Envoy Partnership, 2018) and £2.20 (Liles, 2017).

Timeline of benefits: Kimberlee (2016) suggests that the true benefits of SP initiatives are only likely to be observable after 24 months. In all cases, benefits can be best demonstrated by showing change accrued from the start to the end of the intervention. For service use, additional information needs to be collected from patients for a period prior to them joining the intervention.

A multi-methodological and multi-perspective approach is beneficial when evaluating social prescribing interventions. The best practice is to utilise both qualitative and quantitative methodologies in order to measure the effectiveness of a particular intervention in a comprehensive manner. The qualitative approach affords an understanding of service users' experiences of the intervention and the outcomes for the different types of beneficiaries, as well as enabling an investigation of issues around implementations and the context in which the intervention takes place. A quantitative approach affords an understanding of the effectiveness of an intervention, both in terms of whether desired outcomes are achieved over time, and in terms of cost-benefit analysis.

Similarly, a multiple perspective approach affords an exploration of the intervention's effectiveness, the process surrounding its implementation, and the benefits of the intervention for the different actors. Service users can provide information about effectiveness of the intervention, needs that remain unmet by the intervention, and factors that might impact upon the success of the intervention. Service providers and community organisations can also provide information about unmet needs, and barriers and facilitators to implementing the intervention. Commissioners can provide information about priority setting and implementation of the intervention within their target areas. Community and voluntary organisations can provide information about the effectiveness of the intervention from the perspective of individuals, groups, and communities, as well as an assessment of the sustainability of the intervention's impact.

There is the need for more critical research focusing on ascertaining how, why, and for whom SP works. Research should also investigate group-based differences in outcomes and service access, the impact of differing conceptualisations of SP amongst referrers, service providers and commissioners, and finally, the wider societal impact of SP services (i.e. upon communities instead of being exclusively client focussed). Conducting the robust research needed to answer these questions requires a large-scale, systematic approach rather than focusing on smaller initiatives. Example measures can be found in Halder et al (2018), Kellezi et al (2019)

TOOLS FOR THIS SECTION:

TOOL 5: Evaluating Your SP Service/Group

A basic introduction to how to monitor and evaluate the outcomes and effectiveness of your SP intervention or group.

TOOL 1: SOCIAL PRESCRIBING RESOURCES LIST

Dayson, C. & Bashir, N. (2014). The social and economic impact of the Rotherham Social Prescribing Pilot: Main evaluation report. *Sheffield Hallam University: Centre for Regional Economic and Social Research* (CRESR). http://shura.shu.ac.uk/18961/1/Dayson-SocialAndEconomicImpact-Rotherham%28VoR%29.pdf

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Thomson, LJ, Camic, PM, Chatterjee, HJ (2015) Social Prescribing: A Review of Community Referral Schemes. London: University College London. https://create.canterbury.ac.uk/15655/1/Social_Prescribing_Review_2015.pdf

Wakefield, J. R., Kellezi, B., Stevenson, C., McNamara, N., Bowe, M., Mair, E., Halder, M. M, Wilson, I. (under review) Social Prescribing as 'Social Cure': A longitudinal study of the health benefits of social connectedness within a Social Prescribing pathway

TOOL 2: IS SOCIAL PRESCRIBING RIGHT FOR OUR INTERVENTION?

The question of whether SP is right for you depends on the components and aims of your intervention, and who is likely to be involved. It is useful for you to have though this through from the beginning of any intervention that you are looking to develop or adapt to SP purposes.

<table>
<tr><td colspan="2"><i>ACTIVITY: Describe the key components, aims and actors in your intervention. Then, match these against the examples provided from common SP interventions to see if an SP approach could be right for your intervention.</i></td></tr>
<tr><td>What are the key components of your intervention(s)? What are your patients/client group being asked to do?
1.
2
3.</td><td><i>SP interventions can involve any of the following components (often in combination):</i>
• <i>Regularly attending a group</i>
• <i>Participating in new or existing group activities</i>
• <i>Developing and organising group activities</i>
• <i>Volunteering in community activities</i>
• <i>Support from one professional</i>
• <i>One to one meeting with health coach/link worker/peer supporters.</i></td></tr>
<tr><td>What are the key aims of your intervention(s)? What is your intervention hoping to achieve for your patients/client group?
1.
2.
3.</td><td><i>SP interventions can have any of the following aims:</i>
• <i>Improvements in physical and mental health</i>
• <i>Improvements in managing long term-conditions</i>
• <i>Improvements in social life (loneliness or social isolation)</i>
• <i>Improvement in education access and attainment</i>
• <i>Improvement in housing access</i>
• <i>Improvements in health care access</i>
• <i>Improvements in knowledge about self and others</i>
• <i>Improved access to work or training</i>
• <i>Advocacy on behalf of specific groups</i></td></tr>
<tr><td>Who are the key actors in your intervention(s)? Who is involved in participating in and/or delivering your intervention?
1.
2.
3.</td><td><i>SP interventions can involve any of the following people:</i>
• <i>Individual members using the services provided</i>
• <i>Communities using or benefiting more generally from services provided</i>
• <i>Health service providers (e.g. GP, nurses)</i>
• <i>Community and/or third sector organisations</i>
• <i>Volunteers</i>
• <i>Key workers (e.g. health coach/link worker/peer supporter)</i></td></tr>
</table>

TOOL 3: RECOMMENDATIONS FOR SOCIAL PSYCHOLOGICAL FACTORS TO CONSIDER WHEN DEVELOPING SP INTERVENTIONS:

The 'social prescription' should be one that is meaningful to the patient.	In order to "unlock" the health benefits of SP, SP groups need to foster a strong sense of connection/identification with other group members. Evidence tell us that it is this sense of connection to groups (or in social psychological terms, the social identity derived from group memberships) that confer health benefits, rather than simply the number of social connections an individual possesses. Groups which are meaningful will offer participants a sense of belonging and a sense of purpose. Group sustainability and continuity over time is essential to long-term success. Groups can become meaningful over time as people engage with and learn from others who are facing the same challenges (e.g. chronic illness, isolation). It is important that SP interventions are community centred, providing a sense of wider community connection and community resilience.
Group participation is important because…	Participating in group activities builds social support networks and trust with others. The continuous nature of group activities means that the individuals can anticipate the presence of this continuous support, which is beneficial in itself. Participating in group activities enables individuals to develop personal control and esteem, which can be useful for well-being, as well as for fostering healthy behaviours. Participating in group activities develops collective control and esteem, which can be beneficial for addressing challenges, discrimination, and the injustices one may face by virtue of being a member of a particular group (e.g. refugees, elderly). Group participation can empower individuals to deal with stressful life events by providing valued support and improving their sense of control and agency. Many individuals undergoing extreme life events feel isolated and not understood by others, so groups can foster feelings of being understood by and connected to others who have had similar experiences. Social groups influence individuals in part through their norms and values, which individuals will adopt and adhere to if they feel strongly connected to the group. It is important to investigate these values and norms, as some will be beneficial for health and well-being (e.g. helping

	others) while some can become harmful (e.g. excessive drinking).
SP can work well for a variety of different groups of people	Research in social psychology suggests that SP can work for a variety of different groups of people, including those with complex needs, older adults, residents of socially deprived communities and those recovering from addiction. Joining new groups or maintaining existing groups can be valuable in times of transition, such as when individuals have to deal with change and potential loss (e.g. retiring, moving house, etc.).

TOOL 4: EXAMPLE CASE STUDY

An example case study can be found in Halder et al (2018) and Kellezi et al (2019).

This evaluation project focused on a recently-developed NHS-based pathway initiated in 2017 in Nottingham, England. As with many NHS-based SP pathways, the initiative was supplemental to any other healthcare being received by patients, and was intended to improve illness prevention and patient self-management, ultimately resulting in reduced GP attendance. In this particular initiative, leaflets and posters in participating GP surgeries encouraged individuals experiencing chronic health conditions and loneliness to refer themselves onto the pathway. In addition, GPs who believed a patient could benefit from SP could refer them directly, as could local community organisations. Once identified as being suitable candidates for the initiative, individuals meet with a dedicated health professional (a Health Coach: HC) who assesses their needs, before either prescribing self-care management, or referring them to a community-based Link Worker who could connect them to appropriate third-sector organisations. Service-users were re-contacted for monitoring purposes. The aims of this evaluation were two-fold. First, to evaluate the efficacy of the pathway by exploring the extent to which the initiative led to enhanced service-user wellbeing and a reduction in healthcare use. Second, explore the extent to which group processes (namely activity group identification, social support, community integration, and feelings of group resilience or ‘collective efficacy’) were responsible for these predicted improvements.

Methodology: This project involved a survey study and an interview study. The two studies for the purposes of data triangulation (Jick, 1979) as well as allowing to capture both the longitudinal impact of the pathway and its experiential component.

TOOL 5: EVALUATING YOUR SP SERVICE/GROUP: A BASIC INTRODUCTION

Why evaluate?

Evaluating your SP service or group is important for a number of reasons. A robust demonstration of what is working in your service allows you to tell the world (including funders) about your success in a compelling way. A good evaluation should also allow you to take a close look at how things could be improved in the future. Finally, if you systematically evaluate your activity in an ongoing way, you can look at how changes you implement affect your outcome measures. These evaluations are easier if they are 'baked in' at the design stage of a group or service. Evaluation needn't be complex, and should not significantly interfere with the actual delivery.

Working with an evaluation partner.

If possible, work with an *evaluation partner* to evaluate your service. An evaluation partner is an organisation that agrees to organise, implement and analyse an evaluation of the service/group. As they are independent, your stakeholders (including those using the service) will be more likely to be honest with them (sometimes it can be difficult to be critical of aspects of a service you generally feel positive towards). People viewing the results of the evaluation can also trust that the results are not affected by any level of (conscious or unconscious) bias. Common evaluation partners include Universities or commercial research organisations. You can approach these organisations directly, or tender for bids (your funder may be able to help you identify opportunities to do this). Bear in mind engaging an evaluation partner usually requires funding, so be sure to get estimates when planning your provision and budget. However, you can also conduct limited evaluation yourself with lower levels of resource. A full exposition of how to achieve this is beyond the scope of this section, but we can provide some basic overview information.

Approaches to service evaluation.

A good service evaluation should combine *quantitative* data (analysis of 'hard' data like service metrics, or numeric survey data) and *qualitative* data (i.e. exploration of interviews with stakeholders). It should also include all levels of the service, including the people the service/group is being delivered to, the people delivering it, and the community they both reside in (i.e. you measure impact on individuals, systems, and communities). Some levels of this analysis may be quantitative, some qualitative, and some may include both. Ideally, you explore and record where a set of people are at the start of their journey with you, and then measure change in the same set of people further down their journey (referred to as a *longitudinal evaluation*), or a different set of people at a different stage (referred to as a *cohort evaluation*). In both cases, you are interested in capturing *change*, so you usually record the same outcome measures at each time point.

Quantitative approaches: Which outcomes?

Choosing suitable outcomes is crucial for good quantitative evaluation. A commonly used method of selection is to identify what your service aims to improve, and measure those things. These aims may not be directly related to the actual activity a group is undertaking. For instance, a singing group may aim to improve people's sense of social connection and psychological well-being, via taking part in organised singing rehearsals and competitions. The activity is singing, but the aims (which you need to measure) are improvement in social connection and psychological well-being. One way to identify appropriate scales (questions which measure a given outcome) is via 'Google Scholar' which has free access to many academic journals and relevant psychological scales. You can also ask other services what measures they are using. It is also important to make good use of data you may already have – for instance, the number of groups people attend, or the level of volunteer engagement are examples of parts of a comprehensive evaluation.

Quantitative analyses of data

Looking at whether changes are statistically significant (which allows you to be confident the figures you present differ from one another, and gauge how likely this is to be because of chance factors) can be complex, and you may need to bring in trained individuals to help with this. However, if this not possible, consider providing simple summary data (the mean level of your outcomes at different time-points, with accompanying standard deviations, for instance). This allows you to outline the effect your service is having in a basic, but still effective, way. Consider if you need to break down the information; Does it make sense to examine the effects of your group according to different demographics? Do you want to look at changes across all the groups in a scheme together, or each group separately (or both). The most appropriate way to do this is to specify what analysis you plan to use in advance. Your selection should be driven by the key issues you are trying to explore, and the most important thing you want your reader to take away. It will also be driven by the aim of the evaluation (i.e. is it primarily to improve the service, or to make an argument for funding?).

Qualitative approaches

Qualitative approaches to evaluation allow both a closer and broader look at the impact of your service that is not constrained by responses to *closed questions* (i.e. where the response option is limited to categories set by the researcher like 'yes' or 'no', or a rating to show the extent of agreement) unlike qualitative approaches. In its most basic form, a qualitative approach can be applied in a survey, via inclusion of *open questions*. Open questions invite responses that are text based and open to any response (e.g. What if anything, did you like about the service? How could the service be improved?). To obtain a richer understanding of how the service has had an impact on service users (or other stakeholders) however, in-depth qualitative approaches are necessary. These usually involve semi-structured individual (or focus group) interviews, where the researcher follows a list of key broad open-ended questions (e.g. How did you feel about your referral to the service? What were your expectations? What was your experience of being in the group?), but, also has the flexibility to explore further with additional prompt questions (e.g. Can you tell me more about that? What do you mean when you say…?).

The aim of qualitative approaches is to explore experience rather than to assess outcomes so are often applied alongside quantitative ones in service evaluations, particularly when the goal is to obtain funding. Qualitative and quantitative approaches can occur in parallel as with the example above of asking both open and closed questions in a survey, or a qualitative study with a small subset of individuals who completed the survey. They can also occur sequentially, for example, conducting a qualitative study first to explore the impact of the service as identified by service users, to inform measures used in the quantitative study.

Qualitative data-analysis

For basic qualitative approaches (e.g. open questions in a survey), the data-analysis can be a simple analysis of content. This involves examining the free-text responses to each question to identifying topics raised, and their frequency in the sample. For in-depth qualitative approaches (e.g. semi-structured interviews or focus group interviews) analysis usually involves a systematic process of theme identification and development that meaningfully capture the experience of the group.

Writing it up

When your present an evaluation, it is usual to provide a summary section (often called an executive summary) which details the context of the evaluation and the key findings in brief. Typically, you then provide a more in-depth discussion of the service and surrounding context. This is followed by clear outline of how your evaluation was undertaken (the methodology used, the time-scale, who was sampled and how, etc.) and then an in-depth presentation and discussion of the results. This latter section should highlight and discuss the key findings which you want your readers to know about, and if appropriate suggests issues which need to be considered for future provision.

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