



HOW FAITH-BASED ORGANISATIONS
CAN EVALUATE THEIR WORK

Making the Case for Faith and Health

How faith-based organisations
can evaluate their work

About FaithAction

FaithAction is a national network of faith and community-based organisations involved in social action. We empower these organisations by offering support, advice and training – we help the ‘doers’ do. We also have a key role in facilitating partnerships, sharing good practice between organisations and between sectors, and acting as a connector between government and grassroots organisations. We work to highlight the contribution that faith-based organisations are making to communities up and down the country. We know that the extent and impact of this work, and the reach of faith-based organisations into communities that are often marginalised, mean that faith is too significant to ignore.

FaithAction is a member of the Health and Care Voluntary Sector Strategic Partnership, working with the Department of Health, NHS England and Public Health England. As the faith ‘voice’ within the Strategic Partnership, we ensure that faith is taken into account in the development of new health policies and initiatives. We believe that faith-based organisations have a role to play in raising health outcomes, particularly among communities that typically suffer from health inequalities. Our recent report, *The Impact of Faith-Based Organisations on Public Health and Social Capital*, looks at this issue in more detail. You can read more at www.faithaction.net/report.

Thank you

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Written by Rodie Garland

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Introduction

This booklet is for all faith-based organisations that serve their communities. Its aim is to help them articulate the value of their work. Such organisations might not see themselves as focused on improving health. However, very often the activities they offer are likely to have an impact on the health and wellbeing of the people involved. For example, lacking social connections is thought to be as harmful to health as smoking 15 cigarettes a day,¹ and many faith organisations provide valuable social networks. So, health and wellbeing is all of our business.

Not only are faith-based organisations involved in a huge amount of activity – offering the equivalent of £3 billion annually in terms of support, according to one estimate² – but they also have a reach into communities that goes beyond that of mainstream health services. Whether represented in the congregations of places of worship, or in those served by organisations' wider activities, there are people known to faith-based organisations who include the most marginalised in our society, or those whose health is particularly likely to suffer.

This work by faith-based organisations is worth investing in. In tough economic times, we need to unlock the potential of all parts of civil society to help meet society's needs. Commissioners are seeking solutions that are effective and efficient, and this includes the ability to act 'upstream' – for example, to treat people with long-term conditions before complications arise that cause suffering and are expensive to address. In this climate, faith-based organisations need to be able to provide evidence that their work is effective when it comes to improving health and wellbeing. Anyone investing money – particularly if it is public money – wants to know that they will get a return on their investment. At the same time, there are those who question whether faith-based organisations can really provide solutions, and faith groups sometimes find themselves under more scrutiny than other kinds of organisation.³

All of this means that faith-based organisations need to be able to talk about the work that they do to improve health and wellbeing, and to understand its results.

How to use this booklet

The guidance is designed to help you think through:

- Why evaluating your work is important
- What it is that makes faith-based organisations distinctive, and how you can 'capture' that distinctiveness
- The main things to consider when planning an evaluation
- What to do with the findings once you have them

There are examples of the evaluation experiences of real organisations running throughout and, in the Appendices at the end of the booklet, we provide a selection of resources:

- Examples of tools for collecting data
- Examples of faith-based health work that has already been evaluated – to give you an idea of how it can be done
- Places to go for further help

The whole booklet is designed as a resource to dip in and out of – the sections are self-contained, so you do not need to read from cover to cover.

At FaithAction we are convinced that providers of health and care services from all sectors, whether they are from public health agencies, primary, secondary or tertiary care organisations, should view faith-based organisations as vital strategic and operational partners. This booklet will help faith-based organisations to make the case for that partnership.

Daniel Singleton
National Executive Director, FaithAction

If you only read one thing, read this

Faith organisations involved in health and wellbeing need to be able to answer four questions:

- **What is your 'unique selling point' as a faith organisation involved in health?**
- **What are your assets – people, skills, buildings...?**
- **What health activities can you help deliver – or are you delivering already?**
- **What is the evidence for the benefit of these activities?**

If you want to think seriously about the impact of your work, you will need to collect some data. These are the key questions to make sure you can answer:

- **WHY are you collecting your data?**
- **WHAT KIND of data do you need?**
- **WHEN is the best time to collect your data?**
- **HOW will you collect the data?**
- **How will you STORE the data?**
- **How will you ANALYSE the data?**
- **What will you do with it NEXT?**

Tell us!

As a strategic partner of the Department of Health, FaithAction is here to support faith-based organisations to improve health in their communities. Please let us know what you are doing and how we can help: info@faithaction.net / 0845 094 6350

1. Why this booklet?

At FaithAction we know that there are thousands of faith-based organisations (FBOs) and grassroots groups in the UK that are working hard to serve their communities. From foodbanks and night shelters to clubs for older people and groups for parents and toddlers, and from formal services like education and employment to informal support for people who would otherwise be isolated, faith is making a huge contribution to society.

In many ways, FBOs are also contributing to the health and wellbeing of people in their communities. In fact, there are ways in which all of the above activities could be having an impact on health and wellbeing. For example, it is clear that eating

This is a booklet for faith-based organisations and is about building up the evidence that what these groups are doing works to improve health and wellbeing. The first step is to collect data – on what it is you are doing, with whom and, where possible, what the results are.

properly affects health, but so do having purposeful activity, social connections and help in times of crisis.

So, even if your group does not do anything that is obviously a 'health project', the chances are that your work is connected to health and wellbeing. However, while we are convinced that faith has a positive impact on health, at the moment there is not much evidence from the UK to prove it.

We need to build up the evidence that shows 'what works', and how FBOs are contributing to improved health and wellbeing. When we do this:

- FBOs will find it easier to gain funding to do their important work
- Commissioners will be happier to commission services from FBOs
- Local authorities, public health agencies, voluntary and community sector organisations and others will be more willing to work alongside FBOs to help meet common goals – such as making people healthier and happier

The first step in building up evidence is to collect data – on what it is you are doing, with whom and, where possible, what the results are. This booklet will help you begin to do this.

"Exploring faith communities as a setting for public health action could be an important means of achieving better health."

Prof. Kevin Fenton, National Director of Health and Wellbeing, Public Health England. Foreword to FaithAction's 2014 report, *The Impact of Faith-Based Organisations on Public Health and Social Capital*.

This is not a detailed guide on how to conduct an evaluation of your work. There are existing resources – some developed specifically for small charities – to help you do this, and we point out some of them here. Rather, this booklet makes the case for why

you should contribute to building up the evidence on faith and health, and gives some ideas of things you will need to think about as you get started.

It's worth noting that FBOs and community groups often say that one of the most important things they do is to care for people. Although this booklet is all about the importance of collecting data and evidence, we never want to give the impression that the 'paper' is more important than the person.

On the other hand, if we do not collect data, we could be missing out on a huge opportunity to evidence the benefit of our work, and so enable it to continue. We want to show that the care we provide truly helps people. So it is important to find a way to collect data and evidence that really works – both for you and for those you work with.

Terms used in this booklet

Data

Information about your activities, the people involved, and what happens as a result.

Monitoring

The routine collection of information, usually focusing on progress towards achieving planned outcomes.

Evaluation

The exploration of how and why certain outcomes were achieved (or not achieved). Evaluation looks at the quality and worth of the project, asking about its value and significance to those affected. It may also identify additional and unanticipated outcomes.

Outputs

The tangible activities of your project. An example might be a course of six weekly sessions looking at healthy eating. Outputs only relate to the things you are doing – they don't tell you about the results of the work.

Outcomes

The results of the project in terms of its immediate effects for the beneficiaries. Using the example above, this could be that 12 people improved their ability to cook healthy food.

Impact

The broader or longer-term difference the project makes for its beneficiaries and/or the wider community. In the example above, this could be that 10 families are eating healthy meals more often. Some impacts might be unforeseen, or unintended – but it is important to look for these and learn from them.

Evidence

The information that shows your outcomes and impact: the proof that what you are doing works.

2. What do we already know about faith and health?

2.1 FaithAction's research

The evidence on faith and health was drawn together by FaithAction in our 2014 report, *The Impact of Faith-Based Organisations on Public Health and Social Capital* – www.faithaction.net/report

One of our key findings was that, although there is a large amount of evidence from other countries on health initiatives that have been run in or with FBOs, there is much less from the UK. This booklet was written to try to help build up the body of evidence and demonstrate what a difference faith can make in the UK.

We know that health projects that take place in FBOs can have positive results. Belonging to a faith community also has benefits for health and wellbeing. And FBOs are working to deal with the underlying issues, like poverty, that affect health and wellbeing. However, more evidence from the UK context is needed.

This is a summary of the two main findings of our research.

1. Health promotion activities in FBOs show positive outcomes

There is a lot of evidence from African American churches that have run programmes to help people change their behaviour, in order to prevent or manage certain diseases – like diabetes and cardiovascular diseases – and to increase their participation in health screening programmes.⁴

Programmes like these show **positive outcomes** including:

- **reduced** cholesterol, blood pressure, BMI and weight
- **increased** consumption of fruit and vegetables, uptake of health screening, physical activity and smoking quit rates

A few small programmes have been run in the UK, working with faith groups to reach communities at higher risk of facing certain health issues than the general population. These have promising results – but more evidence is needed if we want to be sure that FBOs are making a difference to health.

2. Simply belonging to a faith community has health benefits

The evidence shows that **regular involvement** in religious activities is linked to **higher wellbeing** (things such as happiness and satisfaction with life). It is also linked to having fewer symptoms of depression.⁵ People who say they have a religious spirituality report having better physical health and better recovery from physical illness compared with people without a religious spirituality. They also have lower mortality rates.⁶

We know that faith communities represent a large proportion of volunteers nationally:⁷ it is estimated that there are **1.9 million volunteers** in FBOs.⁸ The evidence shows that volunteering can positively affect the health and wellbeing of the

volunteers,⁹ so it is likely that, by providing opportunities for volunteering, faith groups are contributing towards better health.

There are also many examples of FBOs working with people in great need – such as those who are homeless, or refugees, or very isolated – and working to address factors such as **poverty, unemployment** and **relationship breakdown**.¹⁰ These are all factors that have been shown to be closely linked with health and wellbeing, even though a project to reduce unemployment might not be seen primarily as a ‘health’ project. Where FBOs are working to address these issues, it is likely that they are contributing to **improved health and wellbeing** too.

Important!

There is some research that finds negative outcomes from belonging to a faith group (such as exclusivity or fundamentalism).¹¹ Furthermore, a project that has been shown to work well in one place will not necessarily work with a different group of people elsewhere. When collecting data, it is important to be open and honest with your findings. If you find outcomes that were not what you would have wanted, these can still be useful for changing and improving how things are done in your organisation.

2.2 What do we know about wellbeing?

A major government review of the evidence around wellbeing¹² came up with ‘**five ways to mental wellbeing**’ – the wellbeing equivalent of eating your ‘five a day’ of fruit and vegetables. Of course, this is not a ‘once and for all’ answer to improving wellbeing, but it is one useful, simple way of thinking about the subject.

Reading through the list, it is striking how many of the ideas are things that **FBOs are regularly helping people to do**. Where your organisation is supporting people in these, it is likely to be contributing towards wellbeing. You might wish to find ways of capturing where this is happening.

1. Connect... With the people around you. With family, friends, colleagues and neighbours. At home, work, school or in your local community. Think of these as the cornerstones of your life and invest time in developing them. Building these connections will support and enrich you every day.

2. Be active... Go for a walk or run. Step outside. Cycle. Play a game. Garden. Dance. Exercising makes you feel good. Most importantly, discover a physical activity you enjoy and that suits your level of mobility and fitness.

3. Take notice... Be curious. Catch sight of the beautiful. Remark on the unusual. Notice the changing seasons. Savour the moment, whether you are walking to work, eating lunch or talking to friends. Be aware of the world around you and what you are feeling. Reflecting on your experiences will help you appreciate what matters to you.

4. Keep learning... Try something new. Rediscover an old interest. Sign up for that course. Take on a different responsibility at work. Fix a bike. Learn to play an instrument or how to cook your favourite food. Set a challenge you enjoy achieving. Learning new things will make you more confident as well as being fun.

5. Give... Do something nice for a friend, or a stranger. Thank someone. Smile. Volunteer your time. Join a community group. Look out, as well as in. Seeing yourself, and your happiness, as linked to the wider community can be incredibly rewarding and creates connections with the people around you.

Reproduced from the Foresight Mental Capital and Wellbeing Project (2008). Final Project report. Mental Capital and Wellbeing: Making the most of ourselves in the 21st century. London: The Government Office for Science.

Read more about the Five Ways to Wellbeing at www.neweconomics.org/projects/entry/five-ways-to-well-being

3. What makes faith distinctive?

3.1 An ABC

FaithAction believes that FBOs can offer something special to the communities they serve. This is about the characteristics that tend to be common to faith-based services – although of course they are not exclusive to FBOs. These can be summed up as:

Availability

Of **people**, in terms of both trained **staff** and a community of **motivated volunteers**. These people offer care and support as the need arises, including outside of the normal working day. Often they have considerable **knowledge and expertise**, built up over long involvement in their communities. They know what the big issues are, and work with people that other services might not reach.

Of **places**, in terms of **accessible buildings and facilities**, often in **areas of high need**, and available daytime and evening, weekdays and weekends.

Belonging

FBOs offer a **point of connection** within communities. They are places where people can find a supportive group, make new friends and overcome social isolation: often they are something akin to an **extended family**. They build 'social capital'¹³ through linking individuals to a variety of others with different skills and resources. They can facilitate integration within the community. And they offer opportunities not just for **receiving** support, but also for **giving** it to others.

Caring

The ethos of FBOs is often one of care for the **whole person**, rather than a focus on a single presenting problem. These organisations look at the root causes of issues, and stick with people for the **long term** – even if it involves sacrifice on the part of the person or organisation doing the caring. And they care about **spiritual wellbeing** as well as offering **physical, practical and emotional support**. This is a different kind of care from that which professional services are able to provide.

Capturing evidence for your work under these headings, **alongside** health-related evidence, will help to show how FBOs are distinctive and are making a difference to health in their communities.

3.2 Capturing the faith factors

Think about what your organisation does that fits under the A, B, C headings. Which of these assets and activities can be measured or recorded?

FaithAction's **Local Impact Assessment tool** will help you collect some of this data. FaithAction members* can download the tool from

www.faithaction.net/2014/03/04/faithaction-toolkit-local-impact-assessment.

Try to find ways of capturing data on your work under the headings of availability, belonging and caring – the things that FBOs tend to have in common.

See also Appendix 1 of this booklet, 'What tools will help me?'

Consider the following questions to help you capture the extent of your work, and what makes your offer distinctive:

Availability

- How long have your paid staff worked in this field? (Total up the number of years)
- How long have your volunteers worked in this field? (Total up the number of years)
- How many of your paid and volunteer staff live in the community in which your group works, or its immediate vicinity?
- In the last month, how many hours have your paid and volunteer staff spent caring for people:
 - between 9am-5pm on weekdays?
 - outside of those hours?
- In the last month, how many hours have your buildings been in use by the community:
 - between 9am-5pm on weekdays?
 - outside of those hours?
- Do you work with a specific group of people (e.g. people from a particular age group or ethnic community, people with a disability or health condition, or people in particular circumstances, e.g. homeless people)? Are there any common health issues that these people face?

Belonging

- How many of those who attend activities run by your group are people who:
 - do not see family members or friends regularly?
 - do not attend other social activities (not run by your group) regularly?
 - are from BME communities?

* FaithAction is currently free to join and registering does not involve any commitment.
www.faithaction.net/register

- have a disability?
 - might suffer from poor health for some reason? What are the reasons?
- How many different ethnic communities are represented by those involved in your group?
- How many of your volunteer or paid staff are previous beneficiaries of your work?

Caring

- What other organisations or services do you work with in order to ensure that people get the care they need?
- What are the motivations of your volunteer staff for the work they do?
- One of the best ways of describing the holistic care offered by FBOs is by collecting case studies, or stories, of how you have worked with individuals and the impact on their lives. Try to collect a variety of these. Tips for writing case studies, and an example case study, are on the following pages.

Faith organisations involved in health and wellbeing need to be able to answer four questions:

- **What is your 'unique selling point' as a faith organisation involved in health?**
- **What are your assets – people, skills, buildings...?**
- **What health activities can you help deliver – or are you delivering already?**
- **What is the evidence for the benefit of these activities?**

Case studies

You could use these questions as a template for your case study. Don't worry if you cannot answer them all – they are just to prompt you. Remember to get people's permission if you want to quote their words, to talk or write publically about them in a way that could identify them, or to publish a photo of them.

- How did the person first come into **contact** with your organisation or group?
- What were the **issues** the person faced when they first came to you?
- What **services or activities** has the person participated in?
- What key **relationships** have they formed with staff, volunteers, other members of your group or members of your partner organisations? Can you describe the impact of these?
- What have been the **changes** in the person since their participation began? Think about changes relating to the issues you listed above, as well as changes in their physical and mental health, relationships, daily routines, appearance and demeanour, confidence, etc.
- How do you **know** that these changes have taken place? Things to record include the **observations** of staff members, things that the person has **done** that they had not done before, and things they have **said** about the impact of their participation.
- How do you know that the changes are **a result of your project**? Are there any external factors that have contributed – such as a change in the person's home or work circumstances? It is important to think about these in order to describe the outcomes of your work accurately.
- Can you point to any examples showing how the project has led to **less use of health services** (e.g. participants not going to A&E, or needing fewer GP appointments)? It might be very difficult to prove that these things were directly caused by your project but, if you are able to demonstrate any successes in this area, commissioners are likely to be interested.
- What, if anything, do you think is the difference that being a **faith-based organisation** has made to your care for this person?

Example: case study

This is a real example of a case study from the evaluation of a mentoring programme.¹⁴ A community-based organisation sends mentors into schools to work with young people who are at risk of becoming NEET (not in education, employment or training). Being NEET has been shown to have a detrimental effect on physical and mental health.¹⁵ The case study is written by one of the mentors about one of the young people he works with.

We have included this not to represent an 'ideal' case study, but as an illustration of how different kinds of evidence can be brought together to tell a story of change.

"I have been working with S on his attendance and motivation in school. In the beginning of our mentoring sessions he seemed very disengaged and unwilling and often said very little in our sessions. I started to use tools such as conversation cards to help prompt conversation. Towards the middle of our course of mentoring sessions he started to open up more and disclose matters that he never confided to anyone. He told me that he is the main carer for his very poorly mother who is battling for her life from kidney failure and also the main carer to his older brother who is disabled and is in a wheelchair. He said this is the cause of his lack of motivation in his education, because he needs to be there for his mum and spend the time he has with her now before she dies. He further disclosed that his dad is an alcoholic and his two older sisters are no longer in contact with family due to the family feud. After this he started coming to mentoring continuously, week after week, and used mentoring as a forum to talk about his issues.

Surprisingly the school was unaware of his difficult home life. Now he's getting the help that he needs and his attendance and motivation have also improved. The school behavioural mentor has noticed a major difference in his motivation; he now makes intervention classes after school a priority and revises consistently for his GCSEs starting in May. His attendance at the beginning of the programme was 77% and now it is 90%. In our last session he said to me:

'Thank you soo much, you have no idea how much mentoring has helped me in my academics and even how to deal with my home life. Having you to talk to has made me feel soo much better.' [sic]

4. Why should I collect evidence?

4.1 Why organisations don't collect evidence

There are lots of reasons why organisations don't collect information on what it is they do, or evaluate their work. The main barriers can be summed up as:

- It takes time and resources away from meeting people's immediate needs and there isn't the funding to do it – **a lack of resources**
- Managers don't see any benefit from evaluating the work, don't know what to do with the findings once they have them, and/or just assume that they are doing good work – **a lack of understanding**
- Staff aren't clear on what to measure or how to do it – **a lack of skills**

All of these are real issues that cannot be ignored. However, they are all things that can be addressed.

Build in a plan at the beginning of your project for how you will collect your evidence. See this as an investment that will help your project to do what it does better, and to be sustainable.

It is true that collecting data and evaluating the work takes time and resources. But this is an **investment**: if it helps the organisation to be better at meeting people's needs, and/or gain funding and become more sustainable, then the time and resources put in will bring benefits. Of course, this also means being willing to learn and change based on what you find out.

There is **help available** in terms of training and resources, both on how to collect data and on what to do with it once you have it – some of which is free. Furthermore, what you do doesn't have to be complicated, especially if the project is small. This guide provides some examples and ideas.

You might also learn **new things** that you did not expect – for example, what it is that you do that really makes a difference. This could help set your strategy as an organisation.

Perhaps the most important thing is to **build in a plan** for collecting data and evaluating the work when you first plan the project and the budget. This is good practice and will help counter the feeling that spending time on evaluation is a diversion from the 'real work'.

However, even if the project has already started, there are still things that you can do. **It is not too late** to think about what you can measure, or to reflect on what you can learn from.

4.2 Why you should collect evidence

Some of the best arguments in favour of collecting data about the work you do and its impact are:

- **To learn:** to understand what is working and what isn't, and so improve your services.
- **To be accountable:** your organisation's board or your funders might require it.
- **To attract investment:** having evidence that what you do 'works' will support your case when you ask for funding.
- **To show the significance of faith:** much of what FBOs do goes unremarked. By collecting evidence of the scale and impact of your work, you will be helping demonstrate that faith is too significant to ignore.

Related to these are other benefits, such as being able to improve the organisation's strategy and marketing, better targeting of beneficiaries and better partnerships with other groups.¹⁶

At FaithAction, we want to help build up the evidence that demonstrates how the work of FBOs is linked to better health. In turn, we hope that this will make it easier for health agencies to work with FBOs, and for funders to fund the work.

We also know that FBOs **have intelligence about their communities** that those who plan public services need. If an FBO collects even simple data on the activities that it does and the numbers and types of participants, this can demonstrate a need for a service, or show where there are changes in demand.¹⁷

Who is the evidence is for?

It's important to know the **audience for your research** – as far as possible – when you set out to evaluate your work. For example, if your findings are primarily for leaders in your own FBO, it might be appropriate to include a theological or reflective element. On the other hand, if you need to report to statutory funders, your work needs to answer their concerns and be measured in the same way as the work of any other organisation.

So, for example, statutory funders are less likely to be concerned with whether your work has helped people to understand their own faith, but more likely to be interested in whether people's sense of wellbeing has improved. If they are funding you to run a project with the goal of helping people stay clean from drugs and get a job, then they will conclude that something is missing if that does not happen. It might be that your participants experience wonderful improvements in another area of their lives, and to you the project feels like a success – but be aware that your definition of success in this case is different from the funder's definition. It is important to supply commissioners with the evidence they require, even if you are aware that your work has other outcomes that you think are important, but that they don't seem to be interested in! It's all a question of what is appropriate for whom.

5. What are the main things to consider?

5.1 Background to evaluation

So far we have been talking both about collecting data and about conducting an evaluation of your work. It might be that you need to collect data as a way of monitoring, for example, how many people are using your services, and how many of these people experience certain outcomes. But if you wish to take things a bit further and produce evidence of the impact of your work, you will need to conduct an **evaluation**.

If there is funding available, you might be able to commission an **external partner** – such as a researcher or a university department – to evaluate your project. Some academics are interested in how faith is connected with health and might be able to offer assistance free of charge. At FaithAction, we would like to see more universities working with FBOs to evaluate their work, so that the results can be published and the evidence base built up – and we can help you to contact interested academics. But if this is not possible, you can, and should, still **evaluate your own work**.

There is lots of advice available – much of it free – on how to go about doing an evaluation of your work. Here we suggest some initial things to think about. Some of the resources you can use, and places you can go to for help, can be found at the end of this booklet and at www.faithaction.net/evaluation.

First things first

Planning an evaluation is a lot easier if you can answer these questions:

1. **Why** are you running this activity?
2. **Who** is your target group? (e.g. people of a particular age range or ethnic/cultural background, or people in particular circumstances e.g. homeless people)
3. **What effects** do you expect as a result of your work?
4. Which of these are the most **important** – and why?
5. Which of these are you able to **measure**?

Next you will need to choose a suitable **method** for doing the measuring that will pick up the effects that you want to see. It is very important to know what change you expect to see, and what aspects of that change you are able to measure, before you go looking for a tool to do the measurement! This need not be complicated: it could be that you only need to ask **one question**. But that question needs to be **well thought-out**.

Example: What to measure?

Pay particular attention to **what** it is important for you to measure, and **when** to do this, given your overall aim. For example, the NHS Blood and Transplant (NHSBT) service has been running an outreach programme to faith groups to encourage people to sign up to the Organ Donor Register. Initially, the evaluation looked at whether the *numbers of people signing the Register* increased.

However, the team recognised that dialogue within faith communities takes time, as people process what they believe about the sensitive topics of death, death rituals and organ donation, and eventually decide what action they will take. So NHSBT took the innovative step of specifically commissioning a Faith & Organ Donation Action Plan. As a result of this, the evaluation is now focusing on counting *numbers of people who have discussed organ donation with their family and loved ones* following the outreach programme, recognising that this is an important precursor to the decision to sign the Register. This will make it easier to demonstrate that the programme is having an impact in the short term, rather than waiting for the number of signatories to the Organ Donor Register to go up at some point in the future.

Find out more about faith and organ donation at www.odt.nhs.uk/pdf/Faith_action_plan.pdf

Theory of Change

A theory of change is something that describes the change you want to make and the steps that need to be in place to make that change happen. Developing a theory of change for your organisation causes you to think through what is really important to you, whether you are doing the right things to achieve your aims and how you can measure your impact. It is a useful exercise, and one we recommend.

New Philanthropy Capital (NPC) provides more information for charities and free publications on developing a theory of change and measuring impact.

www.thinknpc.org/publications/theory-of-change

5.2 What kinds of data should you collect?

There are two main kinds of data that you can collect through research: quantitative and qualitative.

Quantitative data

When people think of measurement, they are often thinking of quantitative measurement: using **numbers** and statistics to express what is going on. This kind of measurement tells you something about **when**, **where**, **how much** or **how often** something is happening. It is often collected through questionnaire surveys with short, 'tick box' type questions.

For example:

In May 2014, our organisation served 57 people, of whom 32 took part in a health check.

Of the 57, 13 were from the Robertson ward of the Borough, and 32 (56%) were female. 6 had a registered disability.

As a result of the health check, 15 people saw their GP to access further treatment.

It is common for numbers such as these to be presented in tables or charts, which might show the results against targets set by a funder, or internally.

Funders often look for quantitative data, because it is the easiest way of showing the impact of their investment. The bigger a project is and the longer it has been running, the more valuable the quantitative data it can provide. Quantitative data also allows different projects and their outcomes to be easily compared with each other, to help decide which is the most effective.

Qualitative data

Qualitative measurement goes into more depth, looking at **how** and **why** effects have been achieved or things have happened as they did. It looks at people's **views** and **experiences**, and is often collected through interviews, focus groups and case studies, as well as through open-ended questions on surveys. The answers people give are analysed to draw out **key themes**.

For small projects, qualitative data is often easier to obtain, and more valuable, than quantitative data. For example, it might not be very useful to say that of the 4 beneficiaries of your work, 50% had no sick days during their involvement with the

Quantitative data uses numbers to describe when, where, how much or how often something is happening. Qualitative data looks at how or why things have happened, by collecting people's views and experiences. It is often best to try to collect both kinds of data.

project. It could be much more useful to do some case studies of the beneficiaries' experiences, describing the changes they have noticed and including some illustrative quotations, for example:

"I feel as though my life has turned around since I started coming to the centre. The volunteers are so friendly and have encouraged me to get out more. I still have bad days, but thanks to them my outlook has become more positive."

Results gained through qualitative measurement are not necessarily less rigorous than quantitative results, and there is guidance available to help you collect good quality data (see for example *The Magenta Book* – details at the end of this booklet).

Collecting and analysing qualitative data is about more than just 'telling stories' – for example, you need to ensure that you have involved a good range of participants, rather than only people who are likely to have similar views. So do not be tempted to think of it as the easy option!

It is often useful to collect **both quantitative and qualitative** data to give as **full a picture** as possible. For example, you might find that some surprising statistics are explained when you carry out interviews.

Describing the work of faith-based organisations

One of the things that FBOs sometimes say is distinctive about the way they work is that they operate across 'silos' – that is, if a homeless person comes to them, for example, they don't look only to make sure that the person has somewhere to sleep, but also to address the other issues the person is facing, such as addiction, poor health or unemployment. **Case studies** can be particularly valuable for describing this kind of work, and for showing how it is done in a way that others can learn from too. See section 3 of this booklet for more about case studies.

Ethnography involves observing people as they go about their everyday lives. It might also include video diaries, photographs, interviews or analysis of objects that form part of the person's life. This kind of research gives a rich insight into a person's life and can be valuable in understanding, for example, how well services work for them. It might be a good way of exploring how a FBO works with someone holistically – but note that it is very time-consuming.

5.3 Other considerations

Control groups and benchmarking

One way of making evidence more valuable is by **comparing the outcomes** for people who received or took part in your service with those of **people who did not take part**. These people are called a 'control group'. In very rigorous research, people will be randomly selected to join either the group receiving the service, or the control group. When the outcomes of the two groups are compared, it should be possible to see whether the service made a difference, or whether those outcomes were likely to have happened anyway. Of course, real life does not always allow for neat experiments like this, especially with small projects. If you are beginning a major project and are keen to demonstrate that it 'works', it could be worth seeking advice from a researcher on running a control group. A simpler approach is to use results from one year's project activity as a **benchmark** against which you can compare results the next year.

Ethics

In order for your evaluation to be considered ethically sound, it is important to be clear on what you want to do, and to ensure that any participants in your research understand what is happening and why. Participants should feel involved in the process, rather than it being something that is 'done to' them. They should be happy to take part rather than feeling forced to in any way. Make it clear that people are free to stop participating at any time if they want to.

It is important that anyone giving data agrees to having the data collected, and no information about them should be kept without their consent. In addition, personal information or data that could identify the participant should not be disclosed to anyone else without the participant's consent. It might be enough to explain briefly and gain a verbal agreement, but consider whether you will need to involve translators or other intermediaries. You should gain parental consent for participants under 18. Again, consent should be given as freely as possible – that is, people should not feel under pressure to provide data or opinions. All personal data must be kept securely and in accordance with the Data Protection Act 1998.

Bear in mind that if you are running a study or 'intervention' purely in order to gather data and evidence, rather than in response to a need you have noticed, there are additional ethical issues to consider – for example, do participants understand that this is the main motivation behind the work?

This is a complex topic, so for more information see the Research Ethics Guidebook at www.ethicsguidebook.ac.uk. This is aimed mainly at academic researchers, but has useful sections on the information you should give participants and how to think through ethical issues. There is a section on data protection at www.ethicsguidebook.ac.uk/Data-Protection-Act-111

6. Now I've decided what to measure... Tips for collecting data

Seven key questions...

WHY are you collecting your data?

WHAT KIND of data do you need?

WHEN is the best time to collect your data?

HOW will you collect the data?

How will you STORE the data?

How will you ANALYSE the data?

What will you do with it NEXT?

6.1 Key things to think about

1. **Keep in mind the reasons **why** you are collecting your data.** You might find that you need to do less than you think in order to achieve your objectives.

Example: you want to collect evidence to prove a certain point in order to attract funding, like showing that being part of your faith group reduces isolation, and that this improves mental health. In fact, the link between reduced isolation and improved mental and physical health is already proven,¹⁸ so you do not need to conduct new research to gather this evidence. What you do need to do is to show that being part of your particular group reduces isolation. You might also need to think about what 'being part of' involves.

2. **Be sure what kind of data you need.** Do you need to measure a **change in people's lives**? Or do you want to collect their **views on the effectiveness of your project**?

Decide what level of **detail** you need. Then be **methodical, systematic and thorough** with data collection. The aim is to collect data with as few gaps as possible, so that the conclusions you draw are **sound and meaningful**. It will help if you think about how you will collect the data at the same time as you design the delivery of the project.

Example: you decide to survey every participant and follow up with them a few weeks later. But half of your participants do not attend in the week you planned to do the follow-up survey. Do you just use the data from the half who did attend? Or could you wait and survey your remaining participants over the following week or two? Could you phone or visit them in the meantime? Could you get a message to

them through someone else, asking them to pop in to do the survey? These are all possible ways of reducing the gaps in your data.

3. Think about **when** is the best time to collect your data.

Example: if someone has just walked through the doors of your project for the first time, pouncing on them with a questionnaire is unlikely to make them feel welcome. If you only want to ask one or two simple questions, you might be able to find a fun, non-threatening way to do this (see below for some ideas). Or could you wait a few weeks before asking the questions?

If you want to look at the difference that participation in your project has made to people by comparing how they felt before and after being involved, you could wait until they have been involved for a while and then ask them to remember how they felt the first time they came along. This might be better in terms of putting them at ease – and give you more accurate results – than asking people personal questions about their feelings or health on their first visit.

On the other hand, if everyone taking part in the project is already known to you, collecting data at the first session could be an ideal way to set a benchmark from which you can demonstrate improvement.

You might need to plan to follow up your participants at a later date. For example, some mosques offer advice on stopping smoking before or during Ramadan. If you are running this kind of project, you could decide to check how many people have managed to keep up their changes a few weeks or months later.

4. Think about **how** you will collect the data. This will depend on who your participants are. The way in which you ask your questions will affect the answers you get. If people feel they are being 'tested', they might hold back, or not answer a question at all rather than give what they think is the 'wrong' answer.

Things to consider

- Can the participants express themselves in English (or the language of your research)? Do you need a translator?
- Are the participants particularly vulnerable? What is the most appropriate way to involve them?
- Do the participants understand why you are collecting the data? It can be hard for people to grasp that evaluation is about the project, not about them, and that they have the right to have questions and opinions about how things should be run.
- Will you ask questions face-to-face, perhaps with a paper questionnaire? On the phone? Or by giving people a computer or tablet to work on? People tend to give different answers in different circumstances – for example, they tend to

give lower scores for questions about their wellbeing when filling in a form on their own, rather than with an interviewer.¹⁹ If you have used a mixture of different ways of collecting data, bear this in mind when you come to analyse your results.

- If you are running a group discussion, will the participants know each other or not? How will you ensure that those who are shy can participate?
- Can you test different ways of asking your questions with a small group first, to find out which ways work best, and check that they are culturally appropriate?
- Can you involve managers and funders in your research, as well as project participants, and make it clear that this is what you are doing? This can help reduce the impression of something being 'done to' the participants, and instead help everyone see the research as a joint effort to make the project better.
- Can you get the participants to evaluate the project themselves? This will not always be possible or desirable, but it can produce findings that are very different from those you would otherwise have reached.

Use **questions that have already been developed and used successfully by other people, wherever possible**. This avoids the danger of having your results skewed because people have misunderstood your question. It also means that your findings can contribute to the existing evidence base and be compared with other research where these same questions were asked.

Some examples of questions can be found in Appendix 1.

Example: Creative ways of collecting feedback

- If you want to ask everyone a simple question with only a couple of possible answers, you could ask them to place a ball into one of two buckets, and see how many balls are in each bucket at the end.
- Asking someone to select a picture of a smiling or sad face can be a simple way of collecting data on how people are feeling. But be warned – in one case, project participants had not understood the concept of evaluation or the symbolism of the pictures. They ended up simply making a pattern from the pictures.
- To find out what is most important to people from a set of options, you could give them a set of cards with a picture or written explanation representing each option, one per card. They have to put the cards in order of what is most important to them. Or you could give them blank cards and ask them to fill in the information as well as ranking the cards.
- To collect qualitative feedback you could ask people to look at a selection of objects and to pick one to represent how they feel. They could then write a comment on a luggage label attached to the object.

- You could ask people to find pictures in magazines to represent their answers to the questions, make a collage and then talk through why they have picked each picture.
- Ask participants to take photos of, draw or make representations from playdough of the things that are important to them, and then to talk you through what they have created (make sure you have a way of recording what was said!)
- You could ask participants to describe themselves or the project using an image or metaphor. If they (or the project) were a TV show/song/ fairy tale character/household object/piece of clothing/colour/food... what would they be? You can then ask about why they chose that metaphor and what it symbolises. It might be appropriate to include metaphors that relate to people's faith, if they are from a faith group.
- If your participants are confident writers, you could ask them to write a 'letter' (to themselves/a partner/their child/a future participant in the project) explaining their thoughts; or they could write (or film on a mobile phone) a 'day in the life' diary, giving insight into their lives.

5. Think about how you will **collate and store your data**. You might use a spreadsheet or database. If you have paper questionnaires, what will you do with them?

6. Think about how you will **analyse your data**. Do you need training, or to involve someone else with the right skills?

For **quantitative** data, an Excel spreadsheet is able to do a great deal of analysis for you. If you use an online survey through a tool such as SurveyMonkey, this will also analyse your results for you – basic analysis is free, or you can upgrade to the paid-for service for more advanced tools. Will some basic percentages be enough? Will you need support to do some further statistical analysis?

For **qualitative** data, you will need to spend time going through the answers and identifying what the main themes are. Ideally, involve others in this so that you can check that you agree on the main points. This will make your conclusions more meaningful.

7. Keep in mind what you plan to **do with the data next**. If you know that you want to find the answer to a specific question for a specific audience, you don't need to spend time asking questions that are interesting to you but not useful! See also section 7 of this booklet, 'Who should I tell about my findings?'

Finally, **don't be discouraged**. You might find answers that seem to be contradictory, or anomalies in your numbers. You are working with real people, not machines, and people don't always do or say what we expect them to!

Example: Surprising results

One group decided to measure whether participants' wellbeing improved over the course of their involvement in the project.²⁰ To do this, they used some ready-made questions to gain a score for each person's wellbeing at the start of their involvement, and again every six months (see the next section for examples of these questions). They also asked each person to comment on what effect being involved in the project had had on their life, in an 'open' question on the paper form.

Surprisingly, some participants' wellbeing scores remained neutral or even went down over the course of time – and yet their responses to the open question suggested that their wellbeing had improved. For example, one person whose wellbeing score went down gave the following answer to the open question:

“Yes, I feel much better. I do more, I work now. I am HAPPY. Feel people need me. When you sitting home or just go to work, you stuck in your own problems. But when you come [to the project] you think more about other's problems and think how you can help. And it is better for my life.” [sic]

Discussions with the project staff members suggest two explanations for the apparent contradiction. One is that over time, the participants felt more relaxed and comfortable at the project, which meant that they felt more able to be honest about feeling unhappy. Another is that although the participants were told that the wellbeing questionnaire was anonymous, it was stapled to the project registration form, which was not. This might have led people to question the anonymity of the form, and fill it in differently than they would have if the wellbeing form had been given to them on its own.

6.2 'Why are we doing this?' – involving other people in collecting data

You might find that you need to get other people involved in collecting data for you – project staff, volunteers or the project participants themselves. If you do this, it is very important to make sure that everyone collecting the data has a clear understanding of why they are doing it and how they need to do so.

Be prepared to spend some time and effort in convincing people to help you, and helping them to see the 'bigger picture' and the benefit of what you want them to do. They might have real concerns about how collecting the data could distract them from important project work, make the beneficiaries feel uncomfortable, or be inappropriate. These need to be addressed so that people's personal doubts don't affect the data that they collect. You might need to remind them that collecting evidence to show the project's effectiveness could help it to keep running.

This is particularly important if your data collectors are volunteers, who can often be asked to do things at the last minute, or who might see themselves as having a specific role that doesn't include this kind of thing!

- **Keep things as simple as possible.** Don't be too ambitious in how much data you try to collect. For example, rather than trying to measure an improvement in a broad area, such as general health, you could concentrate on one specific aspect of health.
- **Be as precise and specific as you can.** Do your helpers know what level of detail is needed when people answer questions? Do they know whether or not it is ok to leave some answers blank?
- **Check on progress regularly.** Don't assume that because you have explained things once, everything is proceeding as you intended.

Participant Based Community Action Research

This is an approach to research that is based on the idea that the participants make the best researchers, if they are appropriately trained. It values people's knowledge and experience, and helps them to come up with solutions to the problems that affect them. The research is facilitated by a team of people who get participants talking with each other, rather than using traditional methods such as questionnaires and interviews. The aim is that the process leads to new ideas and improved ways of working. Many resources are available, but an example toolkit is:

Participatory Appraisal: Practitioner Pack

Kate Gant and John Rowley (2012)

NHS Health Scotland

blogs.staffs.ac.uk/ccu/files/2012/10/participatory-research-resource-pack.pdf

Wondering how to get started? Turn to Appendix 1 for suggestions of tools to help you collect your data.

7. Who should I tell about my findings?

Let's assume that you have collected some great data about your activities – and hopefully about the difference they are making to people's health and wellbeing. What do you do with it all? Below we suggest three audiences to speak to.

You don't need to try to tell everyone everything. While trustees of your project might need to know the fine details, you might be more memorable to a potential funder by leaving them with a few key points – for example, '80% of our participants say their wellbeing has improved', or even 'Three things you didn't know about our project'. Think about what the 'itch' is for your audience – what they really care about – and try to scratch it!

7.1 Your own organisation

Certainly there will be people with an interest in your organisation who should know about your findings:

Managers, staff and volunteers: They deserve to know what has been found, especially if they helped you to collect the data. And importantly, if you have findings that show how your project or service could be improved, you will need to discuss it with them.

For your findings to have an impact, people need to know about them, inside your organisation and out. FaithAction will help you to make sure that your voice is heard within the health system.

Beneficiaries/participants: Again, if they have helped you collect the data, it's good practice to give them the opportunity to hear what you found out.

Trustees/board/faith leaders: they should take an interest in how well the organisation is meeting its aims and any improvements to be made.

Funders: they might require the data as part of the funding agreement. But if you can demonstrate to current or potential funders the value for money that your project has produced, you have a valuable argument for why people should invest in your work in the future.

7.2 FaithAction

We want to collect as much evidence as possible about the difference faith is making. We can also help you think about which local officials it might be useful to approach.

These could include key organisations in the health system, some of which are commissioners of health services and so potential sources of funding. Because the system works differently from area to area, it is not always easy to say who is the best person to approach – but we can help.

7.3 Other organisations

If you are making a difference to health and wellbeing, there will be organisations within the health system that will be interested.

Public Health Teams

Each local authority has a public health department, led by a Director of Public Health. Public health officials are responsible for preventing disease, prolonging life and promoting health and wellbeing among everyone in the community. Public Health England also has centres in the nine regions of England, and four regional teams. They are interested in addressing the key issues for public health locally, so could be interested in the intelligence and points of connection that FBOs can provide.

Health and Wellbeing Board

Each local authority (top tier and unitary authorities) has a health and wellbeing board (HWB). Designed to be the system leaders, HWBs take a strategic view of the health needs of local residents and plan accordingly. HWBs work differently from area to area, and some engage with the voluntary and community sector more than others.

Officially the HWB is a committee of the local council, but it consists of key people in the local health and care system as well as councillors. These might include:

- Directors of Public Health, Children's Services, Adult Social Services
- Local Healthwatch representative
- Provider representatives
- Voluntary sector groups
- Patient or user groups

Through the HWB, FBOs have an opportunity to shape health and care services in their areas. We advise you to read your local area's Health and Wellbeing Strategy (find it by searching online) and to consider what intelligence you have that could contribute to the strategy next time around.

Clinical Commissioning Group

Clinical Commissioning Groups (CCGs) are groups of General Practices that work together to plan and buy health services, including hospital care, community health services and mental health services. There are over 200 CCGs, and every GP practice must belong to one. CCGs also include other professionals such as nurses, as well as lay members. The services they commission can be provided by NHS hospitals, private sector providers, social enterprises or voluntary sector organisations.

Your local CCG probably has a Patient Engagement Forum, which allows patients and the public to be involved in influencing decisions. To find out more, search for the CCG's website and look for a section called something like 'Get Involved'.

Your local GP surgery should also have a Patient Participation Group – a group of patients who want to get involved with, and support the running of, the GP practice. Contact your GP surgery for more information.

Joint Strategic Needs Assessment

The Joint Strategic Needs Assessment (JSNA) is produced by local authorities with other partners and presented to the HWB. It is a piece of research that gives evidence of the needs and assets in the area. The idea is that it provides a snapshot of the local area's current and future health, care and wellbeing needs, to inform future planning and commissioning. It therefore relies on evidence from the local area, so if you are working with people from the local community, any evidence about health needs and assets that you gather can feed into the JSNA. This is particularly valuable if you have evidence about health needs that are going unmet, or evidence from groups that are vulnerable or suffer from inequalities in their health when compared with the general population.

We advise you to read your local area's JSNA and consider what intelligence you have that could contribute.

Healthwatch

Healthwatch is the consumer champion for health and care. It works through a network of groups, one in each local authority area, and its national body, Healthwatch England. It works to ensure that the voices of people who use health and care services are listened to and responded to.

www.healthwatch.co.uk

Other key contacts

- **Your MP** might be interested in a briefing on a specific topic, if you have intelligence to share about his or her constituency. Find your MP at www.parliament.uk/mps-lords-and-offices/mps/
- A local or regional **umbrella body for the voluntary and community sector** can be a good way of publicising your findings, and might have existing relationships with health organisations such as the JSNA team.
- The organisation **Regional Voices** has compiled useful lists of contacts for the health system in each region. See www.regionalvoices.org/whoswho
- Your local authority might have **outreach services** that would be interested in your evidence. Search your council's website.
- **Schools** sometimes allow local groups to come in to run lessons or assemblies, if you have valuable and relevant expertise to share. For example, we know of FBOs that work with schools on issues like self-harm, or awareness about homelessness. Contact the head teacher directly, or the relevant subject head if you know who that is.

What next?

We hope that this booklet has inspired you to think about your work and recognise how you are making a contribution to health and wellbeing in your community. We also hope it has equipped you to start collecting evidence for that contribution.

The rest of this booklet contains:

- Some tools that you might find useful
- Examples of where health initiatives involving FBOs have already been evaluated
- Resources for further information

This booklet is only a starting point for FBOs working in this area. At FaithAction, we would love to hear how you get on, so that we can keep on improving our advice, and making the case that faith is too significant to ignore.

Contact us on 0845 094 6350 or info@faithaction.net

Appendix 1: What tools will help me?

There are many tools available to help you collect evidence, including those designed specifically for voluntary and community sector groups. You might decide to use a ready-made, **standardised tool**. Some of these are free, while others are commercially available. This kind of tool can be useful if it is important to you to be consistent in the way you measure things. You also have the benefit of knowing that it has been tested and found to be reliable.

Alternatively, you could **develop your own system** – which could be one that is used across your organisation as a whole, or something specific to an individual project. This might be appropriate if your project is small, and/or if you want to measure something that is unique to your project.

What you choose should depend on **what it is you want to measure**, as well as the **resources** you have available. For example, you might want to do an overall assessment of your organisation's impact, using a tool that takes many factors into account. Or you might simply want to find out whether people who visit your project have experienced improvements in one area of their health or wellbeing.

We suggest here some existing tools and approaches. This is by no means an exhaustive list, but a starting place. See also www.faithaction.net/evaluation

We have collected information under the following headings:

A1.1 General tools

A1.2 Measuring wellbeing

A1.3 Measuring social isolation and loneliness

A1.4 Measuring self-efficacy: ability to manage health conditions

A1.5 A faith-specific tool

A1.6 Return on investment

- **FaithAction's Local Impact Assessment tool**
- **Cost-benefit analysis**
- **Calculating costs saved**

A1.7 Measuring social value

- **Social value**
- **Social return on investment**
- **Social Accounting and Audit**

A1.1 General tools

Inspiring Impact

Inspiring Impact is a project run for and by the voluntary and community sector, to encourage groups to do more to measure their impact. The website provides information and guidance on how to do this. The **Impact Hub** has a searchable database of hundreds of tools suitable for different types of evaluation, from questions on a single topic (such as self-esteem or anxiety, housing or domestic violence) to handbooks for conducting a community impact assessment. Each tool has a page describing its key features and cost, if any, and giving web links.

inspiringimpact.org/listings

Tools available to buy

The **Outcomes Star** and the **Rickter Scale** are both commonly used within the voluntary sector. These are designed to capture 'distance travelled' and outcomes that are traditionally hard to measure, such as increased confidence, which can be important precursors to other outcomes, such as being ready for employment. Clients rate on a scale how they feel they are progressing against certain outcomes. In conversation with a staff member, the clients think about where on the scale they would like to be and how they can get there. Both tools are available in a number of variations, depending on the outcomes being measured and the client groups and services involved. Training for staff is included in the purchase price.

www.outcomesstar.org.uk

www.rickterscale.com

Questions for measuring general health and wellbeing

A recent review has compared tools for measuring general health, wellbeing or quality of life in community-based projects. Each tool is a set of questions to which participants give an answer on a scale, which allows you to calculate an overall score. They are designed to be used before someone's involvement in the project and again after some time, so that you can see if the score has improved. The review rated each tool for reliability, length, clarity, cost and suitability for use in cross-cultural settings. Three of the tools rated 'excellent' are available free online:

- **Quality of Life Scale (QOLS):** Covers material and physical wellbeing, relationships with other people, social, community and civic activities, personal development and fulfilment, recreation and independence.
www.tellusnaturals.com/documentos/qol.pdf
- **Personal Wellbeing Index (PWI):** Covers standard of living, personal health, achieving in life, personal relationships, personal safety, community-connectedness and future security.
www.acqol.com.au/iwbg/wellbeing-index/pwi-a-english.pdf
- **WHO Quality of Life – Brief (WHOQOL-BREF):** Covers physical health, psychological health, social relationships and environment. Email to request the questionnaire.
www.who.int/substance_abuse/research_tools/whoqolbref/en/

Existing survey questions: UK Data Service Question Bank

This is a resource that allows you to see what questions have previously been asked in social surveys. You can search on keywords: for example, if you search for questions containing the words “happy” and “life” you will see that a question that is frequently asked is:

“If you were to consider your life in general these days, how happy or unhappy would you say you are, on the whole?”

You do not need to register if you want to search only for questions.

discover.ukdataservice.ac.uk/variables

A1.2 Measuring wellbeing

Improved wellbeing (how people feel and function) is a key indicator of success for many community-based projects. The **New Economics Foundation** has produced a free handbook for voluntary organisations and community groups on how to measure wellbeing. It includes sections on what wellbeing is, how to design a questionnaire and how to analyse the data.

The tools that it recommends are a combination of SWEMWBS (see below), the questions on subjective wellbeing used by the Office for National Statistics (also below), and a question that asks whether or not most people can generally be trusted.

Measuring Well-being: A guide for practitioners

Michaelson, J. Mahony, S. and Schifferes, J. (2012)

London: the new economics foundation

www.neweconomics.org/publications/entry/measuring-well-being

WEMWBS

A popular tool for measuring and monitoring wellbeing is the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS). This is a 14-question scale which results in a single score. There is also a shorter version with 7 questions (SWEMWBS). The scales have been tested and are considered reliable. Both versions are free, but you need to register and seek permission to be able to use them. They are copyrighted to NHS Health Scotland and the Universities of Warwick and Edinburgh.

Further information and user guides: www.healthscotland.com/scotlands-health/population/Measuring-positive-mental-health.aspx

Registration:

www2.warwick.ac.uk/fac/med/research/platform/wemwbs/researchers/register

Office for National Statistics (ONS) wellbeing questions

The ONS keeps lists of standard questions used in government surveys:

www.ons.gov.uk/ons/guide-method/harmonisation/secondary-set-of-harmonised-concepts-and-questions/index.html

The ONS has four survey questions to measure personal well-being. These questions have been tested with many people and are known to be reliable. People are asked to respond to the questions on a scale from 0 to 10 where 0 is 'not at all' and 10 is 'completely'. The questions are:

- Overall, how satisfied are you with your life nowadays?
- Overall, to what extent do you feel the things you do in your life are worthwhile?
- Overall, how happy did you feel yesterday?
- Overall, how anxious did you feel yesterday?

The Cantril Self-Anchoring Striving Scale

This is a simple way of measuring wellbeing that has been used in large international polls. Also known as 'Cantril's Ladder', it asks people:

- Please imagine a ladder with steps numbered from zero at the bottom to 10 at the top.
- The top of the ladder represents the best possible life for you and the bottom of the ladder represents the worst possible life for you.
- On which step of the ladder would you say you personally feel you stand at this time? (ladder-present)
- On which step do you think you will stand about five years from now? (ladder-future)

Further information: www.gallup.com/poll/122453/understanding-gallup-uses-cantril-scale.aspx

The CORE Outcome Measure

A tool for measuring psychological distress, which includes measures of wellbeing. There are different versions of the tool, including versions for young people and people with learning disabilities. The forms are free to download, but there is software and training to buy for use alongside the measures.

Further information: www.coreims.co.uk

More information

Further information and resources for measuring wellbeing can be found at the **What Works Centre for Wellbeing**:

whatworkswellbeing.org/what-works/evaluation-wellbeing-impact/

You might find it useful to compare your data on wellbeing with the level of wellbeing in your local area overall:

whatworkswellbeing.org/wellbeing-2/wellbeing-data/

A1.3 Measuring social isolation and loneliness

If you want to measure whether your work has an impact on how lonely or isolated people feel, there are a number of simple, free tools that you can use. What is considered 'normal' in terms of community and loneliness varies between different societies, so when you are choosing a measurement tool, consider how appropriate it is for the community that you work with.

The **Campaign to End Loneliness** has an excellent guide on measuring loneliness among people in your community. It describes four different tools for measuring loneliness, and the features of each. The guide is focused on people in later life, but some of the tools are also suitable for general use. The tools discussed are: the Campaign's own measurement tool; the De Jong Gierveld Loneliness Scale; the UCLA Loneliness Scale; and single-item scales (i.e. consisting of just one question).

Measuring your Impact on Loneliness in Later Life

Campaign to End Loneliness (2015)

London: Campaign to End Loneliness

www.campaigntoendloneliness.org/blog/measuring-loneliness-in-older-age

Questions for measuring social isolation

Some other tools for measuring social isolation that have been tested and are freely available, are:

- **Lubben Social Network Scales (LSNS)**
www.bc.edu/schools/gssw/lubben.html
- **Medical Outcomes Study Social Support Survey (MOS-SSS)**
www.rand.org/health/surveys_tools/mos/mos_socialsupport.html
- **Multidimensional Scale of Perceived Social Support (MSPSS)**
gzimet.wix.com/msspss
- **The Friendship Scale**
afterdeployment.dcoe.mil/sites/default/files/pdfs/assessment-tools/friendship-assessment.pdf

A1.4 Measuring self-efficacy: ability to manage health conditions

Self-efficacy is a term from psychology. It means people's beliefs about their capability to perform a task at a certain level. Self-efficacy beliefs affect how people think, feel and behave. People who have a strong belief in their capabilities approach difficult tasks as challenges rather than threats. But if people who doubt their own capabilities perform badly at a task, they tend to conclude that they are not good enough. These people also tend to be at higher risk of stress and depression.²¹

If your project is about improving people's ability to manage their health condition, you could use a self-efficacy tool to measure your impact. You could ask the questions before and again after your project. These tools can be particularly helpful where you are aiming to build capability within communities to address – or give advice on – particular health issues.

Questions for measuring self-efficacy

- **The General Self-Efficacy Scale (GSE)** is available in 31 languages and is free. userpage.fu-berlin.de/health/selfscal.htm
- **The University of Stanford** in the US has a variety of free health-related question tools, including sets of questions about how confident someone is in managing chronic disease in general, in managing diabetes and in managing arthritis. patienteducation.stanford.edu/research

You can also construct your own set of questions to measure self-efficacy. The following guide shows you how to do this.

Guide for Constructing Self-Efficacy Scales

Bandura, A. (2006).

In Urdan, T. and Pajares, F. (Eds.) *Self-Efficacy Beliefs of Adolescents*. Charlotte, NC: Information Age Publishing.

www.uky.edu/~eushe2/Bandura/BanduraGuide2006.pdf

A1.5 A faith-specific tool

The Christian Faith Practices Scale is a tool that has been developed among Christian churches in the Protestant tradition, although it could be adapted to suit other faiths.

It asks people how often they participate in certain practices as part of their faith, and so could be useful for measuring how many people in your group are involved in social action, and how often. It includes questions about providing hospitality and

care, volunteering time to help others and participating in activities that promote social justice, alongside questions about devotional practices.

You can find the questions here (go to the very end of the article):

www.baylor.edu/content/services/document.php/145852.pdf

A1.6 Return on investment

One way of showing your impact is to demonstrate the value that you create in return for the cost of your activities. You can show the value in terms of money, or in terms of the changes in your stakeholders' lives (this is called social value – see below).

Calculating return on investment can be complex and is not for everyone, but it can be a compelling way of persuading funders that it is worth investing in your work.

FaithAction's Local Impact Assessment tool

FaithAction has developed this tool to help FBOs consider the resources and value they have in their communities, in different spheres (e.g. the buildings they have, volunteering hours worked, money brought into the community through their work).

It is a starting point for calculating what an organisation brings to the community.

www.faithaction.net/2014/03/04/faithaction-toolkit-local-impact-assessment

Cost-benefit analysis

Cost-benefit analysis compares the benefits that an activity brings with the costs of carrying it out. It allows you to be able to say, for example, that for every £1 invested (the cost), you might produce £2 in return (the benefits). In order to do a cost-benefit analysis, you need to be able to calculate your unit cost (which is the cost to your organisation of working with one beneficiary), and to estimate the monetary value of the benefits of your project.

NPC provides further information, including this short article:

www.thinknpc.org/blog/getting-started-with-cost-benefit-analysis.

The Big Lottery Fund has a step-by-step guide to carrying out cost-benefit analysis:

A Guide to Cost Benefit Analysis. Wellbeing Programme: Evaluation and Learning

Ecorys (2013)

London: Big Lottery Fund

www.biglotteryfund.org.uk/

[/media/Files/Research%20Documents/Wellbeing%20in%20England/well-being_cost-benefit%20analysis.pdf](http://www.biglotteryfund.org.uk/media/Files/Research%20Documents/Wellbeing%20in%20England/well-being_cost-benefit%20analysis.pdf)

Calculating costs saved

If you run a service that is normally funded through the health system, you can potentially save the health system a large amount of money. Finding out the usual cost of running the service, and pointing out how much your organisation can save the system by running it instead, is a powerful argument when bidding for funding. It's also simpler than conducting a cost-benefit analysis – and helps highlight the significance of faith.

The **average unit costs** to commissioners for providing many different types of health and social care services have already been worked out. This information is available in the following directory – use the contents section to find what is relevant to you.

If you run a service that is normally funded by the health system, you can calculate how much your work is saving the system. This can help in funding bids and in highlighting the significant contribution that FBOs make.

Unit Costs of Health & Social Care 2014

Lesley Curtis (2014)

Canterbury: University of Kent

www.pssru.ac.uk/project-pages/unit-costs

Example: unit costs

These examples are taken from the *Unit Costs of Health & Social Care 2014* directory, as above.

- 12 hours of **befriending contact for an older adult** costs an estimated £88.
- A 10-minute session of **advice on stopping smoking** costs £36 when given by a GP and £7 when given by a practice nurse.
- An hour's **practical and emotional support for a family in difficulty**, provided by a family support worker, costs £50.
- An **ambulance call-out** to treat a patient and take them to hospital costs £233.

NHS Health Check programme

Every healthy person between the ages of 40 and 74 is invited once every five years to have a check to assess their risk of heart disease, stroke, kidney disease and diabetes. They are then given support and advice to help them reduce or manage that risk. These checks cost a local area hundreds of thousands of pounds each year to administer, but at FaithAction we know of faith groups that have healthcare professionals among their congregations and could offer to run these checks on a voluntary basis. This not only saves costs to the system, but potentially reaches people who might not have attended a GP for the check.

You can calculate the cost to your local area of running these checks by using the 'ready reckoner' tool available at

www.healthcheck.nhs.uk/commissioners_and_healthcare_professionals/national_resources_and_training_development_tools/ready_reckoner_tools

A1.7 Measuring social value

Social value

Where value is experienced by your stakeholders as **changes in their lives** – as is the case for much voluntary sector work – it is called **social value**.

Social value is often understood as the additional social, environmental and economic benefits that communities can gain from the way a service is delivered, over and above the service itself. For example, if an organisation employs young people who were previously unemployed to deliver the service, there will be additional benefits to the community in terms of jobs and skills.

Resources on social value

An excellent introduction to the topic is:

Briefing 2: Measuring social value, social outcomes and impact

Andrea Westall (2012)

Sheffield: NAVCA

www.navca.org.uk/socialvaluebriefings

For more on social value in the health and care system see:

Module: Creating Social Value

Sustainable Development Unit / Public Health England and NHS England (2015)

Cambridge: The Sustainable Development Unit

www.sduhealth.org.uk/resources/default.aspx?q=creating+social+value

The Public Services (Social Value) Act

The **Public Services (Social Value) Act 2012** requires public bodies to consider how the services they commission and procure might improve the economic, social and environmental wellbeing of the area – rather than focusing only on value for money in simple economic terms. Commissioning services from FBOs could help councils and other commissioners to fulfil their duties under the Act, where faith groups are working to improve their communities.

An overview of the Act:

The Social Value Guide

Social Enterprise UK in association with Anthony Collins Solicitors (2012)
London: Social Enterprise UK

www.socialenterprise.org.uk/uploads/files/2012/12/social_value_guide.pdf

The **Social Value Hub** website has information on social value to support organisations interested in implementing the Act.

socialvaluehub.org.uk

Social return on investment

The best way to understand social return on investment, or SROI, is as an extension of cost-benefit analysis, which includes wider social and economic outcomes. It can be used both for evaluating what has already been done, and for estimating or forecasting potential value.

An 'SROI ratio' can be calculated by giving monetary values to as many outcomes as possible (using techniques such as those above, and/or calculating public money saved). These values are then added together and divided by the amount of the resources used or the initial investment.

Social Value UK has more information and an easy-to-understand introduction to social return on investment (SROI). This goes through the five questions that are key to SROI:

- Who changes?
- How do they change?
- How do you know?
- How much of the change is down to you?
- How important are the changes?

More information and details of resources can be found in the boxes which follow.

The Social Value Bank and Wellbeing Valuation

The Social Value Bank allows a project to be measured by looking at how much it improves people's wellbeing. The 'wellbeing value', in pounds, is equivalent to the amount of extra money per year that the average person would need (e.g. by an increase in their salary) to give them the same improvement in their wellbeing. For example, regular volunteering is thought to increase an average person's wellbeing by the same amount as an extra £2,357 of income.

Example: wellbeing values

Regular attendance at voluntary or local organisation	£1,773
Able to obtain advice locally	£2,457
Feel belonging to neighbourhood	£3,753
High confidence (adult)	£13,080
Go to youth clubs (young person)	£2,300

In order to use the values for your organisation, you need to know how to apply them, and have evidence of your activity. To find out more, download the guide to using the values, which is free if you register with HACT (you do not need to be from a housing association). The Value Calculator includes a spreadsheet that allows you to calculate social value based on your data, and tells you what evidence you need to be able to apply that value. It also has surveys to help you collect the data.

The Social Value Bank has been created by the organisation **HACT**, which supports housing associations, and the academic Daniel Fujiwara.

www.hact.org.uk/measuring-social-impact-community-investment-guide-using-wellbeing-valuation-approach

Values reproduced from the Social Value Bank – details as follows:

Title: *Community investment values from the Social Value Bank*; Authors: HACT and Daniel Fujiwara (www.hact.org.uk / www.simetrica.co.uk); Source: www.socialvaluebank.org; Licence: Creative Commons Attribution-NonCommercial-NoDerivatives licence (creativecommons.org/licenses/by-nc-nd/4.0/deed.en_GB)

Starting Out on Social Return on Investment

Social Value UK (2014)

Liverpool: Social Value UK

socialvalueuk.org/publications/publications/cat_view/198-the-guide-to-sroi-supplements

There is an online tool for calculating your SROI, which is available free if you register online.

socialvalueuk.org/publications/sat

A simpler version is also in development, offering free advice by email if you submit online answers to the questions 'who changes?', 'how do they change?' and 'how do you know?'

beta.globalvalueexchange.org/project/new

Social Accounting and Audit

The **Social Audit Network (SAN)** recognises that there has been a dramatic increase in social impact reporting in recent years. It sees this as welcome, but points to some issues such as how much credibility should be attributed to these reports, the expense of employing independent evaluators, and the necessity of routinely collecting impact data in a way that is not too time-consuming. Through its experience of working with grassroots organisations and believing that they can be empowered by keeping track of their own monitoring and evaluation, SAN has developed a process of social audit and accounting.

In the same way that organisations keep financial accounts, it is also possible to keep social accounts, using a social book-keeping system with output and outcome information. Social accounts undergo an independent annual 'social audit' to verify them, just like financial accounts. Social accounts are regularly presented alongside the financial accounts, providing a more holistic picture of an organisation's performance and impact. They enable an organisation to be confident of its claims and accountable to a wide range of its stakeholders, and reassure the wider public of the authenticity of social impact reporting. At the same time, they can also be used to plan and focus future strategic actions. They are especially useful for organisations that run multiple projects at once, as FBOs often do.

SAN believes that the social audit part of social accounting is essential, particularly for organisations with a central purpose around social transformation and change, which want their social impact to be taken seriously. Without social audit, it is easy to be overwhelmed by detailed reports purporting to explain the social, environmental and cultural change that has happened as a result of an organisation's activities. Recent legislation in the form of the Public Services (Social Value) Act 2012 (see above) means that this verification process is an even more important factor.

SAN has developed a framework, summarised below. It is not limited to one evaluation methodology and can accommodate data gathered from many appropriate social impact tools.

More information and details of the framework and the SAN regional coordinators near you are available at www.socialauditnetwork.org

Social Accounting Framework: The four-step process in ten simple stages

Step One: What difference do we want to make?

1. *Think it through*
2. *Clarify the purpose*

Step Two: How do we know we are making a difference?

3. *Engage stakeholders*
4. *Define the scope*
5. *Determine materiality – the indicators that will show the difference*
6. *Make comparisons*

Step Three: What is the difference we are making?

7. *Complete the accounts – analyse data collected, draw up the accounts*

Step Four: Can we prove that we made a difference?

8. *Verification – the Social Audit*
9. *Be transparent – publish the Social Report and Summary*

Repeat in an annual cycle

10. *Embed*

Appendix 2: Where has this been done before?

Here are some examples of projects where FBOs have been involved in projects to improve the health of their communities. Evidence has been collected from these projects to show the difference they are making. We have included them to show the kinds of project it is possible to run with FBOs, and the kinds of data it is possible to collect.

Social Cooking Project 2011-2013

The Social Cooking Project was run in a Sikh gurdwara and a Hindu mandir, in conjunction with the British Heart Foundation (BHF). It aimed to lower the saturated fat and salt intakes of South Asian families attending the places of worship, to reduce levels of cardiovascular disease in the communities. Over two years, dieticians from BHF worked with the cooks at the places of worship, supporting them to prepare food that was lower in fat and salt but still tasty. They also worked with those attending the places of worship to encourage them to donate healthier food.

To evaluate the project, a nutritional analysis was undertaken of the food at three different time points. This found a 50% reduction in saturated fat and up to 40% reduction in salt. It was estimated that this could result in a 2% reduction in deaths from coronary heart disease and a 6% reduction in deaths from diabetes. Research with the diners was also conducted to see whether there was an impact on the taste of the food: this found no negative effect.

www.bhf.org.uk/heart-health/how-we-can-help/social-cooking-project

VIP Mentoring: LifeLine Projects

LifeLine Projects employed an evaluator to assess its Vision, Identity, Purpose (VIP) mentoring programme. LifeLine Projects employs mentors to support young people in secondary schools who are at risk of becoming NEET (not in education, employment or training).

The evaluation used the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS), through an online survey, to assess changes in the young people's wellbeing over time. The young people completed the survey at the start of the project and again at two later points. Focus groups were run with some of the young people, as well as interviews with school and mentoring project staff; data from the schools on student behaviour and attendance was also collected.

The data showed significant improvements in the young people's wellbeing over the course of the programme. The qualitative data shed light on why this might be: for example, having a mentor gave the young person a trusted adult to talk to, and mentors were able to act as mediators between the schools and the young people, ensuring that any issues could be dealt with effectively.

www.lifelineprojects.co.uk/young_people/vision_identity_purpose

Ramadan Education and Awareness in Diabetes (READ) programme

This project ran a 2-hour session for Muslims who had Type 2 diabetes and were fasting during the holy month of Ramadan, educating them in how to manage their diabetes while fasting. The study consisted of 111 patients, 57 of whom attended the session and 54 who did not (these formed the control group). All patients were followed up by their GP. The results found that those who attended the session lost weight after Ramadan and had fewer incidences of hypoglycaemia. Twelve months on, those who attended the session still had better results than those who did not.

A summary of the academic evaluation: www.ncbi.nlm.nih.gov/pubmed/20536496

Cinnamon Faith Action Audits

In 2015 the Cinnamon Network undertook a survey of local faith-based social action across the UK. By collecting data from faith groups it was able to estimate the size of the contribution that the faith sector makes to UK society. An online survey was completed by 2,110 faith groups, with 57 'Local Champion' volunteers working in their local areas to invite groups to take part.

The survey found the types of activity being undertaken included: healthcare; accommodation; fitness activity; befriending; foodbanks; and services for people with disabilities. Over 200 groups were working in partnership with NHS services, and over 100 with GPs. Each year, on average, each faith group contributed to their local community:

- 8 social action projects
- Support for 1,656 beneficiaries
- 4 paid staff and 3,319 paid staff hours
- 66 volunteers and 9,988 volunteer hours
- £111,311 worth of support*

Cinnamon estimates that there are 60,761 faith groups in the UK. If 47.5% of them (the same percentage of faith groups questioned who responded to the survey) deliver what the average group to answer the survey does, this would mean that collectively the faith sector supports 47,823,751 beneficiaries annually and contributes £3 billion worth of support.

www.cinnamonnetwork.co.uk/cinnamon-faithaction-audits/

* Paid staff hours, plus volunteer hours calculated using the living wage of £7.85, plus management

Community events in a country park

A Rocha UK is a Christian charity working for the protection and restoration of the natural world. It produced an evaluation for a funder of its programme of community events in a country park. Feedback was collected through questionnaires, event feedback forms, photos, observation and informal discussion with participants. It collected information on participants' age, ward of residence, ethnic background and religious affiliation.

From the feedback questions asked, the charity was able to show that: 90% of the participants met someone new at the events; over 99% of those who had participated in outdoor activities said that they felt "uplifted" walking around the park and learning about the nature; and over 85% said they learned new skills (e.g. kite making, food foraging). The charity was also able to learn lessons for the future, for example that leafleting door-to-door is the best way to reach people, and that events for families are best run in school holidays.

arocha.org.uk

Cardiovascular disease screening project with the Hindu community

An initiative between the Royal Free Hampstead NHS Trust, H.E.A.R.T. UK and two Hindu temples in the London borough of Brent provided screening in the temples for cardiovascular disease risk factors. The project involved members of the faith community who were also medical professionals, as well as other professional staff and interpreters from the community. Screening events were advertised in the temples and on their websites, and participants attended an appointment for screening and health advice. A total of 434 participants were screened. These were people who had not been tested elsewhere, and 92% were found to have at least one risk factor which could be addressed by changing their behaviour.

A summary of the academic evaluation:

www.ncbi.nlm.nih.gov/pubmed/22151579

Housing Justice Church and Community Night Shelter Network Impact Report

Housing Justice is the national voice of Christian action to prevent homelessness and bad housing, encouraging church responses to housing need. It supports night shelters, drop-ins and other practical projects by providing advice and training for churches and other community groups who work with homeless people.

Its 2014-15 impact report aims to capture the impact of Church and Community Night Shelter projects (CCNS) in England and Wales. Housing Justice worked with Get the Data, which specialises in social impact analytics, to design tools to gather data, and to work with shelter coordinators and volunteers to use the tools. They found that in the network of CCNSs linked with Housing Justice:

- Around 500 churches, church halls, synagogues and mosques opened their premises for use as night shelters between October 2014 and May 2015
- 2,171 guests were accommodated
- An estimated 231,000 volunteer hours were given, valued at over £3m*
- 39% of the guests received assistance to make a positive move on from the shelter into their own accommodation

www.housingjustice.org.uk/news.php/88/new-church-and-community-night-shelter-impact-report-2014-2015

www.getthedata.co.uk

* Valued at £13.20 an hour, calculated based on the median weekly wage in England

Appendix 3: Where can I find out more?

Some suggestions for further reading in addition to the resources highlighted elsewhere in this booklet. This is by no means a comprehensive list, but we will update our website as we become aware of further resources: www.faithaction.net/evaluation.

A3.1 Guides from the UK

Evaluating community projects: A practical guide

Marilyn Taylor, Derrick Purdue, Mandy Wilson and Pete Wilde (2005)

York: Joseph Rowntree Foundation

www.jrf.org.uk/sites/files/jrf/1859354157.pdf

This simple guide has record sheets to fill in, to help with thinking about the work and planning the evaluation. It also describes some of the main different ways of collecting data (questionnaire survey; in-depth interviews; feedback forms; focus groups and roundtable discussions; diaries; press reports; observation; case studies; evaluation workshops and review meetings) and what each is useful for.

The Magenta Book: Guidance for evaluation

HM Treasury (2011)

London: HM Treasury

www.gov.uk/government/publications/the-magenta-book

A resource from the UK government for evaluating policies. It is a long document, but is helpful if you are carrying out a programme based on government policy or hoping to influence policy. Part B is the relevant section, and in particular:

- Chapter 5: steps to take into account when designing an evaluation
- Chapter 6: different kinds of evaluation
- Chapter 7: key considerations for collecting data
- Chapter 8: how to conduct high quality action research and case studies.

The key questions to consider when collecting data can be summarised as:

- What data needs to be gathered to give a reliable measurement against the project objectives?
- What additional data needs to be collected to meet any requirements for feedback on the project and to support any evaluation? (eg contact details of participants, financial information, outcome-related data)
- Who will have responsibility for gathering data? What resources do they need?
- When will the data be gathered? What are the key timeframes?
- In what format is the data required? How will the data be gathered, transferred and stored?
- How will the data be verified to ensure it is accurate and meets requirements?

Standards of Evidence

Ruth Puttick and Joe Ludlow (2013)

London: Nesta

www.nesta.org.uk/publications/nesta-standards-evidence

A short paper that gives an overview of different levels of evidence, from “You can describe what you do and why it matters, logically, coherently and convincingly” to “You have manuals, systems and procedures to ensure consistent replication and positive impact”.

Volunteering Impact Assessment Toolkit

National Council for Voluntary Organisations (NCVO) and Institute for Volunteering Research (2015)

London: NCVO

www.ncvo.org.uk/component/redshop/1-publications/P78-volunteering-impact-assessment-toolkit

A detailed toolkit to help organisations assess the difference that volunteering makes to beneficiaries, volunteers and the organisation itself. It also has step by step guidance on how to carry out research, and the booklet price includes access to downloadable tools and templates, such as questionnaires. NCVO also runs training on assessing the impact of volunteers – see its website.

Toolkit price: £35 (NCVO members) or £50 (non-members).

NCVO has provided a discount code for FaithAction members which gives 10% off all purchases. Email info@faithaction.net for the code.

A3.2 Guides from outside the UK

Evaluating Community-based Child Health Promotion Programs: A Snapshot of Strategies and Methods

Ann Cullen, Tavanya Giles and Jill Rosenthal (2006)

Portland, ME: National Academy for State Health Policy

nashp.org/sites/default/files/community_health_promotion.pdf

A US document that takes a selection of examples of health promotion interventions and describes how each one was evaluated. It includes links to the tools (such as surveys) used and further information.

Evaluating Health Promotion Programs

Public Health Ontario (2012)

Ontario: Agency for Health Protection and Promotion

www.publichealthontario.ca/en/eRepository/Evaluating_health_promotion_programs_2012.pdf

A presentation that goes through the steps to think through when doing an evaluation of a health promotion programme. It is Canadian but much of it can be applied to the UK. The steps it recommends are: clarify programme; engage stakeholders; assess resources; organise and select evaluation questions; determine methods of measurement and procedures; develop work plan, budget and timeline; collect data; process data and analyse the results; interpret and disseminate results; take action.

Looking at Evaluation of Your Faith-Based Intervention/Program: What's the Big Deal?

Jennifer Payne (2005)

Presented at: NACSW Convention 2005 October, Grand Rapids, Michigan. Botsford, CT: North American Association of Christians in Social Work.

www.nacsw.org/Publications/Proceedings2005/PayneJFBEvaluation.pdf

An academic paper from the US, giving food for thought on evaluating faith-based projects, including a worked example.

Participatory Monitoring and Evaluation of Community- and Faith-based Programs: A step-by-step guide for people who want to make HIV and AIDS services and activities more effective in their community

Meera Kaul Shah, Sarah Degnan Kambou, Lakshmi Goparaju, Melissa K. Adams, and James M. Matarazzo (Eds.) (2004)

Washington, DC: CORE Initiative

pdf.usaid.gov/pdf_docs/Pnadb439.pdf

A detailed guide that takes a participatory evaluation approach, produced in association with the US Agency for International Development and using some examples from African contexts.

A3.3 Organisations and websites

BetterEvaluation

betterevaluation.org

A detailed website that aims to improve evaluation practice and theory by sharing information about methods and approaches. It is an international project but based in Australia.

Charities Evaluation Services

www.ces-vol.org.uk/tools-and-resources.html

Part of NCVO, this organisation provides training, consultancy and publications to help charities improve their performance. It also conducts independent evaluations. Its website includes tools to help you think about your aims, objectives, outputs and outcomes.

The International Religious Health Assets Programme (IRHAP)

berkeleycenter.georgetown.edu/organizations/international-religious-health-assets-programme

IRHAP works to promote collaboration and increase knowledge about religious health 'assets'. It focuses on mapping health-related FBOs in Africa, building connections between faith and other public health groups, and researching religion and public health. At the time of writing, the IRHAP website was not functioning, but more information can be found at the above address.

NPC

www.thinknpc.org/publications

NPC (New Philanthropy Capital) is a charity think tank and consultancy helping charities and funders to achieve the greatest impact. Its website includes free publications to help charities develop a theory of change and measure their impact.

Social Research Association (SRA)

the-sra.org.uk/sra_resources/publications

The SRA has resources to help researchers on its website, including a one-page briefing on 'What is high quality social research?'

Public Health Practice Evaluation Scheme (PHPES)

sphr.nihr.ac.uk/phpes

PHPES is a scheme for public health practitioners who want to carry out evaluations of innovative local public health projects. Practitioners can partner with voluntary and community sector organisations – including FBOs – on projects, and apply for funding to evaluate the work. It is run by the School for Public Health Research (part of the National Institute for Health Research). Project must meet certain criteria, and the scheme has 'rounds' for applications, so is not open all of the time.

Workplace Health Promotion

Centers for Disease Control and Prevention website
www.cdc.gov/workplacehealthpromotion/evaluation

Guidance for evaluating work-based health programmes, based in the US. Useful for thinking through what needs to be done to evaluate a health programme, particularly in the section 'Defining the program and forming the evaluation'.

References

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- ¹ Holt-Lunstad, J., Smith, T. and Layton, J. (2010). Social relationships and mortality risk: A meta-analytic review. *PLoS Medicine*, 7(7): e1000316.
- ² Cinnamon Network (2015). *Cinnamon Faith Action Audit National Report*. London: Cinnamon Network.
- ³ See for example the *All Party Parliamentary Group on Faith and Society 2012 Summary Report*, available at www.faiithandsociety.org/resources.
- ⁴ Campbell, M., Hudson, M., Resnicow, K., Blakeney, N., Paxton A. and Baskin, M. (2007). Churchbased health promotion interventions: evidence and lessons learned. *Annual Review of Public Health*, 28: p.213-34;
- DeHaven, M., Hunter, I., Wilder, L., Walton J. and Berry, J. (2004). Health programs in faithbased organizations: are they effective? *American Journal of Public Health*, 94(6): p.1030-6;
- Newlin, K., Dyess, S., Allard, E., Chase S. and Melkus, G. (2012). A methodological review of faith-based health promotion literature: advancing the science to expand delivery of diabetes education to Black Americans. *Journal of Religion and Health*, 51(4): p.1075-97;
- Thompson, E., Berry, D. and Nasir, L. (2009). Weight management in African-Americans using church-based community interventions to prevent type 2 diabetes and cardiovascular disease. *Journal of the National Black Nurses Association*, 20(1): p.59-65.
- ⁵ Clark, A. and Lelkes, O. (2005). Deliver us from evil: Religion as insurance. *Papers on Economics of Religion*, No. 06/03, p.1-36;
- Cohen, A. (2002). The importance of spirituality in wellbeing for Jews and Christians. *Journal of Happiness Studies*, 3(3): p.287-310;
- Dehejia, R., DeLeire, T. and Luttmer, E. (2007). Insuring consumption and happiness through religious organizations. *Journal of Public Economics*, 91(1): p.259-279;
- Myers, D. (2001). *The American paradox: Spiritual hunger in an age of plenty*. New Haven, CT: Yale University Press;
- Ferriss, A. (2002). Religion and the quality of life. *Journal of Happiness Studies*, 3(3): p.199-215.
- Lee, G., DeMaris, A., Bavin S. and Sullivan, R. (2001). Gender differences in the depressive effect of widowhood in later life. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 56(1): p.S56-S61;
- Hayo, B. (2004). *Happiness in Eastern Europe*. Marburg Economic Working Paper No. 12. Marburg: University of Marburg Department of Economics;
- Mochon, D., Norton, M. and Ariely, D. (2008). Getting off the hedonic treadmill, one step at a time: The impact of regular religious practice and exercise on wellbeing. *Journal of Economic Psychology*, 29(5): p.632-642;
- Rasic, D., Robinson, J., Bolton, J., Bienvenu, O. and Sareen, J. (2011). Longitudinal relationships of religious worship attendance and spirituality with major depression, anxiety disorders, and suicidal ideation and attempts: findings from the Baltimore epidemiologic catchment area study. *Journal of Psychiatric Research*. 2011, 45(6): p.848-854;
- Reyes-Ortiz, C., Berges, I., Raji, M., Koenig, H., Kuo, Y. and Markides, K. (2008). Church attendance mediates the association between depressive symptoms and cognitive functioning among older Mexican Americans. *The Journals of Gerontology Series A: Biological Sciences and Medical Science*, 63(5): p.480-486;
- Varon, S. and Riley, A. (1999). Relationship between maternal church attendance and adolescent mental health and social functioning. *Psychiatric Services*, 50(6): p.799-805.
- ⁶ George, L., Larson, D., Koenig, H. and McCullough, M. (2000). Spirituality and health: What we know, what we need to know. *Journal of Social and Clinical Psychology*, 19(1): p.102-116.
- ⁷ Birdwell, J. and Littler, M. (2012). *Faithful citizens: Why those that do God, do good*. London: Demos.
- ⁸ Cinnamon Network (2015), as above.
- ⁹ Konwerski, P. and Nashman, H. (2008). Philanthropy: a benefit for personnel and organisations managing volunteers (volunteer therapy). *Voluntary Action*, 9(1): p.46-59;
- Paylor, J. (2011). *Volunteering and health: evidence of impact and implications for policy and practice. A literature review*. London: Institute for Volunteering Research.
- ¹⁰ Coleman, L. and Glenn, F. (2009). *When Couples Part: Understanding the consequences for adults and children*. London: OnePlusOne;

-
- Stoll, L., Michaelson, L. and Seaford, C. (2012). *Wellbeing evidence for policy: A review*. London: New Economics Foundation;
- Tomlinson, M., Walker, R. and Williams, G. (2008). *The relationship between poverty and childhood wellbeing in Great Britain*. Barnett Papers in Social Research. Oxford: Department of Social Policy and Social Work, University of Oxford.
- ¹¹ Furbey, R., Dinham, A., Farnell, R., Finneron, D., Wilkinson, G., Howarth, C., Hussain, D. and Palmer, S. (2006). *Faith as social capital: connecting or dividing?* Bristol: The Policy Press for the Joseph Rowntree Foundation.
- ¹² Foresight Mental Capital and Wellbeing Project (2008). *Mental Capital and Wellbeing: Making the most of ourselves in the 21st century. Final Project report*. London: The Government Office for Science.
- ¹³ Read more about social capital at www.ons.gov.uk/ons/guide-method/user-guidance/social-capital-guide/the-social-capital-project/guide-to-social-capital.html
- ¹⁴ Reproduced from: November, L. (2015). *LifeLine V.I.P Mentoring Programme: An Impact Assessment*. London: LifeLine Projects.
- ¹⁵ Public Health England / UCL Institute of Health Equity (2014). *Local action on health inequalities: Reducing the number of young people not in employment, education or training (NEET)*. London: Public Health England.
- ¹⁶ Ní Ógáin, E., Lumley, T. and Pritchard, D. (2012). *Making an Impact: Impact measurement among charities and social enterprises in the UK*. London: New Philanthropy Capital; EdComs (2013). *An evaluation of Big Lottery Fund's Monitoring and Evaluation Policy for grant holders*. London: Big Lottery Fund.
- ¹⁷ This point is taken from NHS Confederation (2014). *Comparing apples with oranges? How to make better use of evidence from the voluntary and community sector to improve health outcomes*. London: NHS Confederation www.involveyorkshirehumber.org.uk/uploads/files/briefings/comparing-apples-with-oranges.pdf
- ¹⁸ See for example Henderson, G. (2013). *Public Health Approaches to Social Isolation and Loneliness: A Health and Wellbeing Directorate Seminar*. London: Public Health England. Available www.campaigntoendloneliness.org/phe-approaches-loneliness
- ¹⁹ Office for National Statistics (2015). *Harmonised Concepts and Questions for Social Data Sources: Interim Harmonised Principle. Personal Well-being*. Available www.ons.gov.uk/ons/guide-method/harmonisation/secondary-set-of-harmonised-concepts-and-questions/interim-standard---personal-well-being.pdf
- ²⁰ November, L. (2015). *Community Resources formative evaluation Jan 2015*. London: LifeLine Projects.
- ²¹ Bandura, A. (1994). Self-efficacy. In V. S. Ramachandran (Ed.), *Encyclopedia of human behavior* (Vol. 4, pp. 71-81). New York: Academic Press. (Reprinted in H. Friedman [Ed.], *Encyclopedia of mental health*. San Diego: Academic Press, 1998).

“Exploring faith communities as a setting for public health action could be an important means of achieving better health.”

Professor Kevin Fenton, National Director of Health and Wellbeing
Public Health England



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