The economic and social return of Action for Children's Wheatley Children's Centre, Doncaster

September 2009

Backing the Future: SROI report

Contents

The analysis presented in this report has been developed by **nef** (the new economics foundation) through engaging with many stakeholders including Action for Children. However, overall responsibility for the contents of the report rests with its authors.

Section 1. Introduction and background

This document accompanies a larger report *Backing the Future: why investing in children is good for us all*, which is the culmination of a programme of research carried out in partnership between Action for Children and **nef** (the new economics foundation).

Backing the Future demonstrates the economic and social case for preventing social problems from emerging in the first place, rather than fixing them after they have occurred. It also shows the need for early intervention if and when problems do arise to stop them becoming entrenched. By making the transition to a more preventative system, the UK will improve children's well-being, create a better and more just society, and support our economy by being less wasteful economically and making far better use of our shared but increasingly scarce public resources.

As part of the research, **nef** has conducted *Social Return on Investment* (SROI) analyses on three of Action for Children's projects across England, Wales and Scotland.

SROI is a rigorous measurement framework that helps organisations to understand and manage the social, environmental and economic value that they are creating. It is essentially a form of adjusted cost-benefit analysis which takes into account the full range of social and economic benefits and puts a value on some less tangible outcomes such as improved family relationships. By considering a wider range of effects, it moves the debate away from saving money from public investment to a more comprehensive understanding of what is created as a result.

The use of this type of analysis has several benefits. It enables all outcomes to be considered jointly, expressing all relevant costs, benefits and their relative significance. It enables commissioners of children's services to see beyond the simple unit-cost of services and instead focus on the long-term impact, and trade-offs between competing priorities are made explicit. Negative consequences (intended and unintended) are also accounted for. For organisations, it supports their own strategic planning, highlighting where value is being generated and enabling them to get to better understand their 'theory of change'.

The focus of this report is the SROI analysis of Action for Children's Wheatley Children's Centre (WCC) in Doncaster. **nef** has also conducted SROI analyses of the East Dunbartonshire Family Service and the Family Intervention Team / 5+ Project in Caerphilly.

Section 2. SROI methodology

The SROI methodology[1] employed to analyse the WCC programme consisted of the following approach.

Phase 1: Setting parameters and impact map

Boundaries

- Create the framework for the analysis – what part of the organisation or individual project is to be measured – and prepare background information.
- Describe how the project or organisation works and decide the time period for measurement.

Stakeholders

- Identify the stakeholders whose costs and benefits – associated with the investment or organisation – are to be measured.
- Prioritise key stakeholders and objectives. Materiality – the accountancy term for ensuring that all the areas of performance needed to judge an organisation's performance are captured – is used in the selection of stakeholders and objectives.
- Identify common or overriding objectives.

Impact map

- Conduct stakeholder engagement to assist in the creation of an impact map that describes how the organisation/investment affects key stakeholders.

Phase 2: Data collection

Indicators

- Identify appropriate indicators to capture outcomes and identify monetised equivalent values for those indicators. Where monetary values for indicators are not obvious, a selection of approaches is used to determine financial proxies for intangible impacts.

Data collection

[1] The **nef consulting** SROI methodology adheres to both SROI-UK and SROI-Europe principles of SROI.

- Use tried and tested sources to gather the data – required by the impacts laid out in the impact map – for accurate measurement of identified costs and benefits. In this instance, only output data was available and outcomes data had to be forecasted.

Phase 3: Model and calculate

Model and calculate

- Create a cost-benefit model using gathered data and projections:
  - Calculate the present value of benefits and investment, total value added, SROI ratio and payback period.
  - Use sensitivity analysis to identify the relative significance of data.
  - Account for the displacement, attribution and deadweight of the organisation/investment under review.

Phase 4: Report

Report

- Consider and present the SROI produced by the organisation/investment.
- Identify how the benefits are divided between stakeholders.
- Identify the key factors that affect the SROI ratio.

The SROI methodology can be used in a predictive as well as in an evaluative way. The approach we have taken for WCC is predictive. While WCC has output data available (i.e., number of children attending etc.), at the time of conducting the SROI it had not systematically collected data on either the occurrence of outcomes, or the distance travelled in achieving these outcomes for individuals. We understand the systems are now in place which would enable a more evaluative SROI in the future. For our analysis, however, we therefore predict the value that the Centre should create based on its theory of change (impact map).

Section 3 outlines how the above methodology was applied in the context of the assessment of WCC's activities.

Section 3. Wheatley Children's Centre

Introduction

Action for Children is one of three major providers of children's services in Doncaster.[2] It operates WCC. Wheatley ward is amongst the most deprived areas of Doncaster. The area immediately around the Centre has a higher concentration of BME (Black, minority ethnic) groups than the average for Doncaster – which has traditionally had a low BME representation. Street prostitution and drug use are present in the area surrounding the Centre. For this reason, some of the Centre's adult courses are designed for recovering drug users.

Aims

WCC's aims are geared towards achieving the goals of the recent (Every Child Matters – ECM) Children Act. This legislation states it is the responsibility of all to ensure that children obtain the following outcomes:

1. Be healthy
2. Stay safe
3. Enjoy and achieve
4. Make a positive contribution
5. Achieve economic well-being

WCC has developed theories of change for all their activities that explain how their children's activities achieve the above outcomes. At the time this analysis was undertaken, a distance travelled tool had been developed for measuring the progress of referred children (i.e., higher needs children) against these outcomes. The tool (presented in Table 3) is based on the professional judgement of the case worker and examines progress against a number of indicators for each of the above five ECM outcomes.

Activities

WCC was originally a neighbourhood family centre (providing services for children from 0–14 year of age). It is now a Sure Start children's centre. Sure Start children's centres are designed to provide universal services for children of 0–5 years old and there is a clear expectation to work with those

[2] The local PCT and DMBC (Doncaster Metropolitan Borough Council) are also children services providers.

of high needs (level 3 & 4) as well as low needs (level 1 & 2). WCC also continues to provide services for children over five years of age, in addition to their core service offer to those under five.

Universal

For the period 2008, WCC saw over 800 children access its universal services. Universal services are overwhelmingly directed towards 0–5 year olds. They include:

- Services for babies, toddlers and young children designed to aid normal child development.
- Courses that focus on healthy eating (a direct response to Doncaster's high child-obesity rates).
- Courses that focus in particular on speech, language and communication (an identified need in the area).
- Courses run out of a community centre in another part of Wheatley ward (St Paul's) to increase accessibility for certain user groups.
- After-school clubs are provided for children over five to achieve specific outcomes, such as helping to support families experiencing stress or difficulties.

The length of time that each course/service runs varies from a number of weeks, to a full year.

Referred services

WCC also provides services for children of higher level needs – 3 & 4. It has the additional capacity to offer services aimed at these children due to the on-site presence of a trained social worker (paid for by Doncaster Metropolitan Borough Council, but working for WCC) and a highly experienced and trained staff team.

Services during 2008 included:

- Crèches (for the parents attending parenting classes).
- Transition school groups – for helping with a smooth transition to education.
- One-to-one work.

The median length of engagement for referred case work is approximately 19 months. This is the time between opening and closure of a referred case.

Parent services

A third set of activities that WCC operates is adult education and parenting courses. These courses vary from year to year. During 2008 they included:

- Adult food groups – teaching healthier eating.
- Adult education courses – ESOL and basic numeracy.
- Parenting classes.

Demand from the local community has been the catalyst for the provision of a number of WCC's services. These services tend to be those that are run additional to the core universal services. WCC consults with users as to their needs and plans its programme of work accordingly.

Outputs

The number of children (of needs levels 1 & 2) accessing WCC's universal services during 2008 was in excess of 800. Over 70 parents used the adult/parenting courses offered and 80 children the referred services.

Stakeholder engagement

Table 1 presents the rationale for the selection of material stakeholders. The selection was made in conjunction with WCC staff. The table also lists the method of engagement adopted and the number of stakeholders engaged.

Table 1: Stakeholder audit trail

Stakeholder	Rationale for inclusion/ exclusion	Method of Engagement	No. engaged
Children	Inclusion – Primary beneficiary	Group discussion	15
Parents	Inclusion – Primary beneficiaries plus have direct impact on children	Group interview and individual interview	5
Wider Community			
Schools	Exclusion – insufficient data available to calculate impact	-	-
Drop-in cases	Inclusion – sufficient number of cases to warrant inclusion in analysis	-	-
Child minders	Exclusion – benefits to child minders of use of WCC facilities is marginal	Semi-structured group interview	3
Centre staff*			
Centre manager, social worker	Exclusion – while there was clearly an enjoyment of working at WCC, the low numbers of staff (relative to children) means their impact on the overall analysis would be minimal	Semi-structured interviews	3
Partners – health workers, social worker	Exclusion – services paid for by partner organisation – DMBC	Semi-structured interview	1
State	Inclusion – savings across a range of services	-	-

**Despite being excluded from the analysis, WCC staff were interviewed in developing the programme storyboard that helped inform the programme impact map.*

The interviews were central to the development of the theory of change of WCC. Some of the elements crucial to the achievement of the identified outcomes include:

- The benefit from having available social worker oversight and continuity provided to users by core staff team. This benefit came through strongly in a number of interviews with different stakeholders. The ability to first identify and then be in a position to

offer services to high-needs children on the same site as universal services reduced the stigma of take-up of these specialist services. The continuity provided by staff allowed relationships of trust to develop that aided the achievement of positive outcomes.

- The ability to be able to deal with children seamlessly as they breach the normal age limit of a Sure Start centre (five years of age) came through as a major benefit offered by having a Centre that dealt with children from birth through to 10+ years. The ability to maintain a close relationship with one key worker was mentioned on numerous occasions as proving crucial to the child's improvement across a range of outcomes.
- The parents interviewed on an individual basis had had a relationship with WCC for a number of years and their children had been the beneficiaries of several of WCC's referred services. They had benefitted from WCC's ability to offer both universal services and one-to-one work for their children on the same site. By having both services on site, the stigma of accessing specialist services was significantly reduced.

Impact maps

Central to the SROI methodology is making explicit the theory of the change an organisation or programme is trying to achieve; i.e., to demonstrate that the activities of an organisation logically lead to the identified outputs and finally the outcomes as identified by stakeholders. Table 2 presents a theory of change for WCC.

- WCC has produced detailed theories of change for each of its courses which explains how the activities of each course match the ECM outcomes, namely:
  - Be healthy
  - Stay safe
  - Enjoy and achieve
  - Make a positive contribution
  - Achieve economic well-being
- These outcomes generally match the medium-term outcomes identified in Table 2 (for children) of improved physical and mental health, improved family and non-family relations and better educational performance. Saying that, the focus of the medium-term outcomes is more closely matched with the first three 'child-centred' ECM outcomes. This is because it is recognised that the latter two are longer-term impacts that are not feasible to measure as part of this piece of work.
- The impact maps created by WCC demonstrate how the different universal services are designed to achieve the same ECM outcomes. In this analysis it is assumed, therefore, that the different universal services all achieve similar outcomes i.e., it is not the case that certain universal services only create certain outcomes.

Table 2: Impact map

Stakeholder	Services (activities)*	Outputs	Short-term Outcomes	Medium-term Outcomes
Children (needs 1 & 2)	Universal Services *Crawlers to Walkers* *Walkers to Talkers* *Musical Minis* *Playtime* *Nursery* *St.Paul's* *Food Group Crèche* *After School*	Fed a healthy and nutritious diet Opportunity for physical exercise Time spent in a safe, non-stressful environment Shown love, affection and praise Make new friends Opportunity to have fun and do activities they enjoy Improved behaviour	Increase in confidence and self-esteem Improved social interaction skills Improved educational attendance	Improved physical health Improved mental and emotional health Improved social (non-family) relationships Improved family relationships Improved educational performance
Children (needs 3 & 4)	Universal Services Dinosaur School One-to-one support	Same as above, though at a different level of intensity**	Same as above, though at a different level of intensity	Same as above, though at a different level of intensity
Parents	Adult parenting classes *mellow parenting* *Webster Stratton* *Share Plus* Adult food group Adult education	Opportunity to share knowledge Learn new parenting skills Opportunity to meet others Learn about better nutrition Expand skills through education	Improved self-esteem Improved self-confidence/self-empowerment Healthier diet Better employment prospects	Reduction in social isolation Improved emotional well-being Improved physical health Better paid work

Wider Community				
Schools	Transition Group Dinosaur School	Reduced disruption for other children	Reduced mental health issues from disharmony in class	Better overall education performance
Drop-in cases	Emergency assistance for any family situation	Assistance	Reduced stress	
				Reduced cost of alternative school arrangements
State	Supply of social worker, health workers	Children accessing WCC		Reduction in level of child's health costs
				Reduction in use of counselling services
		Avoidance of taking children into care		Avoidance of costs associated with child taken into care

** WCC offers a range of services to children and parents. Those listed in Table 2 are the courses offered during 2008.*

*** The outcomes for high-needs children were the same as low-needs children. The possible intensity/improvement in those outcomes was assumed to be greater for high-needs children.*

- A number of parenting courses were made available by WCC during 2008 that differed in approach and style. Whereas *The Incredible Years* (a Webster Stratton course) is quite prescriptive in its approach, *Mellow Parenting* and *Share Plus* are more parent-driven. While the courses take different approaches, they are hoping to achieve the same outcomes. This is reflected in the impact map which shows the same outcomes for participants across these different courses.

Data collection

Evidencing the potential benefits identified through stakeholder engagement requires data for each of the outcomes presented on the impact map in Table 2. At present, WCC's data collection focuses on outputs, such as attendance at courses for both children and parents. For this reason, the SROI is predictive – creating a ratio based on an assumption that outcomes are achieved.

WCC has established an 'outcomes distance travelled' tool, using a variety of indicators, to measure whether outcomes are being achieved or not for cases of referred children. However, to date, this tool has been used for only two referred children. Table 3 presents the format of the tool.

Table 3: Existing outcomes progress chart

		Poor		Av	Good	
Be healthy	**Child has access to regular physical exercise.**	1	2	3	4	5
	Child has access to, and receives appropriate medical care.	1	2	3	4	5
	Fed a healthy and nutritious diet	1	2	3	4	5
	Child is able to express himself/herself emotionally. Mental health is stable.	1	2	3	4	5
	Child is sexually healthy	1	2	3	4	5
Stay safe	All child's basic needs are met.	1	2	3	4	5
	Child is safe from significant harm and abuse	1	2	3	4	5
	Child lives in a stable and secure home with routines and boundaries.	1	2	3	4	5
	Child is safe from bullying and discrimination.	1	2	3	4	5
	Child is shown love, affection, and approval.	1	2	3	4	5
Enjoy & achieve	Child appears happy and confident in familiar environments.	1	2	3	4	5
	Child is able to establish secure attachments and relationships	1	2	3	4	5
	Child displays socially acceptable behaviours and interacts positively.	1	2	3	4	5
	Child is happy and willing to become involved in social activities and tasks.	1	2	3	4	5
	Child is happy and achieves in school.	1	2	3	4	5
Make a positive contribution	Child shows an awareness of the environment in which he/she lives.	1	2	3	4	5
	Child appears confident and displays growing self-esteem.	1	2	3	4	5
	Child has positive relationships with peers and others.	1	2	3	4	5
	Child does not bully, or act aggressively towards others.	1	2	3	4	5
	Child is not involved in antisocial or illegal behaviours.	1	2	3	4	5
Achieve economic well-being	Family home is safe and clean.	1	2	3	4	5
	Risk of homelessness is unlikely.	1	2	3	4	5
	Family has sufficient money to meet child's basic needs.	1	2	3	4	5
	The local community in which child lives is decent.	1	2	3	4	5
	Currently engaging in further education or employment.	1	2	3	4	5

- The tool is designed to be used at the start of an intervention with a referred child and then again after a period of time. Any progress made by the child is based on the practitioners' professional judgement.
- The highlighted (bold) indicators in Table 3 could be used to measure the outcomes identified in the SROI impact map (Table 2).

For purposes of the analysis, the scale (magnitude of change) and occurrence (incidence) of outcomes in the economic model should be treated as indicative only.

The indicators identified by WCC (Table 3) could provide ways of identifying whether the impact map outcomes occurred (the five indicators in bold matching the five outcomes identified for children in Table 2). However, because this was not done, academic research provided the basis for modelling the identified outcomes.

Table 4: Quantitative data collection

Stakeholder	Type of data	Method/rationale
Child	Output – actual, Outcomes, forecasted	WCC has the number of attendances by children at the various activities/ courses offered throughout 2008. The children can be broken down to low needs (needs levels 1&2) and high needs (levels 3&4)
Parents	Forecasted	WCC recorded the number of parents attending the courses offered throughout 2008.
Wider community	Forecasted	For drop-in cases, an overall figure for cases dealt with (in a year) was available.
State	Forecasted	Based on high-needs children forecasts

Economic model

The economic model was developed in five stages:

1. Deriving outcome incidences for each stakeholder as set out in data collection.
2. Sourcing a financial proxy or direct cost for each outcome.
3. Determining impact by accounting for deadweight, displacement, and attribution.
4. Determining a benefit period and drop off for each stakeholder.
5. Projecting value into the future.

Outcomes incidences

- A position was taken that every low-needs child that attended the universal services of WCC benefited from the outcomes identified in the impact map (Table 2). While different services may stress certain outcomes, all aim to achieve the full set of outcomes identified in the impact map. For instance, while *Musical Minis* focuses explicitly on development of mental well-being and life skills development through social interaction, language and communication skills, it does not neglect the child's physical well-being.
- This same position was taken for high-needs children (in the absence of comprehensive outcomes data). The high-needs children were split into two groups (0–5 years and 6–10+) as the activities of the former subset did not include the physical health outcome. Otherwise, they shared the outcomes of the older high-needs-children subset.
- For parents, it was assumed all parents attending the parenting classes gained the outcomes improved mental well-being and reduced social isolation. Anecdotal evidence from the stakeholder engagement supports this assumption. It was assumed all those attending the education and food classes benefited in terms of employment prospects and better physical health respectively. While it is possible that parents (of low-needs children) that attend

universal services with their children potentially benefit from WCC, the analysis reflects that gain in the benefit accruing to the child.

Financialising outcomes

As part of the analysis and calculations, SROI requires the 'financialisation' of all the outcomes. This means putting a financial value on each outcome, even those that are not usually traded and for which a value is not obvious. When data is unavailable for a particular cost, we have used a 'proxy', a value that is deemed to be close to the desired outcome. These monetised outcomes are then added together to calculate the total value produced.

When combining monetised outcomes, there is a danger of double-counting benefits. For example, the short-term outcomes 'increase in self-confidence' are likely to be substantially covered by the medium-term outcomes 'improved mental and emotional health'. For this reason we only monetise the medium-term benefits.

Based on discussions with WCC staff and a staff-to-child ratio that is approximately double for high-needs children compared with low-needs children, an assumption was made that the distance travelled towards achieving the outcomes for high-needs children were more valuable than that for low-needs children. The outcomes for high-needs children were deemed more valuable because of the greater societal and individual impact of high-needs children if they were not to achieve those outcomes.

The difference in the magnitude of the outcomes (for low- and high-needs children) is reflected in the model by a reduction in the value of each proxy by one half for low-needs children. The worker:child ratio for low- and high-needs children's services was used to inform this difference.

Otherwise, assumptions were made that outcome occurrences were binary and academic research provided proxies for the different outcomes for the various stakeholders where there was no recognised market value.

Table 5 presents the proxies used in the SROI model.

Table 5: Selected financial proxies and direct costs

	Outcome	Financial proxy[1]	Value (£s)
Children	Improved physical health	Spending on health (per capita)	1,947
	Improved mental and emotional health	Cost of five sessions/week of cognitive behavioural therapy (CBT) in day care at voluntary provider	5,200
	Improved social (non-family) relationships	Annual household spend on recreation and culture	2,985
	Improved family relationships	Annualised cost of a child[2]	9,227
	Improved educational performance	Opportunity cost: average annual salary of 16–17-year-olds in full-time work	9,130
Wider community (drop in cases)	Improved mental well-being	Daily benefit created by WCC (before inclusion of wider community) = net present value (NPV) of total benefit/no. of days in a year[3]	3,159
Parents	Reduced social isolation	Annual household spend on recreation and culture	2,985
	Improved emotional well-being	Cost of five sessions/week of CBT in day care at voluntary provider	5,200
	Improved physical health	Spending on health (per capita)	1,947
	Better employment prospects	Further education – positive pay increase if moving from no qualification to at least a level 2 qualification	1,661
State	Reduction in cost of taking child into care	Foster care costs	3,412
	Reduction in cost of child's health costs	Child's reduced health costs	1,947
	Reduced counselling services	Reduction of other child costs (education, care, relationships)	1,627
	Reduced costs of alternative school arrangements	Cost of remedial help at primary school	11,903

Notes: 1. *Proxy values are annualised figures*

2. *The total cost of raising a child over first 21 years of life, annualised. Assumption that an improved family life might lead to the decision to have another child.*

3. *Range of drop-in cases means that proxy used is the total value generated by WCC proportionate to the time spent dealing with each drop-in case.*

Determining impact

The economic model subtracts for the effects of deadweight and attribution to determine the change that can be credited to the organisation. Due to the lack of outcome-specific benchmarks, the following approach was used for measuring deadweight and attribution for WCC.

- Deadweight
  - *Low-needs children and parents:* based on conversations with health worker. An estimate was provided for the reduction in benefits when universal services or parenting courses were withdrawn.
  - *High-needs children*: an assumption was made that without WCC's 'joined-up approach' of using universal services to first identify, and then encourage take up of referred services, a number of high-needs children would not have received the benefits of those specialist services. The number of high-needs children identified in this way as a percentage of the total number of high-needs children accessing services produced the deadweight figure.
  - *State:* the focus of the outcomes to the state are the savings from assistance provided to high-needs children. The deadweight calculation is therefore the same as for that stakeholder group.
- Attribution
  - Evidence from research into the impact of children's centres suggests the estimated impact of childcare is approximately half that of family factors[3], i.e., the home life of a child has double the impact of childcare services on achieving child development outcomes. We have therefore estimated WCC's attribution for children at 23–30 per cent, assuming 10–30 per cent attribution for factors other than the family home (i.e., health workers and school).
  - For parents, we have assumed a 100 per cent attribution rate as WCC is the sole supplier of the activities designed to lead to the identified outcomes.

Benefit period and drop off

- We have assumed that the benefits period for low-needs children is one year based on the fact that the courses are generally short and can only be expected to have a limited impact (if taken in isolation).
- For high-needs children, the median length of a case is 13 months. With a case closure rate of 34 per cent per annum, we assume that only the closed cases continue to experience benefits beyond the first year of intervention. We further assume that those benefits last for a total of three years. This final assumption is based on the fact that many children re-engage with WCC's services after a few years.

[3] http://www.surestart.gov.uk/publications/?Document=517

- The wider community – in the form of drop in cases – is assumed to have an immediate drop off (i.e., one year), due to the immediacy and temporary nature of the assistance provided.
- For both parents and the State, a drop off in benefits of 50 per cent per annum up to a maximum of five years is assumed.

Changes to financial proxies, deadweight, attribution and the benefits drop-off period are examined in the sensitivity analysis (later in the report) due to the estimation required in creating a base case scenario.

Projecting value into the future

When projecting benefits into the future, it is standard SROI practice to discount any future benefits. The HM Treasury discount rate of 3.5 per cent was applied to all future benefits in the model. Discounting is the final step in constructing the model. The results of the model are discussed in Section 4 (SROI ratio and benefits breakdown).

Section 4. SROI ratio and benefits breakdown

The SROI ratio for WCC is 4.6:1. That is, an estimated £4.6 worth of social value was generated for every £1 spent on the programme between January 2008 and December 2008.

Figure 1 presents the breakdown of the social value created by WCC by stakeholder.

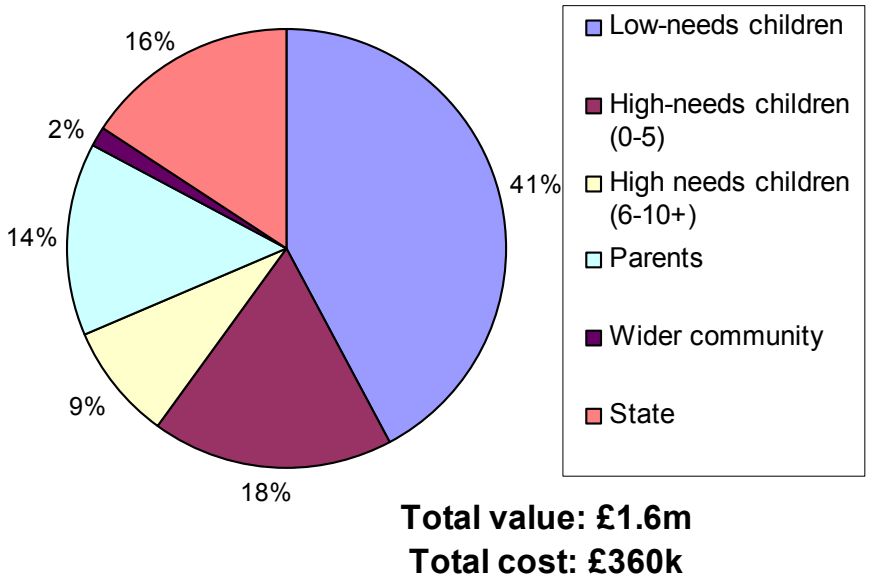

Figure1: Share of value by stakeholder

- The principle beneficiary group are low-needs children. Despite the forecasted outcomes lasting for a shorter period of time for this group in comparison with high-needs children for example, the size of this group (over 800) offsets the shorter benefits period.
- Deriving a combined 27 per cent of the total benefit generated by the work of WCC, the benefits to high-needs children are disproportionate to their representation – they account for only 8 per cent of all persons accessing WCC's services– because of the greater emphasis placed on the impact generated per capita.

- Parents and the State benefit in approximately the same measure from the work of WCC. The principle benefit to the State is estimated to come from the savings from not needing to take children into care and from not needing to provide alternative school arrangements. For parents, reduced social isolation and improved mental well-being are the major contributors to their overall benefit. It should be remembered that only parents attending adult courses are captured in the analysis. Parents that attend the universal services (alongside their children) will potentially see benefits from the possible improvement in the development of their child attending the universal services.

Sensitivity analysis

A number of factors were varied to test the sensitivity of the model:

- *Financial proxies* were systematically varied and demonstrated relatively low sensitivity. For the most significant outcomes (by value) of education, mental health and family relationships, a halving of the unit proxy values resulted in a reduction in the ratio falling no lower than 3.7. This lack of variability suggests robustness in the proxies used.
- *Deadweight and attribution* both have higher sensitivity in the model than the financial proxies. Doubling the deadweight for high-needs children (the deadweight in the base case for low-needs children was already 70 per cent) results in a ratio of 3.0 while halving the attribution across all stakeholders results in the ratio falling to 2.3. This level of sensitivity highlights the importance of accurate measurement of both data for benchmarking purposes and attribution between different influences, for example, school, the home, etc.
- *Drop off* was also varied. If the drop off is increased by 50 per cent across all stakeholders, (i.e., the benefits remain higher for longer), the ratio increases to 7.0. This again indicates sensitivity in the model. While the drop-off rates in the base scenario have face validity, better outcomes tracking of children over the longer term would enable these to be empirically tested.

Section 5. Recommendations

The SROI ratio is an important indicator of value, but needs to be understood within the context of how a given intervention sets out to make a difference. For this reason, *a direct comparison between the ratios for WCC and other Action for Children projects analysed should be avoided.*

The SROI process has indicated how social value is created by WCC for its various stakeholders and therefore what needs to be maintained/reinforced for WCC to continue generating social value. The process has also shown the service delivery approaches which seemed to work well:

- *The community focus and 'tough love' approach used by WCC.* A consistent feature of the stakeholder engagement was the personalised approach and welcoming environment of WCC, as opposed to similar services accessed by its stakeholders. It was also noted, however, that being willing to refer children to the Child Protection Register (CPR) and not 'pandering' to pushy parents also contributed to the respect felt by stakeholders towards WCC.
- *Signposting opportunities for parents.* WCC is in an excellent position, situated in the heart of the community, to act as a disseminator of opportunities for parents offered by other service providers, be it assistance with drugs programmes, adult education, etc.

In relation to measurement, if Action for Children intends to capture the benefits to all of the children that attend WCC, an accurate tool for measuring progress against identified outcomes needs to be utilised for all children and parents in the future. The tool developed by the centre (presented in Table 3) is one option.

Another might be a tool but with a defined scale of progress – i.e., a greater emphasis on the objective, rather than subjective. A defined scale provides a range of statements and actual examples that help place an individual on that scale. The *Outcomes Star* is an example of such a tool.[4] Such a system would enable evaluative SROIs to be conducted in the future.

For low-needs children, a lighter-touch tool may need to be developed due to the greater number of low-needs children that attend WCC and the increased workload any monitoring of their progress would naturally entail for staff.

4 http://www.homelessoutcomes.org.uk/resources/1/Outcomes%20Manuals%202nd%20Ed/Star_Actionplan_2ndEd.pdf

Appendix 1: Financial proxies and modelling assumptions

Basics	Value (£s)	Source
Total number of low-needs children (Jan–Dec 2008)	**875**	Wheatley Children Centre
0–4	772	
5–10+	103	
Total number of high-needs children (Jan–Dec 2008)	**84**	Wheatley Children Centre
0–4	48	
5–10+	36	
Total number of Parents (Jan–Dec 2008)	**71**	Wheatley Children Centre
Parenting classes	28	
Education	23	
Food	20	
Costs and assumptions	**Value**	**Source**
Low-needs children		
Outcome: Improved mental and emotional health		
Annual cost of five sessions/week of CBT in day care at voluntary provider	5,200	PSSRU Unit Costs 2007 http://www.pssru.ac.uk/uc/uc2007contents.htm
Outcome: Improved family relations		
Cost of child to family over 21 years (annualised)	9,227	Liverpool Victoria http://www.lv.com/media_centre/press_releases/lv=%20cost%20of%20a%20child
Outcome: Improved social (non-family) relations		
Annual household spend on recreation and culture	2,985	http://www.statistics.gov.uk/pdfdir/fs1108.pdf
Outcome: Improved physical health		
Spending on health (per capita)	1,947	http://budget.treasury.gov.uk/where_taxpayers_money_is_spent.htm, https://www.cia.gov/library/publications/the-world-factbook/geos/uk.html

Costs and assumptions continued	Value	Source
Distance travelled	50%	Assumption that distance travelled for universal children is half that of high-needs children. Proxy used is double the ratio of children to carers for referred courses versus universal courses
Attribution	30%	Based on assumption that centre plus home account for 90 per cent of impact and that home is twice as important as centre (research paper). Other 10 per cent is referral from health worker
Deadweight	70%	Based on conversation with health worker (see notes)
High-needs children (0–5)		
Frequency of positive (non-negative) outcomes occuring	100%	Estimate: In absence of outcomes data
Outcome: Improved education		
Opportunity cost: average annual salary of 16–17-year-olds in full-time work	9,130	ONS http://www.statistics.gov.uk/downloads/theme_labour/ASHE_2008/tab6_7a.xls
Outcome: Improved mental and emotional health		
Annual cost of five sessions/week of CBT in day care at voluntary provider	5,200	Taken from Coventry: high needs (PSSRU Unit Costs 2007)
Outcome: Improved family relations		
Cost of child to family over 21 years (annualised)	9,227	Liverpool Victoria http://www.lv.com/media_centre/press_releases/lv=%20cost%20of%20a%20child
Outcome: Improved social (non-family) relations		
Annual household spend on recreation and culture	2,985	http://www.statistics.gov.uk/pdfdir/fs1108.pdf
Attribution	30%	Based on assumption that centre plus home account for 90 per cent of impact and that home is twice as important as centre (research paper). Other 10 per cent is referral from health worker
Deadweight	44%	Assumption that absence of joined up approach would lead to percentage of high-needs cases slipping through net

Costs & Assumptions continued	Value	Source
High-needs children (6-10+)		
Frequency of positive (non-negative) outcomes occurring	100%	Estimate: In absence of outcomes data
Outcome: Improved education		
Opportunity cost: average annual salary of 16-17 year olds in full time work	9,130	ONS http://www.statistics.gov.uk/downloads/theme_labour/ASHE_2008/tab6_7a.xls
Outcome: Improved mental & emotional health		
Annual cost of 5 sessions/week of CBT in day care at voluntary provider	5,200	Taken from Coventry: high needs (PSSRU Unit Costs 2007)
Outcome: Improved family relations		
Cost of child to family over 21 years	9,227	Liverpool Victoria http://www.lv.com/media_centre/press_releases/lv=%20cost%20of%20a%20child
Outcome: Improved social (non-family) relations		
Annual family spend on recreation and culture	2,985	http://www.statistics.gov.uk/pdfdir/fs1108.pdf
Outcome: Improved physical health		
Spending on health (per capita)	1,947	http://budget.treasury.gov.uk/where_taxpayers_money_is_spent.htm, https://www.cia.gov/library/publications/the-world-factbook/geos/uk.html
Attribution	23%	Based on assumption that centre plus home account for 70 per cent of impact and that home is twice as important as centre (research paper). Other 30 per cent is 20 per cent for school and 10 per cent for referral from health worker
Deadweight	44%	Assumption that absence of joined up approach would lead to percentage of high-needs cases slipping through net

Costs and assumptions continued	Value	Source
Parents		
Frequency of positive (non-negative) outcomes occurring Outcome: Reduced social isolation	100%	Assumption that attending centre leads to a reduction in social isolation for all
Annual family spend on recreation and culture	2,985	http://www.statistics.gov.uk/pdfdir/fs1108.pdf
Frequency of positive (non-negative) outcomes occurring Outcome: Improved mental and emotional health	39%	Assumption that only parenting classes leads to an improvement in mental health
Annual cost of five sessions/week of CBT in day care at voluntary provider	5,200	Taken from Coventry: high needs (PSSRU Unit Costs 2007)
Frequency of positive (non-negative) outcomes occurring Outcome: Improved physical health	28%	Percentage of total adults attending food classes
Spending on health	1,947	http://budget.treasury.gov.uk/where_taxpayers_money_is_spent.htm, https://www.cia.gov/library/publications/the-world-factbook/geos/uk.html
Frequency of positive (non-negative) outcomes occurring Outcome: Better employment prospects	32%	Percentage of total adults attending education classes
Further education - positive pay increase if moving from no qual to at least a level 2 qual	1,661	University of Warwick http://www.leedsthomasdanby.ac.uk/courses/higher/facts.cfm multiplied by minimum wage job from Coventry
Attribution	100%	No external partners involved in service provision
Deadweight	70%	Based on conversation with health worker (see notes)

Costs and assumptions continued	Value	Source
State		
Frequency of positive (non-negative) outcomes occurring	100%	Same as frequency for high-needs children
Outcome: Avoidance of taking children into care		
Foster care costs	3,412	BMJ: Financial cost of social exclusion: follow up study of antisocial children into adulthood
Outcome: Reduction of child health costs		
Child's reduced health costs	1947	http://budget.treasury.gov.uk/where_taxpayers_money_is_spent.htm, https://www.cia.gov/library/publications/the-world-factbook/geos/uk.html
Outcome: Reduced counselling services		
Reduction of other child costs (education, care, relationships)	1,627	BMJ: Financial cost of social exclusion: follow up study of antisocial children into adulthood
Outcome: Reduced cost of alternative school arrangements		
Cost of remedial help at primary school	11,903	Annual cost, BMJ: Financial cost of social exclusion, Scott. S, Knapp. M, Henderson, J
Cost of exclusion from primary school	2,000	1996, Exclusion from school, Blyth, E. and Milner, J. Chp. 9, Carl Parsons
Attribution	27%	Proportionate to high-needs children above and below five years
Deadweight	44%	Same as high-needs children

Costs and assumptions continued	Value	Source
Wider community –drop-in cases		
Approximately 0.5 days spent per occurrence	12	number of occurrences per year
Outcome: Reduced mental health issues (stress)		
Improved mental well-being	4,586	Daily benefit created by WCC (before inclusion of wider community) = NPV of total benefit/no. of days in a year
Attribution	50%	Assumed while WCC did coordinating, used one other agency to solve problem
Deadweight	0%	That they came to WCC suggests they didn't feel they had anywhere else to go of comparable quality/care
Drop off		
Low-needs children	100%	Shortness of the courses means that not possible to attribute much more than a year
High-needs children	66%	Case closure data used as proxy for benefits period – i.e., 100 per cent benefit during intervention (median intervention is 13 months), only 34 per cent benefit beyond as only 34 per cent of live cases closed per year, and with 34 per cent drop off, all benefits are concluded by year 3 (3x34 per cent)
Parents	50%	Estimate
Wider community (drop-in cases)	100%	As benefit is instant
State	50%	Estimate: proxies used are annual amounts and assume state needs to pay for five years
Discount rate	3.5%	Treasury

Other reports related to this project include:

- Full project report:
  - *Backing the Future: why investing in children is good for us all*
- Practical 'how to' documents:
  - *A guide to commissioning children's services for better outcomes*
  - *A guide to measuring children's well-being*
  - *A guide to co-producing children's services*
- SROI assessment reports for two Action for Children services:
  - *The economic and social return of Action for Children's East Dunbartonshire Family Service*
  - *The economic and social return of Action for Children's Family Intervention Team / 5+ Project, Caerphilly*
- Report on the Citizens' Juries:
  - *How can government act to increase the well-being and happiness of children and young people in the UK? A report on two citizens' juries.*

All available at www.neweconomics.org and www.actionforchildren.org.uk