HIGHWAY HOUSE

- SOCIAL RETURN ON INVESTMENT -

Impacts of Homelessness on the UK

UK economic cost of homelessness is £24,000 - £30, 000 per person per year

Around 2000 people sleep rough in the UK

80% of homeless people have a mental health problem

73% of homeless people have physical health problems

35% eat less than 2 meals a day

Financial savings made due to Highway House

Less demand for temporary accommodation = £109, 200 saved

Reduced burden of unemployment benefits = £92, 172 saved

Reduced strain on A&E =£24, 973 saved

Reduced Crime = £3, 500 saved

Reduced demand for mental health services = £73, 398 saved

FINAL SOCIAL RETURN ON INVESTMENT = 1 : 5

(for every £1 invested in Highway House, £5 is returned to society)

HIGHWAY HOUSE more than a homeless shelter

INSTITUTE FOR HEALTH AND HUMAN DEVELOPMENT

UEL University of East London

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Assessing the Social Return on Investment of Highway House, a Homeless Shelter in Haringey, London

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Contents

Glossary

HH	Refers to ‘Highway House’, but the homeless shelter was founded by the Highway of Holiness church.
SROI	Refers to ‘Social Return on Investment’, explained in full below in section 5.1.
PV	Refers to Present Value.

1 Executive summary

Homelessness is an increasing challenge for society and the state. In addition to posing significant long-term health problems for those affected, it presents a significant financial cost to the public. On this ground, it is important to develop evidence and evaluation tools to assess the financial contribution of homeless projects, as their saving to the public sector could be quite considerable and help both third sector organisations and the public sector to justify further investment.

In this report, we assess the economic value to society resulting from a homeless support service called Highway House (former Highway Homeless project) which provides a range of services to homeless people including a temporary accommodation (shelter); signposting service to help clients to find permanent housing; employment and other services (e.g. drug rehabilitation and other NHS services); psychological counselling; and healthcare support i.e. a place where clients can recover from major health problems.

In order to explore social value, we used an assessment framework called Social Return on Investment (SROI) which compares a project's net benefits to the investment required to generate those benefits over a certain period of time (Emerson and Cabaj, 2000). In practice, we used cost estimates from various studies to attribute a financial value to a range of support services delivered by Highway House (HH). Estimates were complemented by primary and secondary data collected from Highway House.

Primary data collection
We conducted qualitative interviews with 30 past and present Highway House service users1. Due to ethical reasons and limited resources, some participants were selected by the HH director. Participants provided information about their physical and mental health, demographic profile, and their service use (e.g. health services, hospitals, employment services, housing services). An 'outcome star' tool was used to estimate physical, mental and behavioural change resulting from their stay at HH. Whilst we initially intended to use the outcome star with all participants, in practice we only used this to assess the impact of two HH support services and triangulated different data sources (financial proxies, secondary data collection) to provide the final SROI assessment.

Secondary data collection
We analysed registration forms to understand more about the socio-demographic profile of the homeless population using the service and also explored attendance records to generate an average rate of attendance which was used to improve the quality of the SROI assessment. Referral letters were also analysed in order to generate more information about the pathways followed by homeless people and associated cost savings for referring organisations that should be accounted for in the SROI estimate.

SROI assessment
In assessing the SROI, we followed established practice (Nicholls et al 2008) which accounts for deadweight, displacement, attribution and drop-offs (for an overall summary table see appendix 10.2). We deliberately minimised the impact of Highway House by choosing the lowest financial proxy values we could find from published studies (e.g. Curtis, 2014). This approach, we argue, lends more credibility to the final result. The final result is as follows: for **one** pound invested in supporting the work of Highway of Holiness, the return to society is **five** pounds, thus the ratio is **1:5**.

In order to consider different influences on the final costing, we also conducted a sensitivity analysis (see section 7.3) which accounts for the influence of different assumptions on the final result. This indicates that the minimum SROI ratio for HH is £1 : £4.

[1] Ethical approval was obtained by the University of East London Ethics Committee (UREC). UREC_1415_37

When compared with other SROI studies, the HH SROI ratio (1:5) tends to be in the lower half of the range. Other SROI projects range from £1:£3.92 (Crisis skylight in Oxford Economics, 2008) to £1:£11 (Emmaus UK in Lawlor 2012). However, it is noticeable that despite several efforts to generate coherent standards across the board, there are still wide variations in the way SROI assessments are conducted, thus it is difficult to draw firm conclusions about the relative value of each of project. Furthermore, we noticed that part of the variability may be due to the fact that the SROI ratio tends to be much larger when more clients are assisted with the same resource input. As HH serves relatively few people (n=30), its SROI tends to be smaller because it cannot exploit economies of scale. If adequate investment were to be made in its growth, the SROI ratio would potentially be higher than other similar projects.

Finally, it is also important to recognise that beyond the numbers, HH does provide life changing support for homeless people who have not received help through more established statutory support organisations. In this sense, HH caters for one the most marginalised groups within the homeless population (see case study on p.24), a group that traditionally receives minimal help from statutory bodies as it does not fit easily into the conventional homeless support regulatory framework.

2 Introduction

Homelessness is not just a pertinent issue in terms of its ethical and social implications, but has also a financial cost for both society and the State. Tackling homelessness would therefore be beneficial for people concerned but also in terms of long term savings for the public sector including for instance the National Health Service (NHS), the Home Office, Department for Work and Pension (DWP), and Department for Communities and Local Government, among others.

Homelessness has an important range of costs including[2]:

- Failed tenancies (MEAM manifesto accommodation and support £19K)
- Health and substance misuse problems which lead to increased contact with A&E (MEAM manifesto in 2009 showed hospital costs £150, drug treatment £3,000, medication £400)
- More at risk of coming into contact with the criminal justice system, often as victims
- Prolonged unemployment with associated lack of input to tax system and additional welfare costs.

Depending on the source (NEF, 2008; MEAM, 2009), cost per annum for individual homelessness ranges from £24K to £26K per year. Yet, the number of homeless individuals in the UK continues to rise and, as a direct result of cuts in public expenditure and economic recession, is likely to rise even further in the future. The introduction of the benefit cap will see at least 11,390 households in the UK lose £150 a week. In Haringey, where HH is located, this will make 6,900 homes unaffordable to families on housing benefits (Davies et al, 2013).

Despite this, the number of homeless projects (day centres, direct access hostels, and second stage accommodation) has experienced a net decline in the UK - especially in London - according to HUK (Homeless UK, 2013) which continuously monitors homeless services through Homeless Link. The number of bed spaces in the UK has continuously declined since February 2010 – regardless of the fact that the demand for bed spaces is ever growing. London (which hosts the highest number of homeless people) has experienced the largest decline (-11%) in bed spaces.

In the borough of Haringey where Highway House is located, the most recent homeless strategy focuses on reducing the council's use of temporary accommodation in place of more cost effective strategies (Haringey Council, 2014). However, there are over 4,000 people living in temporary accommodation, which makes Haringey the fourth highest borough in terms of acceptance rates (Haringey Council, 2015).

In this context, it is imperative to develop evidence and evaluation tools to assess the social value of homeless projects like HH, as their cost saving to the public purse could be considerable and might lead to net cost savings for local authorities which, in adult and social care, face one of the biggest areas of expenditure. Whilst further investment in homeless projects might be considered as an initial cost, it is important to highlight that their use, and thus the long term savings from the decreased access of homeless people to housing, employment, health and other services is likely to lead to considerable net savings in the future.

[2] www.homeless.org.uk

3 SROI Stage 1: Establishing Scope and identifying stakeholders

3.1 Establishing the scope of the exercise

The scope of this exercise is to provide an assessment of the social value of Highway House, a church based charity that supports homeless people by providing temporary accommodation (shelter) and signposting to more permanent accommodation, employment, and other services (e.g. drug rehabilitation, mental health services). Thus, this report is written with funders and commissioners in mind and thus attempts to facilitate their decision making process by providing robust evidence of HH impact, whether positive or negative. This work was undertaken by the Institute for Health and Human Development based at University of East London and was funded by the University.

3.2 Description of Highway House

Highway House (HH) formerly known as 'Highway Homeless Project' is a homeless shelter and was not planned. The building that HH operates from is in fact a church (Highway of Holiness), and has continued to be a church since the homeless shelter began in 2009. The shelter was initiated when, during a community outreach session in 2009, the church came into contact with two homeless people nearby who were in need of urgent support. The church provided them with food, and, within a month, more than 20 homeless people relied on the church for food. During the winter in 2009, HH became an alternation between a shelter for the homeless at night, and a church during the day. HH provides shelter and support to homeless people every single night of the year, and has done for six consecutive years.

Due to providing a shelter for people with complex health problems from the very start, perhaps inevitably HH has experienced many patient referrals from hospitals, the police, MPs and a range of other organisations and institutions across London. HH welcomes patients with complex health problems and who may be presenting co-morbidities (i.e. suffering from a combination of health issues such as alcoholism and mental health problems) and provides them with a safe shelter to recover in. Often, this has resulted in complicated and infrastructural changes to the HH building in order to comply with NHS regulation and host people that would otherwise be sent to a different NHS infrastructure (of course with associated cost implications) or end up back on the street. If patients were to find themselves back on the street after treatment, it is very likely they would return to hospital suffering even worse health conditions, and this circle would continue to repeat itself with considerable cost implications each time. HH provides an alternative to this costly cycle.

Further services provided by HH include psychological counselling for those in need, nutritional advice, English teaching, and various other means of support. Psychological counselling is particularly important for most people who approach the shelter. Counselling is provided directly by the Pastor, who is a qualified counsellor, in a flexible and ad-hoc manner responding to the needs of each individual. This is seen a unique feature of the support service provided by the church. Throughout the last six years, whole families as well as a number of individual people have been referred to HH by the council, the prison system, health services (see appendix 10.4 for more details) and other homeless services as evidenced by reviews of letters referring people to the shelter.

Furthermore, HH provides shelter and support for marginalised homeless people, and so supports individuals who are not eligible to access statutory services due to their migrant status in the UK. Analysis of data on attendance for the year 2013 show that HH provides a place to sleep to an average of 33 clients per night, although this number is considerably higher during winter months reaching a peak of 43. The length of stay is split in three almost equal parts: 30% of clients spend one night, 34% spend between two and 30 days, 36%

spend between 31 and 180 days. Yet, some clients spend 12 months or more if their health conditions are particularly poor.

Analysis of admission forms which includes data on 180 clients for the period 2009-2014 show that almost all clients are men (93%)[3], mean age 36 years ranging from 19 to 71 years old. About 70% of clients originate from Europe and half of these from Poland, Romania, Lithuania and Latvia respectively. Of the remaining 30% of clients, half are Black African (15%), 7% Asian and only 2% are white British. This reflects the development of HH which has historically supported European migrants facing homelessness and may explain the importance of 'word of mouth' as a networking mechanism helping to signpost people from the same background and language to the support provision offered by HH.

Table 1: Length of time spent by each client in the UK before admission to HH

Length of time in the UK before admission to HH	**N**	**%**
less than one month	14	15.6
1 month - 3 months	9	10.0
3 months - 6 months	16	17.8
6 months - 12 months	9	10.0
more than 12 months	42	46.7
Total	90	100.0

Almost half of the clients (47%) had been in the UK for more than one year before they entered HH. About 30% of them suffered from at least one health problem[4] and 11% declared substance misuse. Interestingly, 16% had arrived in the UK less than 30 days before they entered HH which means that they found it difficult to find adequate accommodation and probably lacked social networks of support. Some of these may have been escaping dangerous situations in their own country. However, caution is important in interpreting these results as the size of the sample is very small to generalise to a wider population from any evidence presented here.

[3] This is because church policy does not allow women and men to sleep in the same space.
[4] Back pain, broken leg, depression, diabetes, neurosis, dental problems, sickle cell anaemia, skin problems

4 Methodology

The main research question of this study is as follows:

What is the social value of Highway House?

The methodology used to assess the social value of HH is called Social Return on Investment (SROI). The SROI approach was used to calculate the financial benefits to society of HH over a period of five years and is usually expressed in financial terms. Other researchers have adopted this method in measuring the impact of homeless projects (Bagley, 2012; Laylor, 2012). Unlike cost-benefit analysis, SROI is underpinned by strong stakeholder involvement and emphasizes sustainability as long term views of outcomes are considered (Vardakoulias, 2013).

We upheld the following principles that are contained in SROI guidelines (Cupitt, 2009):

- Stakeholders were involved,
- Transparency,
- Valuation of only important outcomes
- Verification of results,
- Adherence to strict inclusion criteria,
- Understanding changes,
- Avoiding overestimation of output.

This approach was underpinned by the use of primary and secondary data. We combined these data with published information about full economic costs of a wide range of activities and professions to provide the final assessment of SROI for HH.

4.1 Primary Data Collection

Primary data were collected from HH clients between November 2014 and February 2015. HH clients were asked questions about their experience of the intervention, service use both within and outside HH, and demographic profile (see appendix 10.3)

We conducted 30 interviews with HH clients, all of these except one were carried out face to face. In order to collect more complete information about the impact of HH, we interviewed two groups: the first made up of residents and the second made up of ex-residents had left the shelter and were living independently. This provided us with considerable information on the impact of HH. Due to ethical reasons and resource constraints, we were unable to contact the participants ourselves at random. Therefore, most of the participants were identified and recruited by the HH director, Pastor Alex Gyasi. Data about service use was also collected through an interview with Pastor Alex Gyasi.

All interviews were digitally recorded and signed consent was taken from each respondent. For a proportion of respondents interviewed (n=15), we also collected information about a range of outcomes before and after support received through HH. We did this by using an outcome star tool (MacKeith, 2011) and asked respondents about the following elements of life: social networks, drug and alcohol misuse, managing money, physical health, as well as emotional and mental health. It is widely accepted that collecting retrospective data can be challenging because respondents are likely to have difficulties when attempting to accurately remember details of their past experiences (Berney et al, 2003). Thus, to reduce recall bias, we collected information from the remaining respondents by using more open ended questions which enabled

the interview process to be more fluid and explore some areas of interest in more depth. We also made use of translators who often had also experienced homelessness. This was an important strategy as translators could appreciate the depth of respondents' experience.

4.2 Secondary Data

Secondary data were also collected including: (i) attendance rates of all people staying at HH each night for 10 months (Jan-Oct 2013); (ii) the demographic profile of each client from admission forms, and (iii) number and type of referrals from referral letters for 2013/14. This provided us with a better understanding of the make-up of the overall client population. The number and type of referral forms were useful in understanding the variety of organisations referring to HH, and the organisations HH referred clients to during their stay in order to support them in specific areas.

5 SROI stage 2: Mapping Inputs, Outputs, Outcomes, Indicators and Financial Proxies

5.1 Introduction

In order to assess the SROI of HH, inputs, outputs, outcomes, indicators and financial proxies must be calculated. These can be defined as follows (Boyd, 2004):

• Inputs - resources invested in your activity

• Outputs - the direct and tangible products from the activity (i.e. people trained, trees planted, products sold)

• Outcomes - changes to people resulting from the activity (i.e. a new job, increased income, improved stability in life)

• Impact = Outcomes with an estimate of what would have happened anyway deducted (deadweight), attrition, displacement and drop-off (see 5.1-5.4)

5.2 Inputs

The range of inputs (fixed and variable costs) sustained by HH in the year 2014 were £94,910. The breakdown is available upon request.

A large number of organisations referred homeless people to HH. This provided important evidence and direction for the SROI assessment. However, we were only able to analyse referrals to HH for the year 2013/2014, thus the information on referrals used here is likely to underestimate the actual number of referrals HH experiences. A variety of hospitals from across London referred people suffering with a variety of acute health conditions and on the whole asked HH to support patients through recovery after surgery. Other referring organisations included mental health services, other homeless support organisations, ethnic minority specific organisations, and churches (appendix 10.4).

5.3 Outputs

HH has been found to influence the following outputs within one year:

- Increased knowledge of functional English among all non-English residents.
- 53% increase in employment rate among all residents.
- An increase in volunteering rate and willingness to volunteer.
- 100% reduction in drug and alcohol use.
- Provision of a safe abode.

5.3.1 Training in Functional English

Most of HH clients interviewed were not able to communicate in English, thus training in functional English was instrumental to enable them to find employment (Nawyn et al., 2012), accommodation and seek other forms of support. In response to this need, HH organised training in functional English for its residents at least twice every year. This training run for four months and usually consisted of two sessions every week, each session lasting for a minimum of three hours.

2 courses (4 months each)	=	8 months

8 months	=	24 weeks
24 weeks (2 sessions per week)	=	48 sessions
48 sessions (3hours per session)	=	144 hours

Primary data collection revealed that seven residents out of the 30 interviewed attended training in functional English. A financial proxy from published sources (LLE, 2015) was used to assess the cost averted from training in functional English.

144 hours	=	£20*144
	=	£2,880.00
7 residents	=	£20,160.00 (total cost averted)

Seven residents reported to have taken courses in functional English, the total cost averted form training in functional English will be equivalent to **£20,160.00** for one year.

5.3.2 Employment

Various studies have demonstrated the negative effect of unemployment on people's health and wellbeing (McKee-Ryan et al., 2005; Mohr and Otto, 2011; Paul and Moser, 2006). As well as creating a state of financial instability which increases stress levels (Webb et al., 2013; Raphael et al., 2005), unemployment has also a direct effect on living conditions and physical health (Benzeval et al., 2014). The HH assisted its residents with advice on employment which included (but is not limited to) providing a contact address which is usually required to secure paid employment, provision of suitable clothing for interviews and tools for work, assisting with job searches, writing support and reviewing resident's curriculum vitae.

By helping service users into employment, HH contributed to:

1. Reducing the burden of certain unemployment related benefits paid by the government
2. Increasing taxes paid into government revenue resulting from additional spending which will incur a higher direct or excise tax.

Reduced burden of unemployment benefits: on average, HH residents were aged 25 years or over. Thus, the financial proxy allocated to this indicator was the Job Seeker's Allowance (for 25+) which is valued at £3,807.2 per year, i.e.£73.1 per week for 52 weeks (gov.uk, 2015).

1 week	=	£73.1
1 year (52 weeks)	=	£3,807.20 per person

Primary data collection showed that 16 residents secured employment while at HH.

1 resident	=	£3,807.20
16 residents	=	£60,915.20 per annum

Hence, by assisting 53% of its residents (16 out of 30) into employment, HH successfully reduced the burden of unemployment on DWP by **£60,915.20** per annum.

Tax generated from employment: The cumulative income of all HH residents who found employed (n=16) while at staying at HH was approximately £208,164.00 per annum, generating an estimated annual tax of **£31,309.20** per annum.

However, some caution is important in interpreting these data as they assume that unemployed individuals have access to at least one benefit. This may have not been the case for some of HH clients who did not have access to any welfare support during the period of data collection. This calculation also assumes that all employed while staying at HH will remain in employment for at least one year (this milestone was achieved by over 50% of the respondents).

5.3.3 Volunteering

Volunteering provides a platform for individuals to enhance their skills and can also help in improving mental health by providing a platform that encourages social interactions (Surujlal and Dhurup, 2008). HH encourages provides several volunteering opportunities to residents and non-residents both in and out of the shelter.

The financial value of helping people into volunteering was derived by allocating the equivalent cost of employing workers in these roles. Table 3 shows a list of activities and their corresponding financial value.

Table 3: financial contribution of volunteering by activity

Activity	Number of volunteers per day	Hours volunteered daily	Averted hourly wage (ONS, 2014)	Financial proxy (daily)
cook	2	5 hours	£7.98	£79.80
Night warden	1	10 hours	£9.34	£93.4
Cleaner	1	3 hours	£7.49	£22.47
				£195.67

1 day	=	£195.67
1 week (7 days)	=	£1,369.69
1 year (52 weeks)	=	£71,223.88

Hence the financial value of volunteering is **£71,223.88**

5.3.4 Having a Safe Place to Stay

The primary outcome of the HH was the provision of a safe place for homeless individuals to stay. The opportunity cost of staying in HH was:

- Having no fixed abode (which can be argued to have an impact on mental and physical health as discussed later).
- Living in a temporary accommodation provided by the council.

In order to establish the minimum financial impact, the cost of the council providing a bed and breakfast or hostel as a temporary housing option was used as the lower limit for financial proxy. Within the Borough of Haringey, this is valued at about £10 per night (home.co.uk). Therefore, the cost of providing temporary housing for an individual was estimated to be £3,640.00 per annum.

1 day	=	£10.00
1 week (7 days)	=	£70.00
1 year (52 weeks)	=	£3,640.00

The cost averted for housing 30 residents can be estimated at **£109,200.00**

5.3.5 Alcohol and Drug Use

A number of studies have shown that homeless people tend to make disproportionate greater use of alcohol and drug. Several researchers have found positive association between alcohol misuse and poor mental health statuses (Balsa et al, 2009). Alcohol related cost to the NHS is usually about £3.5bn per annum, excluding the health cost of alcohol related crimes (ONS, 2014).

Calculating the financial value of reduced alcohol intake was based on ODPM's (2005) assumption that the treatment cost for alcohol problems amounts to 20 hours of counselling. On this basis and considering that the cost per consultation is estimated at £56 per consultation (Curtis, 2014), the financial cost of reducing alcohol intake of four HH users will can be valued at **£4,480.** However, this figure does not take into account the fact that alcohol and/or drug misuse may have been the cause of homelessness rather than the effect of homelessness. This particular point is discussed in the sensitivity analysis (sec. 7.3).

5.4 Outcomes

Primary data collection showed that HH was able to achieve the following benefits for the majority of its clients (for a summary see appendix 10.1):

- Effectively enhance the quality of life of its residents by improving their mental and physical health
- Reduce offending rate among HH residents, thus, averting funds that would have been spent to manage criminal activities in the borough
- Improve client's self-esteem
- Provide an environment to build social capital
- Avert spending from several government revenues

5.4.1 Improved Mental Health of HH residents

At the time of data collection, HH provided much needed emotional and mental support to residents in many forms including the provision of an environment which encouraged social interaction and development of social capital which, according to some studies, appears to lead to considerable improvements in mental wellbeing (Dorsey, S. and Forehand, R. 2003). Furthermore, HH offered free counselling sessions to residents. As reported by respondents, counselling led to positive emotional

and mental wellbeing outcomes. In order to allocate a financial value, the cost of a session of mental health counselling per hour was selected as the desired proxy.

Participants' change in mental wellbeing was used as a proxy in allocating magnitude of the effect of counselling sessions. Residents were allocated to 4 different classes based on their level of change.

Class 1	0 change reported on outcome star	17 residents
Class 2	Between 1 and 3 units	2 residents
Class 3	Between 4 and 6 units	8 residents
Class 4	Above 6 units of change	3 residents

Class 1 was allocated a total of 4 hours as every resident of HH gets 4 hours of counselling upon entry. Class 2, 3 and 4 were allocated 10, 15 and 30 hours respectively based on the assumption that the more counselling residents received, the better their mental health. Furthermore, people with poorer mental wellbeing have an increased need for counselling.

Class 1	17 residents	68 hours
Class 2	2 residents	20 hours
Class 3	8 residents	120 hours
Class 4	3 residents	90 hours

The financial cost of an hour of counselling is valued at £50 (Curtis, 2014 pg.51). Therefore, the total cost averted within a year is **£14,900**

Total hours spent counselling	=	68+20+120+90
	=	298
Financial value (298 hours* £50)	=	£14,900

Mental Health Service Reallocation Away from HH Service Users

The allocated proxy to this output is the total local authority expenditure (minus capital costs relating to land and buildings) on care homes for people with mental health problems valued at £941 per resident in a week (Curtis, 2014).

As three HH users reported considerable mental health problems requiring class 4 counselling support, HH averted **£73,398** (£941*3*26wks) from mental health services as this figure would have been spent in supporting them in local authority care homes in a year. This was calculated for six months only, to take into account of the average length of stay of this group of three respondents.

5.4.2 Physical Health

Physical health of homeless people is usually worse than their settled counterparts (Homeless Link, 2010). They are less likely to be registered with a GP, typically owning to their residential status and their inability to provide a proof of address to complete GP registration. In order to access health services, the majority of homeless individuals make use of A&E walk-in clinics. Lack of registration with GPs prevents many homeless people from accessing health support early on, leading to late A&E admission when their health has deteriorated significantly and reached crisis point. This inappropriate

use of NHS services has a negative effect on both the health of homeless people and government revenue (Crisis, 2002) as visits to A&E are significantly more expensive. HH was able to address this problem by providing its clients with an address as well as support to register with a local GP. However, the cost of GP visits was discounted from A&E access as it is not provided directly by HH and therefore should not form part of its impact.

The cost of A&E services is usually about £106 (Curtis, 2014; pg. 91) which yields an estimated value of £318 per homeless person, considering that the frequency of hospital visits among homeless population is three visits per year (Mpath, 2014). For a sample size of 30, the value can be estimated at £9,540.

Eight users reported to have visited the GP once while they were at HH. The financial burden of this visit is estimated to be £536 (£67*8 GP consultations) (Curtis, 2014). Hence, the financial value of HH on physical health for a year was estimated to be **£9,004** (£9,540-£536). This cost is likely to underestimate the total cost to the NHS, as the NHS would have to pay for hospital admission and stay. However, data on the frequency of hospital admissions for homeless people is not available, thus we could not assess this part of the cost to the NHS.

Nutritionist (physical health)

As part of a strategy to improve physical health and wellbeing of residents, the HH provided free nutritional counselling to its residents. The average number of attendees was seven per session. The HH typically provided a three hour session once per week.

1 year	=	52 weeks
52 weeks (1 sessions per week)	=	52 sessions
52 sessions (3hours per session)	=	156 hours

At the rate of £33 per hour (PSSRU, 2014, pg. 238)

156 hours	=	£33*156
	=	£5,148

With an average of 7 residents are usually present for the training, the cost averted can be estimated as **£36,036.00**

Nurse Visits (physical health)

Typically, homeless people have a higher prevalence rate of disease when compared to the general population (Homeless Link, 2010). Nurses, recruited initially through the church, volunteered their services at HH by conducting health checks and free consultations for HH residents. Within a year, a total of 40 hours was spent by all nurses volunteering in the shelter. The objective of this screening was to reduce the incidence of cardiovascular disease among residents by detecting health issues before they become more acute. Oxford Economics (2011) estimates that society saves £1,673 for every person who is screened yearly. However, this is likely to be an underestimate as the screening done for HH residents also includes tuberculosis screening.

Accounting for all 30 residents, it has been estimated that HH saves **£50,190.00** per annum by providing free health checks to its residents

5.4.3 Offending Rate

By providing some basic amenities, HH unarguably reduced the involvement of its clients in crime. Four users reported a decline in criminal activities during the interview process conducted. This decline in criminality was allocated a financial proxy equivalent to the average cost of theft (£844 per annum; Dubourg *et al*., 2005). The total cost of crime averted was estimated to be **£3,538.31** per year.

Assumption

Point changes along the outcome star are of similar weight

6 SROI stage 3: Establishing Impact

In evaluating a SROI it is important to consider the potential effect of a number of elements including deadweight, displacement, attribution and drop-offs. Considering these elements helps to provide a more realistic picture and avoid overestimation of HH impact.

6.1 Deadweight

An important step towards an appropriate SROI evaluation is the assessment of deadweight. Deadweight measures what would have happened without the existence of HH. Ideally, this would be calculated by comparing the impact of HH on its users with other homeless people who have not received any support from any service. However, given the resources available and ethical issues involved, it is very difficult to conduct this type of study. We have made a range of assumptions about deadweight for each outcome considered which can be found in table 4.

Table 4: Deadweight estimates and assumptions

	OUTCOMES	DEADWEIGHT	ESTIMATES AND ASSUMPTIONS
Training in functional English	Enhanced functional English	30%	40% as residents are likely to learn functional English by conversing regularly with other residents

Money management	Improved knowledge on managing money	5%	A homeless survey (Pleace et al, 2008) reports that about 5% of those who identified has homeless are able to manage their money.
Having a safe accommodation stay	Reduced cost of providing temporary accommodation.	0%	If users had been provided temporary accommodation, they would not have been in HH. I.e. without the HH all surveyed participants would have ended up on the street or worse (as reported by participants).
Volunteering	Increased interest among HH residents to volunteer	13%	13% of homeless people are in volunteering roles. Thus, it's assumed that 13% of this outcome would have occurred without HH.
Employment	Reduced burden of unemployment benefits. Increase in revenue from tax.	52%	The results of a survey by Singh (2005) shows that 52% of homeless people do not claim Job Seekers allowance(48% claim jsa).
	Increase in revenue from tax.	15%	15% of the homeless population are employed (Crane et al, 2003).
Physical health	Improved number of GP consultations per year	74% (*)	26% of homeless people experience difficulty in registering for a GP. Therefore it is assumed that about 74% of HH users will have registered with the GP without the help of HH
	Reduced strain on A&E (averted visits to A&E yearly)	21%	79% of homeless population visits A&E (Crisis 2002). Hence, it is assumed that 21% of HH users would have not visited A&E if they were not in HH.
	Improved feeding and dietary pattern	26.5%	26.5% of the population consume the recommended daily requirements of fruits and vegetable (ONS, 2015; http://www.hscic.gov.uk/catalogue/PUB16988/obes-phys-acti-diet-eng-2015.pdf).
	Free health checks and tuberculosis screening by nurses	31%	The uptake rate of NHS Health checks among the general public is 31%. However, it is assumed that people with no fixed abode would have a lower percentage.
Mental Health	Reduced expenditure on care homes for people with mental health problems.	0%	It is assumed that if members of HH had found assistance in care homes, they would not have been in HH. Therefore, HH would have been the alternative.
	General improvement in mental wellbeing.	33%	33% as may be in other temp providers and still accessible to service provision, although these improvements may not be accessible if couch surfing or if no fixed abode.
Alcohol and drug use	Efficient management of previous alcohol problems.	27%	A general survey of 2500 homeless people report that 27% of homeless people are recovering from alcohol problems (Homeless Links, 2014)

	Reduced incidence of drug use	0%	No identified drug user/ past user.
Offending rate	Reduced crime rate	0%	http://www.met.police.uk/crimefigures/# quotes a 1.4% increase in crime rate between Jan 2013 (1844 crimes) and Jan 2014 (1870 crimes).

(*) this outcome has been discounted from the calculation as it had been discounted in the initial calculation.

6.2 Attribution

Attribution is an estimate of the proportion of the outcome caused by external influences (organisations or people). The higher the attribution, the larger the portion of the impact that cannot be allocated to HH. We partly estimated attribution by asking respondents information about their use of other services while staying at HH, therefore providing us with an estimate of the impact of HH versus the impact of other services. This showed that most HH clients had not used other services for sleeping arrangements, although they did make use of other services during the day. As HH provided shelter, breakfast, dinner and cleaning facilities, as well as other support services, the attribution of other support services is likely to be mild. We have assessed these for each outcome in table 5.

Table 5: Attribution estimates and assumptions

	OUTCOMES	ATTRIBUTION	ESTIMATES AND ASSUMPTIONS
Training in functional English	Enhanced functional English	0%	No attribution as the training was conducted by HH staff and residents.
Money management	Improved knowledge on managing money	0%	No attribution as the training course was conducted by HH staff.
Having a safe accommodation stay	Reduced cost of providing temporary accommodation.	0%	0% as the cost of accommodating HH residents is funded solely by HH management.
Volunteering	Increased interest among HH residents to volunteer	0%	The HH staffs are responsible for motivating residents to engage in voluntary activities.
Employment	Reduced burden of unemployment benefits. Increase in revenue from tax.	15%	The HH receives support from external organisations regarding advice on benefits. However, HH staffs coordinate these sessions.

	Increase in revenue from tax.	25%	The outcome can be attributed, to some extent, other external organisations such as the employers.
Physical health	Increased number of GP consultations per year	15% (*)	Although HH is responsible for registering residents with a GP, some of the impact might result from increase in Health awareness among residents.
	Reduced strain on A&E (averted visits to A&E yearly)	0%	The reduction among HH residents has been caused by work of HH staff and nurses
	Improved feeding and dietary pattern	25%	Although the cost of the nutritionist has been considered during the analysis, other factors might contribute to this improvement (e.g availability of healthy alternatives).
	Free health checks and tuberculosis screening by nurses	25%	Other factors outside the HH are likely to influence the physical health and wellbeing of residents.
Mental Health	Reduced expenditure on care homes for people with mental health problems.	0%	No attribution as provision of safe abode for these groups was made available by the HH.
	General improvement in mental wellbeing.	25%	25% as referrals were made from health centres and Hospitals
Alcohol and drug use	Efficient management of previous alcohol problems.	25%	25% of the outcome can be attributed to HAGA alcohol advisory group.
	Reduced incidence of drug misuse	0%	No identified drug user/ past drug user.
Offending rate	Reduced crime rate	50%	Some of the impact of HH on offending rate among residents can be allocated to the Haringey police.

(*) this outcome has been discounted from the calculation as it had been discounted in the initial calculation.

6.3 Displacement

Displacement is a measure of how much of an outcome displaces a similar outcome produced by another service (e.g. other homeless shelters in the area, health support services). As homeless services are scarce, their support does not lead to any displacement effect. Typically, a person facing homelessness does not have more than one choice in terms of support (Matyres, 2013; Bagley, 2012; Lawlor, 2012). We could not find any displacement effect through our primary research collection. Moreover, as shown in appendix 10.4, many organisations including hospitals, other NHS services, homeless shelters, ethnic based organisations have referred homeless people to HH. This shows that HH supports one of the most vulnerable groups within the homeless population.

6.4 Duration and Drop off

The proportion of the outcome discounted as drop-off is determined by the duration of the outcome. Ideally, the magnitude of the outcome is likely to reduce over time. To account for this, a fixed percentage is deducted from the remaining outcome at the end of each year. Drop off is usually discounted for outcomes that last for more than a year.

Three outcome groups have been identified (Table 6):

- Short-term outcomes
- Medium-term outcomes (consisting of outcomes resulting from behavioural changes)
- Long-term outcomes (consisting majorly of outcomes based on skills learnt)

Table 6: Short and long term outcomes

Short term outcomes - 1 year	Medium term outcomes - 3 years (% drop off)	Long term outcome - 5 years (% drop off)
Improved health status achieved by providing free health checks and tuberculosis screening by nurses	General improvement in mental wellbeing (20%)	Reduced crime rate
Increased interest among HH residents to volunteer	Reduced incidence of drug misuse (20%)	Improved knowledge on managing money (25%)
Reduced cost of providing temporary accommodation (average length of stay in HH =58 months)	Efficient management of previous alcohol problems (20%)	Enhanced functional English
Reduced expenditure on care homes for people with mental health problems		Improved feeding and dietary pattern (75%)

		Reduced strain on A&E (averted visits to A&E yearly) 20%
		Increased number of GP consultations per year (25%)
		Increase in revenue from tax. (15% haygroup, 2014 - http://atrium.haygroup.com/uk/your-challenges/misc.aspx?id=3878)
		Reduced burden of unemployment benefits. 15% hay group, 2014

7 SROI stage 4: Calculating the SROI

7.1 Establishing the Present Value (PV)

During SROI calculation, the 'time value of money' is usually recognised. This concept is based on the idea that people prefer to receive money today as future payments are uncertain and alternative investment may be more convenient (Cupitt, 2009). In order to account for this, Table 7 shows the Present Value (PV) of estimated financial benefits has been discounted over the period of five years using a basic rate (r) of 3.5% (Treasury, 2003).

Table 7: Value of impact over five years

Year	1	2	3	4	5
Impact	£357,297.71	£70,661.91	£58,421.13	£45,703.66	£40,454.53
Present value =	Impact in year $1/(1+r)$	Impact in year $2/(1+r)^2$	Impact in year $3/(1+r)^3$	Impact in year $4/(1+r)^4$	Impact in year $5/(1+r)^5$
Present value for each year	£345,215.18	£65,963.65	£52,692.52	£39,828.10	£34,061.62

The Total Present Value of HH is £537,761.07 (sum of the values in the third row, table 7).

7.2 Calculating the Social Return on Investment (SROI) ratio

The SROI Ratio makes a comparison between the invested inputs and the financial value of the proposed outcome. The former was calculated as £94,910.04 while the latter was obtained as £537,761.07.

Thus, the net SROI	=	£537,761.07	:	£94,910.04
	=	5.67	:	1

Thus, if we include the assumptions made in relation to deadweight, attrition and drop-offs, we can conclude that for every £1 invested into the HH, an additional £5.67 worth of social impact over a period of 5 years is generated. However, this ratio can vary substantially depending on the range of assumptions about deadweight, displacements, attribution, and drop off we presented above (see sec. 6.1 to 6.4). As a result, we conducted a sensitivity analysis which produces a range of possible SROI ratios within which the SROI of HH is most likely to fall.

7.3 Sensitivity Analysis

The sensitivity analysis explores how SROI would change when assumptions about the impact of HH are changed. It produces a range within which it is realistic to expect SROI to fall into. These variations include changes in financial quantity of outcomes, magnitude of deadweight, attribution and drop-off. We considered the following scenarios:

1. Lowering attribution: we only identified some external organisations or people who contributed to the outcome of the surveyed HH clients. However, it is reasonable to expect that some residents may have attended a form of social gathering (like churches, visiting family) and may have benefitted from these outings in ways that have not been considered during the SROI calculation. In order to account for this, an additional 10% and 20% of all HH outcomes are attributed to outside (unaccounted) factors. This changes the SROI ratio to 5.03 : 1 and 4.38 : 1 respectively.
2. Increasing deadweight: the assessment of deadweight may have been underestimated to due to limited empirical data available on health outcomes of homeless people in Haringey. As a result, deadweight is increased by 10%. This generates a new ratio of 4.92 : 1.
3. Lowering drop-offs: the estimated duration of outcomes may have been underestimated (table 6). For instance, some skills once learnt cannot be unlearnt, therefore their duration is well beyond the initial stated period of five years. In order to account for this, all the drop off outcomes in table 6 have lowered by 10%. This results in a ratio of 5.18 : 1.

If we consider all these scenarios, the SROI ratio does not drop below £4 for every £1 invested. This could be considered as the minimum SROI ratio for HH.

7.4 Payback Period

The Payback period is the point at which the financial value of the social outcomes starts to exceed invested input (Table 8). It therefore describes how long it will take for the investment to be paid off. The payback period for the SROI has been calculated as 10 months.

Table 8: Payback period

Investment	£94,910.04

Average Annual Impact	£114,507.79
Annual impact/12	£9,542.32
Payback period (months)= Investment/ (Annual impact/12)	≈10 months

Case study 1: Mr Petre

Brief History: Mr Petre (fictional name) is one of at least 14 clients who were referred to HH from a London based hospital. He stayed at the shelter for 12 months where he was provided with necessary support and care to recover from his life threatening illness. When he was admitted to the shelter, he had just gone through an extremely debilitating health condition which incapacitated his mobility and self-care. He was described to have been both depressed and in severe pain at the time of admission. HH helped him to cope with his condition by providing emotional, financial and physical support throughout his recovery.

Outcome: Mr Petre is currently in work and lives an independent life. Below is a brief analysis of the benefit and costs of housing Mr Petre for a year.

Cost of housing Mr Petre in HH

Item	Quantity	Unit price	Duration	Price
Feeding	3 meals per day	£1 per meal	365 days	£1,095.00
Housing	B&B for 1 year	£10 per day (homes.co.uk)	365 days	£3,650.00
Toiletries and bedding	Estimate given by HH management		365 days	£258.00
Total				**£5,003.00**

The cost of housing Mr Petre at HH was estimated at £5,003.00, as in the break-down above.

Benefits derived from Housing Mr Petre at HH: While staying at the shelter, Mr Petre was provided with social, mental and physical care. The cost averted from these are as follows:

Averted cost of Hospital Admissions: Several nurses who were volunteering at HH attended to Mr Petre's daily needs during his recovery. The nurse's responsibilities included changing his bandages, administering medication, performing health checks and providing social care. The volunteer nurses were reported to have visited a minimum of 2 times per week throughout the duration of Mr Petre's stay. By the combined effort of the volunteer nurses and the shelter, HH averted the cost of hospital admission for a year which would have been incurred if Mr Petre had stayed in the hospital.

Proxy: cost of hospital admission for those who need a period of recuperation following an illness.

1 year impact= £34,985 (Curtis, 2014)

Counselling: Mr Petre was also provided with counselling while at HH. He received counselling on average 3 times a week for the first three weeks, followed by once a week thereafter. Each session would typically last for an average of an hour (giving a total of 96 hours). By providing these counselling services, HH contributed to improving Mr Petre's mental wellbeing substantially. The cost of an hour of mental health counselling has been allocated as a proxy to this impact (£50 ph-Curtis, 2014). Thus, the cost of mental health counselling provided by HH is estimated at £4,800.

Further Benefits: Another benefit for Mr Petre was improved social networks achieved through the shelter's setting and the consistent opportunity to converse with other residents. Finally, Mr Petre gained employment as a result of employment related training provided by the HH management during his stay at the shelter. The social benefit derived from investing £5,003 into HH, with respect to Mr Petre's case, is £39,785 (£34,985+£4,800). During his stay in HH, every £1 spent on Mr Petre averted £8 worth of social responsibility, which would have been incurred by the society had it not been for HH (i.e. SROI - 8:1)

8 Conclusions

This study found that the Social Return on Investment for Highway House is £1 : £5. Thus, for every £1 of investment in Highway House, £5 is produced in the form of public value. We carefully considered each outcome variable used in this analysis, and followed established guidelines published by the Cabinet Office (Nicholls et al, 2008) which include analysis of deadweight, attrition, displacement, and drop-offs. Throughout this analysis, we have deliberately chosen the lowest financial proxy we could find in order to avoid overestimating the financial impact of HH. We also produced a sensitivity analysis to consider different scenarios. This allowed us to detect major potential changes in the initial assumptions, and to reach the conclusion that a **minimum** SROI ratio for HH is in fact £1 : £4.

Although the presentation of these numbers offer us an important tool to aid policy related decision making, it is also important to remember the human dimension of the support offered by HH and to reconnect the reader with the human struggle some homeless people face (see case study of Mr Petre in the previous page). In such extreme cases, the work of HH not only saves people's lives, but also saves considerable resources to the public purse, and therefore pushes the SROI ratio up to £1 : £8. It is also important to recognise that beyond these numbers, HH does provide life changing support for homeless people who have not received help through more established statutory support organisations. In this sense, HH caters for one the most marginalised groups within the homeless population, which is an important fact to remember.

As policy makers need to choose between many options, it is useful and important for them to able to put the SROI ratio we have calculated into context. Thus, how does the SROI for HH compare with the SROI of other homeless support projects? We did not have the resources and the time to conduct a systematic review of all the SROI of homeless projects published (see sec 12 for additional references). However, we reviewed seven SROI studies to explore the range of SROI assessments. We found wide variability amongst these (see table 9) with ratios ranging from £1 : £3.92 to £1 : £11. Part of this variability may be due to the fact that the SROI ratio tends to be much larger when more clients are assisted with the same resource input. Thus, studies that include a greater number of people tend to show a greater SROI ratio. For instance, *Stay Well at Home* (which showed one of the highest SROI ratios) covered 319 people in their evaluation.

As HH serves relatively few people (n=30) and could increase its scale substantially, its SROI ratio and thus social value could increase with it. Any investment in HH that may help it to grow and provide a service to a larger number of people will yield a larger SROI ratio and return to the public.

Table 9: SROI evaluating homeless projects

Study	Year	SROI assessment
Fab Pad (Durie, 2007)	2007	For every £1 invested by the government in support, £8.38 of social return was derived in reduced health care costs, reduced welfare benefits expenditure and reduced costs of repeat homelessness.
Crisis Skylight (Oxford Economics, 2009)	2009	£1 invested in Crisis' services for homeless people saves society an average of £3.92.
Leeds survivor led crisis service (Bagley (2012)	2012	£5.17 worth of benefit is derived per £1 invested
Emmaus UK (Lawlor, 2012)	2012	ratio of £11 for every £1 invested
Action on Addiction (Interface, 2014)	2014	£1 Invested will generate a return of £2.76
Stay well at home (ACK, 2012)	2012	£1 Invested will generate a return of £11
Porchlight (Matyres, 2013)	2013	£1 invested in Porchlight will likely produce £5.95 of social value.

9 Limitations

Despite our attempts to conduct the best possible assessment of SROI, it is important to highlight the following limitations:

- We were unable to select participants at random. As a result, the SROI assessment may have been partly overestimated. However, we put in place other strategies to minimise the effect of this bias such as using low financial proxies, and carefully accounting for deadweight, attrition, displacement and drop-offs.
- The size of the sample was small, thus it was difficult to estimate the level of potential outcomes for a wider population of shelter users.
- We could only input data on service users' attendance for the year 2013 and had to generalise attendance rates from this year.
- We assumed that point changes along the outcome star are of similar weight. However, one may argue that going from 1 to 5 is much more difficult than going from 5 to 10. Further research needs to be undertaken and other methods may be chosen in future to assess the appropriate extent of health change.

10 Appendices

10.1 Outcomes

Table showing the outcomes, indicators and financial proxies used during calculation of SROI ratio.

	OUTCOMES	INDICATORS	QTY	FINANCIAL PROXY	SOURCE	VALUE (PA)	ASSUMPTIONS
HH RESIDENT							
Training in functional English	Enhanced functional English	Number of HH users attending training in functional English	7	Cost of an hour section of functional English		£10,080.00	Actual value
Money management	Improved money management skills	Number of users enrolled in money management training while at HH.	5	Cost per training session in money management for a year	MATREC, 2013	£7,080.00	Each successful completion of training in money management is equivalent to one year training of 2 sessions per month in MATREC
Expulsion from HH			5	cost of renting bread and breakfast in Haringey for 6 months			
HARINGEY COUNCIL							
Having a safe accommodation stay	Reduced cost of providing temporary accommodation.	Average number of users in a year	30	Cost of bed and breakfast	Home.co.uk	£109,200.00	Actual value
UK GOVERNMENT TREASURY							

Volunteering	Improved wellbeing of residents	Number of non-residents volunteering as cooks, night wardens and cleaners	4	Average hourly pay per occupation	ONS, 2014	£71,223.88	Actual value
Employment	Reduced burden of unemployment benefits.	Number of HH users in employment not receiving Job Seekers Allowance	16	Job seekers allowance for individuals above 25 years of age.	https://www.gov.uk/jobseekers-allowance/what-youll-get	£60,915.20	Unemployed individuals have access to at least one benefit All employed HH users will stay employed for a duration of one year (a milestone which has been achieved by over 50% employed HH users surveyed).
	Increase in revenue from tax.	Number of HH users earning above £20,600	9	Tax bands UK workers	Semi-structured interview of HH users	£31,309.20	Actual value
NHS							
Physical health	Reduced strain on A&E	Averted visits to A&E per year	27	Unit cost of hospital visits (without admission)	PSSRU, 2011	£9,540.00	Homeless people make use of A&E 3 times per year (Mpath, 2014)
		Number of GP consultations per year	8	Unit cost of GP consultations	Curtis, 2014	-£536.00	Actual value
	Improved feeding and dietary pattern	Number of healthy eating sessions delivered by a nutritionist	52 hours	Unit cost of a dietician per hour	Curtis, 2014	£36,036	Actual Value
	Free health checks and tuberculosis screening by nurses	Average number of residents being screened annually	30	Cost saved from screening	Oxford Economics, 2011	£50,190.00	Actual value
Mental Health	Reduced expenditure on care homes for people	Number of users reporting mental health problems	3	local authority expenditure (minus capital costs relating to land and buildings)	Curtis, 2014	£73,398.00	Actual value

	with mental health problems.			on care homes for people with mental health problems			
	Improvement in mental health	Reported changes in mental health	298 hours	Cost of one hour of counselling	Curtis, 2014	£14,900.00	Actual change
Alcohol and drug use	Efficient management of previous alcohol problems.	Number of HH users reporting reduced intake in alcohol	4	Cost of counselling for 20 hours	Curtis, 2014	£4,480.00	Treatment cost for alcohol problems amounts to 20 hours of counselling (ODPM, 2005).
	Reduced incidence of drug use	Number of HH users reporting reduced drug misuse.	0	Health costs per problem drug user	Home Office, 2000	£0.00	There was no change in drug use because no user identified as a previous drug user.
JUSTICE SYSTEM							
Offending rate	Reduced crime rate	Reported changes in offending rate	23 units	Unit cost of theft and petty crimes	Economic and social costs of crime, 2005	£3,538.31	Point changes along the outcome star are of similar weight

10.2 Impact Map

SROI – THE IMPACT MAP FOR THE ACTIVITIES OF HH																								
Organisation	Highway House (HH)																							
Objectives	Provide a place to sleep for homeless people often newly arrived migrants and provide additional services including signposting services													Time:	2009 to 2015									
Scope	Activity	Max 90 places for homeless people to sleep, 365 days a year, other services, incl. counselling, English classes, employability, drug recovery etc.																						
	Contact/ funding	Funded through Church																						
Stage 1		**Stage 2**				**Stage 3**									**Stage 4**					**Stage 5**				
Stakeholders	**Intended/ Unintended Changes**	**Input**				**Output/ Outcome**									**Deadweight**	**Displacement**	**Attribution**	**Drop Off**	**Impact**	**Calculating SROI- Discount rate (3.5%)**				
		description	**Source**	**Indicator**	**Value (£)**	**description**	**Indicator**	**Source**	**Quantity**	**Duration**	**Financial Proxy**	**Source**	**Value (£)**		**%**	**%**	**%**	**%**		**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
		What was invested?	**Soure of information**	**what was used to measure it?**	**financial value**	**How would you describe the change?**	**How would you measure it?**	**where was the information obtained?**	**How much change was there?**	**How long does it last?**	**What proxy was used to value the change?**	**Where was the sorurce of the financial proxy?**	**What is the financial value of the change?**		**What would have happened without HH?**	**Does it displace other outcomes?**	**Proportion of external contribution**	**Does the outcome drop off in future years?**	**Quantity*financial proxy-deadweight, displacement and attribution**	**after activity**				
HH Management	Providing a safe abode for homeless residents	Fixed Cost	Interview with HH management	Public liability insurance	£94,910.04										0%	0%	0%	0%						
				Rent											0%	0%	0%	0%						
				Business rate											0%	0%	0%	0%						
				Business insurance											0%	0%	0%	0%						
				Service charge											0%	0%	0%	0%						
				Parking											0%	0%	0%	0%						
				Waste											0%	0%	0%	0%						
				Equipment											0%	0%	0%	0%						
				Building maintenance											0%	0%	0%	0%						
				Transportation											0%	0%	0%	0%						
				Administrator											0%	0%	0%	0%						
				Electricity											0%	0%	0%	0%						
				Pest control											0%	0%	0%	0%						
		Variable cost	Interviews with HH management	Beddings											0%	0%	0%	0%						
				Toiletries											0%	0%	0%	0%						
				Clothing											0%	0%	0%	0%						
				Transport											0%	0%	0%	0%						
				Food											0%	0%	0%	0%						
				Gas											0%	0%	0%	0%						
				Telephone/ Internet											0%	0%	0%	0%						
HH Residents	Training in Functional English					Enhanced functional English	Number of HH users attending training in functional English	Cross-sectional survey of HH residents	7 residents	1 year	Cost of an hour section of functional English		£10,080.00		40%	0%	0%	0%	£6,048.00	£6,048.00	£6,048.00	£6,048.00	£6,048.00	£6,048.00
	Training in Money Management					Improved money management skills	Number of users enrolled in money management training while at HH.		5 residents	1 year	Cost per training session in money management for a year	MATREC, 2013	£7,080.00		5%	0%	0%	0%	£6,726.00	£6,726.00	£6,726.00	£6,726.00	£6,726.00	£6,726.00
	Improved social skills					increased friendships, relationships and social networks	Average number of HH residents in a year		34 residents	1 year			Time		0%	0%	0%	0%	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
	Formal qualification					training, qualification	number of people at HH who gained formal qualification		3 residents	1 year			£0.00		0%	0%	0%	0%	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
	Expulsion from HH					Expulsion from HH for repeatedly breaking rules	number of people at HH who were expelled in the given period	Interview with HH management	5 residents	1 year	cost of renting bread and breakfast in Haringey for 6 months	home.co.uk	-£9,000.00		0%	0%	0%	100%	-£9,000.00	-£9,000.00	£0.00	£0.00	£0.00	£0.00
Haringey council	Decline in homeless population					Reduced cost of providing temporary accommodation.	Average number of residents in a year		30 residents	1 year	Cost of bed and breakfast	home.co.uk	£109,200.00		0%	0%	0%	100%	£109,200.00	£109,200.00	£0.00	£0.00	£0.00	£0.00
NHS	Improving Physical health					Reduced strain on A&E	Averted visits to A&E per year	Cross-sectional survey of HH residents	27 visits	1 year	Unit cost of hospital visits (without admission)	PSSRU, 2011	£9,540.00		21%	0%	0%	20%	£7,536.60	£7,536.60	£6,029.28	£4,823.42	£3,858.74	£3,086.99
							Number of GP consultations per year		8 consultations	1 year	Unit cost of GP consultations	PSSRU, 2014	-£536.00		74%	0%	15%	25%	-£118.46	-£118.46	-£88.84	-£66.63	-£49.97	-£37.48
						Improved feeding and dietary pattern	Number of healthy eating sessions delivered by a nutritionist		50 hours	1 year	Unit cost of a dietician per hour	PSSRU, 2014	£36,036.00		27%	0%	25%	75%	£19,864.85	£19,864.85	£4,966.21	£1,241.55	£310.39	£77.60
						Free health checks and tuberculosis screening by nurses	Average number of residents being screened annually		30 residents	1 year	Cost saved from screening	Oxford Economics, 2011	£50,190.00		31%	0%	25%	100%	£25,973.33	£25,973.33	£0.00	£0.00	£0.00	£0.00
	Improving Mental Health					Reduced expenditure on care homes for people with mental health problems.	Number of users reporting mental health problems		3 residents	1 year	local authority expenditure (minus capital costs relating to land and buildings) on care homes for people with mental health problems	PSSRU, 2014	£73,398.00		0%	0%	0%	100%	£73,398.00	£73,398.00	£0.00	£0.00	£0.00	£0.00
						Improvement in mental health	Reported changes in mental health		298 hours	1 year	Cost of one hour of mental health counselling	PSSRU, 2014	£14,900.00		33%	0%	25%	20%	£7,487.25	£7,487.25	£5,989.80	£4,791.84	£0.00	£0.00
	Alcohol and drug use					Efficient management of previous alcohol problems.	Number of HH residents reporting reduced intake in alcohol		4 residents	1 year	Cost of counselling for 20 hours	PSSRU, 2014	£4,480.00		27%	0%	50%	20%	£1,635.20	£1,635.20	£1,308.16	£1,046.53	£0.00	£0.00
						Reduced incidence of drug use	Number of HH residents reporting reduced drug misuse.		None	1 year	Health costs per problem drug user	Home Office, 2000	£0.00		0%	0%	0%	100%	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Justice system	Reduced crime rate					lont-term resource reallocation due to reduced crime/ASB commmitted by HH users	Estimated number of HH users reporting reduced contact with police (Outcome star)	Outcome star	23 units	1 year	Unit cost of theft and petty crimes	Economic and social costs of crime, 2005	£3,538.31		0%	0%	50%	10%	£1,769.16	£1,769.16	£1,592.24	£1,433.02	£1,289.71	£1,160.74
UK Government Treasury	Increased volunteering					sense of self-worth in helping others. This is a particularly vulnerable group	Number of non-residents volunteering as cooks, night wardens and cleaners	Cross-sectional survey of HH residents	4 residents	1 year	Average hourly pay per occupation	ASHE 2014	£71,223.88		13%	0%	0%	100%	£61,964.78	£61,964.78	£0.00	£0.00	£0.00	£0.00
	Reduced unemployment rate					Reduced burden of unemployment benefits	Number of HH users in employment not receiving Job Seekers Allowance		16 residents	1 year	Job seekers allowance for individuals above 25 years of age.	https://www.gov.uk/jobseekers-allowance/what-youll-get	£60,915.20		52%	0%	15%	15%	£24,853.40	£24,853.40	£21,125.39	£17,956.58	£15,263.10	£12,973.63
						long-term tax revenue increase due to HH long-term improvement: employment	Number of HH users earning above £20,600 annually		9 residents	1 year	Actual value	Survey of of HH residents	£31,309.20		15%	0%	25%	15%	£19,959.62	£19,959.62	£16,965.67	£14,420.82	£12,257.70	£10,419.04
TOTAL					£94,910.04														£357,297.71	£357,297.71	£70,661.91	£58,421.13	£45,703.66	£40,454.53

Present value of each year	£345,215.18	£65,963.65	£52,692.52	£39,828.10	£34,061.62
Total Present Value					£537,761.07
Net Present Value (Total Present Value - Total Input)					£442,851.03
SROI (Total Present Value/ Total Input)					£5.67
Net SROI (Net Present Value/ Total Input)					£4.67

Thus, the net Social Return On Investment for every £1 invested in HOH over a 5 year period is £5.67

10.3 Topic Guide (list of questions asked during semi structured interviews

INTRODUCTORY QUESTIONNAIRE

Social Return on Investment of Highway House

Assessing the social impact of organisations which support homeless people

For Interviewer: this questionnaire has three main sections, with a fourth section only for those who have left the Highway House.

1: Participant's story & use of services

2. Changes to health & wellbeing (measuring change from past to present)

3. Demographics

To begin: Have an open discussion with the participant to understand more about their personal experience. This may last for 15-20 minutes and the idea is for you get to know the person's experience, and hopefully that they may open up and feel more familiar with you.

1. PARTICIPANT'S STORY AND USE OF SERVICES

2. When did you come into the service? (must be more than 4 weeks ago)

   Month: ……Year: ……..

3. Did you live in Haringey before becoming homeless?

   Yes / No

4. Did you live in Haringey while you were homeless?

   Yes / No

5. What brought you to the service?

   …….

6. Were you referred by an organisation/some other place, did you come here through word of mouth, or directly from the street?

……

7. What support have you received **from** Highway House?

	Tick as appropriate	**How long (days)**
Functional English		
Help with finding employment (search on computers etc)		
Employment training (DWP)		
Money management		
Basic IT training		
Drug and alcohol misuse		
Psychological counselling		
Others Specify		

8. Are you currently

	Tick as appropriate	**How long (days)**	**Before or while at HH?**
Training			
Formal Education			
Employment			
Volunteering			
Receiving benefits (housing, JSA, income support else) specify			
Others			

9. What support have you received from **external organisations** while staying at HH?

	Reasons for visiting	**How long (days)**
Hospitals		
GPs		

Mental health services		
Housing services		
Drug or alcohol projects		
Other homeless organisations (manna day centre, crisis uk, no second night out)		
Churches		
Welfare benefits (e.g. income, housing, JSA etc)		
Training (education)		
others		

10. KEY CHANGES IN PARTICIPANT'S HEALTH & WELL-BEING

NOTE: You do not need to write the discussions from this section down, simply record it.

1. Looking at changes to people since joining Highway House:

    1. What has **changed in your life** since coming to Highway House? Examples?
        - *What happened first? Then what happened?*
        - *And what did that change allow you to do afterward?*

    2. NOTE: Probe for changes in relation to each of the following:

        - Social networks and relationships
        - Drug & alcohol misuse
        - Physical health
        - Emotional and mental health
        - Offending

2. Unintended: Were there any unexpected changes – any surprises?

3. Negative: Were all the changes positive? Were there any negative changes?

4. How do you know that the changes have happened? What could you show us to **prove** that these changes happened? In your opinion, how should we **measure** those changes?

5. What are these changes **worth to you**? Can you compare these changes to other things just as important to you?

6. What might have happened had you not been able to coming to Highway House?

7. What additional support have you made use of? Examples?

8. Are there other people that may have experienced changes because of Highway House?

9. Was there any additional expense or action you had to take to make the most of Highway House?

10. Overall, have your expectations been met by Highway House? If you feel there have not been changes or that your expectations have not been met, have you any suggestions of what you would like to happen?

11. What are your plans for the **future**? (e.g. education, employment)

12. Could you suggest **three key changes** that would help the government to support people out of homelessness?

11. DEMOGRAPHIC PROFILE

1. Gender (please circle)
    a. Male
    b. Female
    c. transgender

2. Ethnic group (please circle)
    a. White British
    b. Black or Black British
    c. Asian or Asian British
    d. Mixed
    e. Chinese
    f. White other ……
    Eastern European (please indicate country of origin in Eastern Europe)

3. Age/year of Birth……

4. How long have you been living in the UK for?

    Month…… Year……

5. What is your first language?.....

6. Highest level of Education completed:
    a. Primary ☐
    b. Secondary (GCSE or equivalent) ☐
    c. Further ('A' Level or equivalent) ☐
    d. Higher (university degree) ☐
    e. Prefers not to say ☐

7. Employment status

a. Working in a paid job (30+ hours) ☐

b. Working in a paid job (Less than 30 hours) ☐

c. Self employed ☐

d. Not in paid employment/looking after house or home ☐

e. Student ☐

f. Unemployed ☐

g. Retired from paid employment ☐

h Unable to work due to illness/disability ☐

i. volunteering ☐

j. Prefers not to say ☐

8. Monthly average take home income? (gross income)

a. From £0 to £200 ☐

b. From £200 to £399 ☐

c. From £400 to £829 ☐

d. From £830 to £1249 ☐

e. From £1,250 to £1,649 ☐

f. From £1,650 to £2,099 ☐

g. From £2,100 to £2,499 ☐

h. More than £2,500 ☐

i. Prefers not to say ☐

9. Marital status (please circle)

a. Married
b. Single
c. Divorced
d. Widowed
e. Separated
f. Coupled (relationship with someone of the opposite sex)
g. Partnered (relationship with someone of the same sex)

12. FOR RESPONDENTS WHO HAVE LEFT HH

1. Where do you live now?

	Tick as appropriate
Rented accommodation	
Do you share with other people?	
Own a property	
Another shelter	
Did HH help you with finding this accommodation?	Yes / No
How long have you been living there?	
Did you start living there straight after you left HH?	Yes / No

2. Do you work now? (includes part time and self-employed)

    a) If yes, what job do you do? .....

    b) How long have you been working there? .....

    c) Did you start just after you left HH? Yes / no

10.4 Number of clients' referrals to and from Highway House by organisation

Organisation	Number of referrals to HH
Hospitals	
Royal Free	2
UCL	6
King's college	1
Guy's St Thomas	1
North Middlesex	1
Whipps Cross University Hospital	2
Other NHS organisations	
Chelsea and Westminster Healthcare	1
Mental health services	
Enfield	3
Haringey	1
East London and the city uni	2
British Red Cross	2
Croydon Health Services	2
Staunton GP practice	1

Westminster Drug Project	1
Imperial Healthcare NHS Trust	1
Homeless organisations	
Crisis UK	3
No second night out	1
Deptford Reach	2
Manna Day Centre	9
Providence Row	1
Heaven Day Centre	
Pathway healthcare for homeless people	3
Housing justice	1
Upper Room (Meals etc)	6
Notre Dame Refugee Centre	1
Migrant and ethnic specific organisations	
Hackney migrant centre	2
ASAP (asylum)	1
Arab Advice Bureau	1

Refugee council	1
Churches	
Jesuit Refugee Service	1
White Chapel Mission	3
Missionaries of Charity	1
Growth (evangelical night Shelter)	3
Other organisations	
New Horizon Youth Centre	2
Solicitor (Bhatt Murphy)	1

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