Evaluation of a project to Maximise Access to and Uptake of Services, Grants and Benefits in Rural Areas

Final Report

October 2011
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Appendix I – Steering Group Members

Appendix II – SROI assumptions

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Acknowledgements

Deloitte would like to thank everyone who contributed to this research.
EXECUTIVE SUMMARY

Introduction
Deloitte was commissioned by the Department of Agriculture and Rural Development (DARD) and the Public Health Agency ((PHA) to undertake an evaluation of the maximising access to and uptake of services, grants and benefits in rural areas (maximising access project or the project). This report sets out the findings from the evaluation.

Context Summary
We have considered a range of policy and strategy documents, and outlined the strategic “fit” with the maximising access project. The project is aimed at improving the quality of life of rural citizens across Northern Ireland.

Section 2 has served to highlight the strategic and policy context within which the maximising access project has been operating and the current and future challenges associated with its delivery. The key messages include:

• The maximising access project has the potential to contribute to a number of government polices including those related to health, children and young people, rural development, anti-poverty and social inclusion.

• The current context within the wider economic environment presents challenges for innovative projects to articulate their value as question and scrutiny in relation to spend increase.

• Changing economic conditions also present challenges for the target audience of the maximising access programme in terms of increasing levels of unemployment, poverty and exclusion.

• Developing policy in relation to the new PfG and DARD strategic / corporate plans. It is imperative as these two polices develop that maximising access continues to fit within their developing framework.

Performance Summary
Section 3 presents the performance of the project against the intended output targets set at the outset. Overall, using the numbers of referrals generated as an indicator of success the project has performed well against its original objectives.

The Section also considers the views / opinion of stakeholders of the project including all of the lead organisations procured to deliver across the 13 identified zones in terms of project processes and operation. Findings would suggest that the majority of stakeholders are positive about the project in terms of its intended aims and how it has performed. There are also a number of challenges that have been identified and things to be considered in looking forward to any future phases of the project.

Project Impact
The evidence presented in the project impact section of the final report indicates that the services / activities provided under maximising access are additional to the services / activities that would be provided in the absence of funding.

Significant impacts have been identified across a broad range of stakeholders. For many households the project appears to be serving individuals who may not be willing (or able) to avail of mainstream provision and addressing gaps in accessibility to mainstream provision. The project has provided an opportunity for stakeholders to ‘think outside the box’ to provide activities that otherwise would not have been funded, and to deliver a ‘unique community development approach’ to engagement with the targeted households.
In terms of purely economic outcomes the project has the potential to lever in as a minimum £3.7m for the households. This figure is a conservative estimate based on the information available on outcomes to date and does not include the many social benefits which can also be attributed to the project. This would suggest a minimum leverage of £4.46 for every £1 spent by DARD /PHA.

Using the SROI methodology this figure would increase to £6,992,661.95. This gives a social return of £8.62 for every £1 invested in the project.

Overall, our assessment would indicate that the project has provided value for money.

**Summary of key messages from the analysis**

- It is important to recognise the context within which the project has been developed and managed. The breadth of offering of services and the number of key partners both at a community and strategic level are significant. The fact that the project was able to move from a ‘pilot’ in one area to a ‘regional’ project without any significant challenges (albeit with some teething challenges) is notable of its effectiveness.

- The project has supported local community organisations, key referral organisations and statutory stakeholders to develop their knowledge and understanding of the needs within disadvantaged rural communities.

- The project has allowed identification and engagement with a range of vulnerable rural households, who would otherwise be left isolated and in receipt of limited generic support. Anecdotally at least, additionality levels would appear to be quite high with many of the stakeholders discussing the added value of the community development model in terms of identifying those most in need and building trust and empathy with the households.

- In terms of delivery the project has afforded an inter-agency and cross-sectoral approach to tackle issues within the rural context. Access, co-operation and expertise has been apparent at the bottom level through the community development model across the 13 zones and using the experience, knowledge and networks of community activists and voluntary / community groups. At the top level, right through to the Minister in DARD and senior officials within PHA in providing strategic direction to the overall project. The actual delivery model of the project is cited by all stakeholders as “best practice” in terms of a project approach.

- What is delivered and who delivers it are two features of the project which contribute most to its overall effectiveness in maximising access. In terms of the sheer volume of referrals produced through the project, performance has at minimum delivered what had been ambitiously targeted within the original economic appraisal for the project. Using referrals as a proxy for accessibility to each of these areas suggests that the project has been effective in maximising access.

- The direct impact of the funding is continuing to be monitored as referrals across the agencies are processed. However, as is discussed within Section 6 these impacts / outcomes have the potential to be significant.

- The practical aspects of the project in terms of identifying households using the ‘bottom-up’ community development model and engagement at all levels through the different forums were appreciated by stakeholders and lead organisations. The other feature of the project which differentiates itself from other interventions designed to increase access to benefits, grants and services is the fact that enablers engage directly with the individual households identified within their household (i.e. the enabler goes to them).
Evidence and experience indicates that to access the most difficult to reach and those suffering greatest inequalities and disadvantage requires a more innovative, extensive and personal approach to that traditionally used. Addressing issues as sensitive as poverty and exclusion requires a supportive and sympathetic approach that will build trust and commitment. The maximising access project has attempted to do this using a community development model which has been, anecdotally at least, largely effective.

As a minimum what we can say is that some of all of these groups have been engaged in all areas. However, it is important to note these groups were identified for guidance rather than targets. Anecdotally, during the lead organisation consultations some groups actively used these target groups in prioritising and targeting households (e.g., through engagement with representative organisations including those with disabilities, ethnic minorities etc). In other areas however lead organisations discussed specific challenges with engaging with particular representative organisations or had so many targeted households identified that they did not need to specifically target in areas.

From our analysis of monitoring data, consultations / case studies and review of feedback / evaluation work undertaken by PHA we have identified economic and social impacts on individual households and on the lead organisations involved in the project delivery across a broad range of areas including improved access and awareness of entitlement, strategic linkages between community / voluntary groups and statutory bodies and increased understanding / awareness of need.

Recommendations

Based on our analysis of findings, we have identified a number of recommendations for PHA and DARD in terms of the strategic and operational direction of the project for phase II.

Strategic Recommendations

Continued Need

It is evident from the evaluation that the project has engaged with a significant number of rural dwellers. The households engaged on the project have been identified with local knowledge as vulnerable and in need of support. Many of those engaged may not otherwise have been supported in accessing the range of benefits, grants and services.

The project continues to fit with a range of Government strategies and policies at a regional and local level across rural areas in Northern Ireland. As is discussed in Section 2 there is also potential growth in demand for interventions of this nature as a result of the impact of the economic downturn and the potential implications of this on the hardest to reach communities, specifically those who may continue to be hidden in rural areas.

Recommendation 1:

The rationale for maximising access to those “most in need” in rural areas remains and it is recommended that DARD through the Rural Anti-Poverty Strategy and Social Inclusion Framework should continue to provide a specific intervention to meet this need.

Identifying Need

Identification of those “most in need” should continue to be a focus for the project in looking forward. Findings from the evaluation would suggest that use of the community development approach has supported vulnerable households to be identified by the local community and encouraged to participate in the initiative.

This approach is particularly relevant if the project were to move out of the “most deprived” SOAs into more affluent areas where deprived / disadvantaged households may be hidden within more affluent neighbourhoods / communities.
**Recommendation 2:**

It is recommended that in consideration of a future phase of the project the community development approach to engaging those most in need should continue to be applied.

Local knowledge / experience and links with the communities targeted are vital in maximising the impact of project. We recommend that a procurement process should be established to identify local community organisations with the capacity, expertise and skills to deliver across a full zone. In particular, this should include consideration of how potential lead organisations can demonstrate existing links / networks across the zone(s) they intend to work across.

**Recommendation 3:**

Further to recommendation 2 we would also recommend that lead organisations through the tendering process are asked to establish / identify a plan to establish local zone-based steering groups to identify and target households. This group should include individuals and local organisations from across the zone who have knowledge and access to information on vulnerable households. This should include special interest groups at a local level (e.g. those specifically working with target groups, for instance, ethnic minorities etc) and could also include individuals with specific knowledge of the local areas (e.g. local clergy, postmen, local councillors etc).

This group should then be tasked with identifying the most vulnerable households across the zones and creating a database who will then be contacted and asked if they wish to take part.

**Management / Operational considerations**

The management and operational structures of the project have been described as “best practice” by key stakeholders of the initiative. This includes strategic direction provided by the Regional Project Management Forum, a Regional Operational Group overseeing project implementation and a Lead Organisations Forum to exchange learning and addressing risks / challenges.

**Recommendation 4:**

It is recommended therefore that for any future phase of the project consideration be given to continuing these overall management structures. In addition, in line with recommendation 10 we would also recommend inclusion / engagement of regional bodies representing the identified targeted groups of the project within these management structures. This could include for example, bodies working with Ethnic Minorities, Disabled persons, Lone Parents etc.

**Referral organisations / agencies**

Buy-in to the process by referral agencies and particularly at a local level agency staff is essential if maximum benefits, grants and service uptake is to be realised. Within the evaluation we have identified some challenges with moving households through the referral process to actual outcome in terms of timing, local differences in approach and local relationships between lead organisations and key referral agencies.

**Recommendation 5:**

We recommend that further work is undertaken at both a strategic and operational level for any future phase of the project to ensure that all key stakeholders are fully aware of their roles and responsibilities and “buy-in” is ensured across the key agencies in support of maximising the outcomes.
In line with recommendation 3 and the establishment of local steering groups for identifying households we would also recommend consideration of partnerships between lead organisations and referrals agencies at a local level to ensure consistency in referrals across the zones and to support the monitoring of referrals from point of referral to outcome. Potentially this could include signed Partnership Agreements both at a strategic level and at a local level to ensure consistency in relationships across the operational areas of the project.

**Strengthening collaboration**

Collaborative working between the community and voluntary sector and the statutory sector remains desirable in meeting the needs of vulnerable rural dwellers, particularly given the increased pressure to demonstrate that resources are used in the most efficient and effective way. It is important however that funding provided through maximising access is not used to replicate statutory services or duplicate other efforts within the local communities engaged.

The first phase of the project has demonstrated positive collaboration both at a strategic and operational level across the project. However, it also indicated some continued challenges, particularly at a local level which highlights the importance of continuing to develop and facilitate understanding (and trust) between the statutory sector and the community and voluntary sector of the benefits of working collaboratively to maximise impact through referrals between the sectors. In particular, processes for sustaining relationships into the longer term between stakeholders of the project could be an important legacy of the maximising access project.

**Recommendation 6:**

In relation to improved and continued collaboration we have recommended through recommendations 2, 3 and 5 areas for continuation from the first phase into the second phase to support the positive elements of collaboration experienced and evidenced through the evaluation.

A further area to consider is in marketing the most positive aspects of collaboration within the project. In particular, how can the positive message and lessons of collaboration be shared with agencies / organisations outside of the project for them to integrate the learning into future practice and support broader collaboration between the sectors? We recommend that consideration be given to taking opportunities to share best practice with agencies when opportunities are available.

Finally, as is discussed the evaluation has evidenced positive collaboration for the purposes of the project. However, we would also recommend as phase II develops consideration of how relationships across all levels of the project can be sustained into the longer period in support of meeting need within the rural community over the longer term.

**Operational Recommendations**

**Enablers**

The position of enabler is a key role within the project, from supporting household identification, through persuading / encouraging participation and effective referral of households to ensure maximised impact. Recommendations for enablers have been considered across a number of dimensions below.

**Recommendation 7:**

**Enabler selection**

Consideration should be given to the development of more robust selection criteria for enablers to include, for example, motivation to become an enabler, previous training experience, previous knowledge of working with vulnerable households, interview skills and agreement to the time commitment required for the project.
In addition, the development of enhanced and consistent formal support structures for enablers through monitoring, post-visit supervision should support the enhanced recruitment and retention of enablers.

**Enabler training**

Feedback from lead organisations and enablers captured through the evaluation indicates support for more focus on some aspects of the training and potentially a more interactive training experience.

This could include role plays of potential incidents that may be experienced in households (e.g. how to overcome a particularly difficult household in partaking in the project) and support enhanced understanding of the day-to-day nature of the role.

**Enabler quality**

It is imperative that structures are introduced to monitor the quality of enablers and ensure that enablers are delivering the core aspects of the project consistently.

We understand that phase II of the project may include lead organisations employing an “enabler team” as part of the contract. We would welcome this approach. However, we would also recommend that individual contracts / agreement are developed between lead organisations which consider all aspects of the role and include details of ongoing monitoring and supervision of enablers through regular reviews to ensure consistencies in the longer term across the project. This should include commitment from the lead organisations to monitor enabler quality at a local level and bring details of challenges / issues and progress to the Lead Organisation Forum.

**Enabler forum**

Consider the establishment of an enabler networking forum that enablers from across the project can use to contact and network with other enablers. This network should encourage greater sharing of best practice and lessons learned in training but could also provide a peer network of support for enablers to discuss issues, share experiences thus supporting wider project objectives.

**Marketing the project**

The promotion and awareness of the project should be an area of focus at both a strategic and operational level of the project. Evidence from the evaluation has largely been positive in terms of economic and social value and individual case studies.

**Recommendation 8:**

We recommend that consideration be given to the development of a full marketing plan for the project which considers how the project should be promoted at both strategic and operational levels. The success of the first phase of the project could potentially encourage vulnerable households to come forward and the information could also be used at a local level to support those identified to participate in the project.

In line with strategic recommendation 5 and sharing lessons / best practice with other key stakeholders outside of the project we would also recommend sharing information where possible on the community development model approach and operational / management arrangements with key agencies.

We recognise that phase II of the project will be branded as the “MARA” project and we welcome this approach in ensuring consistency in marketing / promotion of the project across the region.

Finally, we would recommend that any potential marketing plan would include a more proactive effort with various local and regional media outlets to inform, promote and raise awareness of both the aims of the project and its impacts when they materialise.
Sharing and learning best practice

One of the key benefits associated with the Lead Organisation Forum was the ability for lead organisations to share best practice and learning lessons with each other. Whilst this is welcome and a valuable aspect of the project further consideration should be given to building on this to find effective ways to share knowledge, experience and good practice and sustain these relationships into the longer term.

Recommendation 9:

Consideration should be given to development of a formal mechanism for sharing / learning across the project. Potentially this could include an intranet for all stakeholders to engage / share knowledge with each other from project inception, through the targeting / engagement process to referral.

Targeting the hardest to reach

Some lead organisations mentioned the difficulties of reaching specific groups within their zones. This is perhaps reflected in the smaller number of households engaged outside of the traditionally defined vulnerable (i.e. older people and those with disabilities).

Recommendation 10:

In line with strategic recommendations 2 and 3 the project should directly engage with a range of regional representative organisations across the key target groups to develop a dialogue with particular hard to reach groups (e.g. why the project needs their help, explain the project and what it aims to achieve, and ask for advice / support in engaging with particular groups / communities). This could include groups who represent ethnic minorities, disabled, lone adults, etc.

Referral Tracking

Through our analysis of management information the tracking of referrals towards outcomes was highlighted as being a key difficulty.

Recommendation 11:

We recognise that the new IT system is planned for phase II and training will be provided for this. However we recommend that all stakeholders continue to work in this area to ensure referral tracking is consistent and that opportunities’ for inconsistency across different zones is minimised.

Householder Feedback

The case studies undertaken has part of the project have provided positive examples at an individual household level of the impacts / outcomes associated with the project.

Recommendation 12:

We recommend that a systematic approach to collecting householder feedback over the longer term should be introduced and the findings from the feedback should be addressed on an ongoing basis by potential contractors and PHA / DARD during contracted meetings.

This could take the form of case studies, with a mandatory focus on the projects role. There could also be an opportunity for households to feedback through more informal mechanisms such as internet / websites etc.
Strengthening quality

Our analysis has highlighted a lack of consistency in terms of quality controls relating to enablers across the zones. When quality controls were in place, they had been developed as a result of the individual lead organisation rather than the project (e.g. this included capturing details of communications between enablers, lead organisations and households where particular issues arose). Whilst no serious incidents occurred as a result of the project, further consideration should be given to consistent protocols across the zones in terms of dealing with specific incidents requiring follow-up support by enablers, lead organisations and others.

**Recommendation 13:**

We recommend that quality standards are increasingly project driven. In doing this PHA / DARD should consider ‘best practice’ for quality controls in working directly with “vulnerable individuals”. This could involve enhanced training around key areas of client interviewing, interaction and protection and should be made consistent across all of the zones.

Building Links / Relationships early

A key aspect of the project is the important role played by lead organisations in engaging and utilising key individuals / influencers and groups at a local level to identify the most vulnerable households. As is discussed in the analysis of findings there was a different response in some areas to the project when enablers were engaging with different households.

**Recommendation 14:**

If similar projects are being implemented in rural areas in the future it is important to take time to identify the key people who have extensive local knowledge and also to ensure a representative spread of people across the geographic area. This is necessary if those who would benefit most are to be identified. Individuals in occupations such as postmen / local clergy etc can have considerable knowledge with regards the personal circumstances of potential beneficiaries of the project. It is important that relationships are developed in advance of going into the community to ensure appropriate targeting at the “most in need”.

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PHA / DARD – Evaluation of Maximising Access Project
Final Report

11
1 INTRODUCTION AND BACKGROUND

1.1 Introduction
Deloitte was commissioned by the Department of Agriculture and Rural Development (DARD) and the Public Health Agency (PHA) to undertake an evaluation of the maximising access to and uptake of services, grants and benefits in rural areas (maximising access project or the project). This report sets out the findings from the evaluation.

This section of the report considers the background to the evaluation, its overall objectives and outlines our approach.

1.2 Background
The maximising access project is an initiative aimed at facilitating a cross-departmental co-ordinated service to maximise access to benefits, grants and local services to support rural dwellers living in or at risk of poverty and social exclusion.

The project is based upon a previous pilot initiative carried out in rural areas of Fermanagh and Tyrone. Evidence from the pilot suggested that visiting people in their own homes and using a “personal touch” encourages people to avail of services and grants which they would not otherwise have known about or been able to apply for. The project seeks to identify vulnerable households in the 88 most deprived rural super output areas of Northern Ireland. Trained enablers visit the household, complete a number of questionnaires and provide a range of information to the householder regarding local services available. The households will also be referred or signposted onto a range of services / agencies (e.g. Advice Northern Ireland, Citizens Advice Bureaux, Northern Ireland Housing Executive, Community Transport, Warm Homes, Local Services etc) and will be provided with follow up support.

The Public Health Agency (PHA) has developed and is implementing an evaluation framework, the overall aim of which is:

“To describe and review the implementation of the Improving access to and uptake of grants, services and benefits project (the intervention) and to assess the resultant impacts on access to services and on the wellbeing of rural dwellers”

The purpose of this evaluation is to support this wider evaluation framework focussing on the value of the outcomes realised from the Project in economic and social terms.

1.3 Terms of Reference
It is within this context that DARD / PHA has commissioned this evaluation. The key aims of which are to:

- evaluate the effectiveness of the project (qualitatively and quantitatively) and evaluate the effectiveness of delivery;
- consider the effectiveness of the project in terms of maximising access to benefits, grants and local services to support rural dwellers living in or at risk of poverty and social exclusion;
- assess how successful the project has been in accessing the hardest to reach groups;
- report on specific and notable success stories with quantifiable evidence as to the impact of the intervention on the individuals involved;
- quantify in local and regional terms what are (and can be) the economic and social impacts of the project; and
• make recommendations as to the scalability of the initiative and how PHA / DARD could / should maximise this?

1.4 Our Approach

Our approach to the assignment is summarised in Table 1.1 below.
<table>
<thead>
<tr>
<th>Stage</th>
<th>Summary of Approach</th>
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<tbody>
<tr>
<td>• Project initiation</td>
<td>• Project initiation meeting with the evaluation sub-group on 23rd February 2011 (Steering Group members provided in Appendix I); and</td>
</tr>
<tr>
<td></td>
<td>• Production of Project Initiation Document.</td>
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<tr>
<td>• Desk Review and Planning</td>
<td>• Programme of consultation agreed;</td>
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<tr>
<td></td>
<td>• Review of the strategic context;</td>
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<tr>
<td></td>
<td>• Collation and organisation of data; and</td>
</tr>
<tr>
<td></td>
<td>• Developed the evaluation framework including discussion guides for use during Stage 3.</td>
</tr>
<tr>
<td>• Mapping Outcomes</td>
<td>• Completed consultations with 9 lead organisations;</td>
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<tr>
<td></td>
<td>• Completed strategic stakeholder consultations including representatives from the regional operational group and regional project management forum; and</td>
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<tr>
<td></td>
<td>• Completed householder case studies.</td>
</tr>
<tr>
<td>• Data Analysis and SROI Calculations</td>
<td>• Analysis of Findings;</td>
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<td></td>
<td>• SROI development and calculation; and</td>
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<tr>
<td></td>
<td>• Steering Group Workshop.</td>
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<tr>
<td>• Reporting</td>
<td>• Production of Draft Report; and</td>
</tr>
<tr>
<td></td>
<td>• Production of Final Report.</td>
</tr>
</tbody>
</table>
1.5 Report Structure

The remainder of this report is structured as follows:

- **Section 2** – outlines the strategic context for the evaluation including key developments over the review period and an overview of the project's operation;

- **Section 3** – outlines the performance of the maximising access project against the output targets identified within the original economic appraisal for the project. This section also contains consultation findings in relation to the overall project processes and case studies undertaken with households;

- **Section 4** – considers the wider economic benefits associated with the project across the range of stakeholders. It also considers the analysis and findings in relation to the estimated SROI on households of the intervention based on information available to date;

- **Section 5** – brings together the data analysis, consultation and views of the evaluation team to present our analysis of findings against the terms of reference for the project; and

- **Section 6** – highlights our overall conclusions, providing PHA / DARD and other relevant stakeholders with an understanding of the emerging lessons from the project and recommend ways of applying and building upon them in the future.
2 STRATEGIC CONTEXT

2.1 Introduction

The purpose of this Section of the report is to provide an overview of the maximising access project and the economic, strategic and policy context within which it operates. This includes consideration of the key government documents which shape the context for this evaluation.

2.2 Overview: Maximising Access Project

This subsection provides a high level overview of the maximising access project in terms of its operation across Northern Ireland.

2.2.1 Background

The project is based upon a previous pilot initiative carried out in rural areas of Fermanagh and Tyrone. Evidence from the pilot suggested that visiting people in their own homes and using a “personal touch” encouraged people to avail of services and grants which they would not otherwise have known about or been able to apply for. Maximising access has sought to identify vulnerable households in the 88 most deprived rural Super Output Areas (SOAs) of Northern Ireland as identified by Northern Ireland Statistics and Research Agency (NISRA) via the Northern Ireland Neighbourhood Information Service (NINIS http://www.ninis.nisra.gov.uk/)

Figure 2.1 provides an overview of the SOAs and the 13 zones in which the SOAs were organised for the purpose of the project.

Figure 2.1 – Overview of Maximising Access Zones

Source: PHA / DARD
2.2.2 Project implementation

PHA tendered for local lead organisations to implement the project across the 13 zones identified in Figure 2.1. In total, nine lead organisations were resourced to:

- identify vulnerable people in their community using local knowledge;
- recruit and train members of the local community to become enablers so as to carry out home visits and signpost people to local services;
- provide follow up support and monitoring of uptake of services to ensure project outcomes are achieved;
- create sustainable capacity in the community to address these issues in the long term; and
- allow lead organisations to identify their target households.

For the purposes of the maximising access project the following groups were classified as vulnerable people:

- ethnic minorities;
- lone parents;
- older people;
- carers;
- disabled people;
- lone adult households;
- farm families; and
- low income families.

2.2.3 Project Targets

The following project targets have been set for the maximising access project:

- To improve the health and wellbeing of rural dwellers by increasing access to services/grants/benefits and measuring the impact by carrying out a health impact assessment;
- To identify at least 4200 vulnerable households in the community using local knowledge;
- To recruit and train at least 200 members of the local community to build capacity and awareness of services/grants/benefits;
- To carry out at least 4200 home visits and signpost people to local services/grants/benefits;
- To provide follow up support and monitoring of uptake of services to ensure project outcomes are achieved for at least 4200 households;
- To increase access to energy efficiency and housing grants for at least 25 per cent of targeted households;
- To increase access to benefits for at least 16 per cent of targeted households;
- To increase access to a range of local services for at least 50 per cent of targeted households;
To increase collaboration between the community/voluntary sector and the statutory sector by working with at least twelve lead community organisations and at least 50 local community groups; and

To reduce social exclusion by linking at least 50 per cent of targeted households to a range of statutory, community and voluntary services.

Performance of the project against these objectives is presented in Section 4.

2.3 Government Policy and Strategy

This subsection provides a high level overview of Government Policy and Strategy relevant to the operation and implementation of the maximising access project.

2.3.1 Programme for Government 2008 – 2011

The Programme for Government (PIG) sets out the key plans for the Northern Ireland Executive for the period 2008-2011. Its over-arching aim is:

“to build a peaceful, fair and prosperous society in Northern Ireland, with respect for the rule of law and where everyone can enjoy a better quality of life now and in years to come”.

The maximising access project has directly contributed towards a number of the Public Service Agreement (PSA) targets and aims as listed below in Table 2.1.

Table 2.1 Summary of PSA and potential ‘maximising access’ contributions

<table>
<thead>
<tr>
<th>PSA Objective</th>
<th>Aim</th>
<th>Potential maximising access project contributions</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSA 6 – Children and Family</td>
<td>To ensure that children are cared for, live in safety, are protected from abuse, receive the support they need to achieve their full potential, become more independent and grow into well adjusted adults, taking their place in the community</td>
<td>Maximising access has the potential to directly impact on the lives of children in rural areas by supporting an overall reduction in households’ poverty and social exclusion through increased access to benefits, grants and local services.</td>
</tr>
<tr>
<td>PSA 7 – Making People’s Lives Better;</td>
<td>Drive a programme across Government to reduce poverty and address inequality and disadvantage</td>
<td>Maximising access has worked specifically in the 88 most deprived SOAs in NI and across a range of targeted vulnerable groups as identified in section 3.2.2. The project aims to engage and identify those most in need using local knowledge. The overall aim of the project is to support a reduction in inequality and disadvantage by increasing accessibility to a wide range of benefits, grants and services.</td>
</tr>
<tr>
<td>PSA 8 – Promoting Health and Addressing Health Inequalities</td>
<td>Promote healthy lifestyles, address the causes of poor health and wellbeing and achieve measurable reductions in health inequalities and preventable illnesses</td>
<td>Improving the health and wellbeing of rural dwellers by increasing access to services, grants and benefits is a key target of the project. The link between poverty, social disadvantage and poor health is well defined. In attempting to reduce poverty and social exclusion the project will likely have a direct and indirect impact on the health of the targeted population.</td>
</tr>
</tbody>
</table>
### PSA Objective

<table>
<thead>
<tr>
<th>PSA Objective</th>
<th>Aim</th>
<th>Potential maximising access project contributions</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSA 12 – Housing, Urban Regeneration and Community Development</td>
<td>Promote decent, energy efficient, affordable housing and regenerate areas and towns and city centres and support community development to create environments which enhance quality of life and contribute to well being</td>
<td>Specifically in relation to improved housing efficiency through maximising access to the warm homes scheme and home safety checks. In addition, the project aims to support increased capacity within community through trained enablers offering support and lead organisations monitoring the uptake of services and increasing statutory capacity to identify the hardest to reach households.</td>
</tr>
<tr>
<td>PSA 17 – Rural Infrastructure</td>
<td>Helping rural communities improve the physical, economic and social infrastructure of their areas</td>
<td>Maximising access aims to support increased collaboration between community / voluntary sector and statutory sector through the project delivery mechanisms. This includes a regional operational group set up to direct the project strategically and a project management group set up to manage the operational side of the project. Increased access to benefits, grants and services within local communities will also likely have impacts in terms of improving the economic and social infrastructure within rural areas.</td>
</tr>
</tbody>
</table>

### Strategic Fit:
The maximising access project provides a direct link to the current PfG through its potential to contribute positively to the PSA targets and aims listed above.

### 2.3.2 Lifetime Opportunities – Governments Anti-Poverty and Social Inclusion Strategy for Northern Ireland

It has been widely recognised that in spite of sustained improvements in economic performance in Northern Ireland, significant inequalities still persist throughout society. In order to address this, the Northern Ireland Anti-Poverty Strategy was launched by OFMDFM in 2007 to work towards reducing poverty and social exclusion amongst individuals, families and communities. The overall aim of the strategy is to improve the income and living conditions of the most disadvantaged.

The proposed framework includes three high level priorities:

- to build the capacity of individuals to participate in the labour market and to take advantage of the opportunities offered by the market economy;
- to increase employment opportunities and to reduce the barriers to employment; and
- to deal with financial exclusion.

The Strategy recognises that although many departments are targeting those in need, there is a need for a more coordinated approach with a focus on the outcome of actions taken to address poverty. As such, departments will be required to incorporate the Anti-Poverty Strategy in their departmental action plans in order to bring greater transparency and accountability to the process.
Strategic Fit:
The maximising access project has the potential to directly contribute to Lifetime Opportunities by identifying at least 4,200 vulnerable households in the community using local knowledge and increasing access / signposting these households to local services, grants and benefits.

2.3.3 DARD Strategic Plan 2006-2011

This document outlines DARD's vision of "a thriving and sustainable rural community and environment in Northern Ireland", with the aim to "put the customer first, build partnerships, value staff and be efficient, adaptable, responsive to change, and focused on making a difference".

Sustainable development is the overarching driver of change for DARD over this period. It will shape the context of what DARD does and how it is done, and whether it is in relation to the environment, the agri-food or fishing industry or rural development. Particular reference in the strategic plan relates to DARD's role in helping to promote access to and provision of services, contributing to a confident, rural community.

The fundamentals of the aims and vision are detailed in the goals:

- To improve performance in the market place;
- To strengthen the social and economic infrastructure of rural areas;
- To enhance animal, fish and plant health and welfare; and
- To develop a more sustainable environment.

Strategic Fit:
The maximising access project can support DARD in promoting accessibility to and provision of services within disadvantaged and vulnerable rural communities.

2.3.4 DARD Rural Development Strategy & Programme 2007 – 2013

DARD's Rural Development Strategy 2007 – 2013 notes the strategic context for the broad strategic direction and framework for rural development policy in Northern Ireland. The overall theme of the Strategy is:

"Diversifying the rural economy, protecting the rural environment and sustaining rural communities"

This Rural Strategy defines four broad aims:

- Key Aim 1: Creating a Rural Champion;
- Key Aim 2: Improving Performance in the Marketplace;
- Key Aim 3: Conserving and Investing in the Rural Environment; and
- Key Aim 4: Strengthening the social and Economic Infrastructure of Rural Areas.

Rural areas continue to face a broad spectrum of challenges and difficulties. However, there also continues to be significant potential for them to contribute to sustainable development of NI as a whole. The purpose of this Rural Strategy is to guide DARD’s approach to helping rural communities both address these challenges and unlock their potential.
Strategic Fit:
Maximising access can support DARD and partners in seeking to address these challenges, specifically key aim 4: strengthening the social and economic infrastructure of rural areas.

2.3.5 The Northern Ireland Rural Development Programme 2007 – 2013

The Northern Ireland Rural Development Programme (NIRDP) 2007-2013 will be funded through a single Rural Fund - European Agricultural Fund for Rural Development (EAFRD) - based around four distinct themes or “Axes” around which rural development programmes need to operate. A key element of the NIRDP is that it should be needs based, drawing down funding as appropriate to meet the needs of the rural areas in Northern Ireland.

There are four distinct themes or ‘Axes’ around which rural development programmes need to operate:

- Improving the competitiveness of agriculture and forestry by supporting restructuring, development and innovation (Axis 1).
- Improving the environment and countryside by supporting land management (Axis 2).
- Improving the quality of life in rural areas and encouraging diversification of economic activity (Axis 3).
- Using a LEADER-type approach (Axis 4).

NIRDP also aims to assist the creation of employment opportunities and opportunities for growth while considering the needs of women, young people and older workers. The programme, which is an integral part of the Department’s rural strategy, will put more than £500 million into the Northern Ireland agriculture industry and wider rural development over the 2007 – 2013 period. It will seek to improve the competitiveness of the farming sector, improve the land, environment and countryside and improve diversification and quality of life in rural areas.

The proposal is that a substantial part of the programme will be delivered locally through local action groups, and a significant proportion of its funding will go directly to the farming sector. That money will be used to improve training, to disseminate best practice, to modernise farms, to support those in less-favoured areas, to increase forestry potential and to support environmental improvements and land management. More than 75 per cent of the total programme funding will go directly to support the farming sector.

The programme will also support the wider rural community through a suite of measures designed to improve the quality of life in rural areas. The programme contains measures to create business, to increase tourism potential, to regenerate villages and towns, to provide basic services for the rural community and to maintain and enhance Northern Ireland’s cultural and natural heritage.

Strategic Fit:
The maximising access project has particular resonance with the aims of improving quality of life in rural areas by supporting communities and individuals to access benefits, grants and local services. This potentially has impacts in terms of improved health and wellbeing, living conditions and reducing poverty and social inclusion.

2.3.6 DARD’s Rural Anti-Poverty and Social Exclusion Programme

As part of the PfG, DARD has been allocated £10.4m for actions to address rural poverty and social exclusion across the budget years up to 31 March 2011.
In order to ensure the most effective and efficient use of the available funding from PfG, DARD has developed a Rural Anti-Poverty and Social Inclusion Policy Framework. The framework seeks to identify where gaps exist in the fight against poverty and exclusion in rural areas, and sets out how they might be addressed through innovative, partnership-led approaches with other government departments and stakeholders.

A number of key priorities have been identified including:

- Fuel Poverty;
- Rural Transport and Access;
- Community Development;
- Childcare; and
- The Challenge Programme.

The overall objective of the framework is to:

- Provide mechanisms and support to those living in rural communities to identify and tackle poverty and social exclusion in their areas; and
- Provide access to the necessary tools and support to address these concerns in a sustainable manner.

The anticipated outputs arising from this framework are a contribution to the elimination of poverty in rural areas and assurance that all actions taken in rural areas are fully inclusive of the population.

**Strategic Fit:**

The DARD rural anti-poverty and social exclusion programme is closely aligned to the PfG. As noted above, maximising access can directly contribute to meeting the PSA targets relevant to making people’s lives better, rural infrastructure, reducing health inequalities and community development.

### 2.3.7 The Rural Anti Poverty and Social Inclusion – Challenge Programme

The Rural Anti Poverty and Social Inclusion Framework highlights that there are those people in society that are socially excluded due to other reasons, including being discriminated against on the basis of age, religion or race etc. In order to ensure that rural poverty and social exclusion needs are addressed as widely as possible, the Challenge Programme aims to encourage local communities, farming and rural groups to identify needs unique to their area and sector under one of the eight target groups:

- Children and Young People;
- Lone Parents;
- Unemployed;
- Disabled;
- Elderly;
- Ethnic Minorities; and
- Low Paid Workers.
The Challenge Programme aims to provide solutions that address the particular and distinct challenges faced by rural people/communities in relation to Poverty and Social Exclusion issues. However, as noted in the Framework document: “Providing evidence of social exclusion has been noted to be difficult, particularly in identifying individuals who cannot or do not wish to be part of the wider society and often social exclusion has been linked primarily to poverty measures. This does not then reflect the position of those who are not in poverty but who cannot enter society due to other reasons.”

Strategic Fit:
The maximising access project seeks to address many of the key target groups and issues identified as requiring intervention as part of the challenge programme. It is specifically targeted within the 88 most deprived communities and also has related target groups of individuals closely aligned to those targeted within the challenge programme. Whilst it connects with the Challenge Programme it can also directly help to address three of the other key areas identified in the framework namely; community development, fuel poverty and rural transport and access.

2.3.8 Investing for Health Strategy
The Strategy is based upon the recognition that inequalities, which exist in health between rich and poor are widening and argues that the wider determinants of health can be addressed by integrated interventions and a co-ordinated approach between all sectors.

The Strategy has two overarching goals:

- To improve the health of our people by increasing the length of their lives and increasing the number of years they spend free from disease, illness and disability; and
- To reduce inequalities in health between geographic areas, socio-economic and minority groups.

These goals are expressed as targets in life expectancy and reduction in long standing illness, targeted at the most disadvantaged communities and people and are supported through seven objectives, three of which are particularly relevant for the maximising access project:

- Objective 1 To reduce poverty in families with children;
- Objective 3 To promote mental health and emotional well-being at individual and community level; and
- Objective 4 To offer everyone the opportunity to live and work in a healthy environment and to live in a decent affordable home.

Strategic Fit:
The cross-sectoral approach to maximising access fits strategically with the overall aim of Investing for Health to provide integrated interventions. In addition, the project aims to improve the health and well being of rural dwellers by increasing their access to benefits, grants and services.
2.3.9 A Healthier Future - A Twenty Year Vision for Health and Wellbeing in NI 2005 – 2025

“A Healthier Future” sets out a vision for how health and social care services in Northern Ireland will develop and function over the next twenty years. In order to succeed, it must embrace the measures needed to promote health and wellbeing, support, protect the most vulnerable and facilitate the delivery of services. It recognises in particular the need to contribute to effective working across organisations and to tackle the inequalities that so often give rise to poor health. In doing so, “A Healthier Future”, places a special emphasis on promoting equality of access for all groups in our society. The Strategy identifies a number of key policy directions, actions and outcomes that will contribute to the achievement of the vision.

**Strategic Fit:**
Maximising access fits strategically with a number of key areas of the vision particularly in relation to improving the physical and mental health and social wellbeing of the people of Northern Ireland by maximising access to local services that individuals have not been able to or known about previously.


The Department for Social Development “Warmer Healthier Homes: A New Fuel Poverty Strategy” (DSD, 2011) sets out a vision for “a society in which people live in a warm, comfortable home and need not worry about the effect of the cold on their health”.

The Strategy recognises that fuel poverty in Northern Ireland is a growing challenge and estimates that upward of 44 percent of people across the region live in fuel poverty (i.e. 44 percent of households have to pay more than ten percent of their income on energy costs). The number of people living in fuel poverty in Northern Ireland is identified as being significantly higher than across the rest of the UK; however an upward trend is evident across all regions.

Low income, poor energy efficiency and high energy / fuel costs are highlighted as the main causes of fuel poverty. In particular, the Strategy focuses on removing energy inefficiency as a cause of fuel poverty, opens new ground on fuel prices, while exerting influence on other Departments and Agencies to help tackle prices and low incomes. The Strategy recognises that a partnership approach is required to tackle fuel poverty and the cross-departmental nature of poverty more generally.

Overall the Strategy identifies 18 actions under four key areas:

1. Targeting of Resources;
2. Improving Energy Efficiency;
3. Achieving Affordable Energy; and

**Strategic Fit:**
The maximising access project provides a strategic fit across all of the key areas of the Warmer Healthier Homes strategy. It is targeted at the most vulnerable households in the identified 88 most deprived rural super output areas. In addition, a key outcome anticipated within the maximising access project involves increasing access to energy efficiency measures and housing grants for at least 25 per cent of households. In total, 1,300 people have been referred to the Warms Homes Scheme to date through the project with
anticipated savings in terms of reduced heating bills but also increased comfort and quality of life for households. Increasing access to benefits and supporting vulnerable individuals to claim their full entitlement also directly relates to the key target area of achieving affordable energy through increasing and maximising household incomes. Finally, the strategic and operational management structures of the project involving statutory and community / voluntary partners has supported and consolidated effective partnership working.

2.3.11 A Ten Year Strategy for Children and Young People in Northern Ireland 2006 – 2016

In June 2006, The Office of the First Minister and Deputy First Minister (OFMDFM) published a ten year strategy for children and young people living in Northern Ireland. The aim of the strategy is to achieve improved outcomes for all children and young people and to narrow the gaps between those who do best and those who do worst in life. The aim of this strategy is to ensure that by 2016 all our children and young people are fulfilling their potential.

The vision for the strategy is that “all children and young people living in Northern Ireland will thrive and look forward with confidence to the future”.

The strategy identifies an outcomes framework on which the vision of the strategy will be measured. Progress and evidence should exist that indicates that our children and young people are:

- Healthy;
- Enjoying, learning and achieving;
- Living in safety and with stability;
- Experiencing economic and environmental well-being;
- Contributing positively to community and social; and
- Living in a society with respects their rights.

Strategic Fit:

The maximising access project has the potential to contribute to a number of the indicators identified within the strategy including reduction in the proportion of children living in absolute poverty through increased benefit and grant uptake. Increased access to local services and grants related to energy efficiency and home safety also provide opportunities for a decrease in the number of young people living in homes which fail the decent homes standard.


This strategy establishes a framework:

- to tackle racial inequalities in Northern Ireland and to open up opportunity for all;
- to eradicate racism and hate crime; and
- together with A Shared Future, to initiate actions to promote good race relations.

It sets out a long term, high level vision of the society that we are working to achieve:

“A society in which racial diversity is supported, understood, valued and respected, where racism in any of its forms is not tolerated and where we live together as a society and enjoy equality of opportunity and equal protection.”
Strategic Fit:

As is highlighted in section 3.2.2 ethnic minorities were highlighted as a key target group for the maximising access project. This is specifically in line with objectives of the racial equality strategy in terms of increasing participation and equality of opportunity for people of different ethnic backgrounds in Northern Ireland.

2.3.13 A Sustainable Development Strategy for Northern Ireland

The Northern Ireland Sustainable Development Strategy (First Steps towards Sustainability) was launched by the Secretary of State in May 2006 and is Government's response to the challenges of securing a better future for the present generation and protecting the future for generations to come. It sets out the principles which must influence public sector policy and decision-making and wider societal behaviour to ensure that we can achieve our objectives of a Northern Ireland with a thriving economy, prosperity and quality of life for all combined with a healthy environment.

The strategy has at its core a long-term vision of a sustainable society. The building of such a society is a challenging agenda which requires actions to address a wide range of issues including community relations, tackling poverty and social exclusion, providing good quality employment opportunities, ensuring people can acquire the necessary skills and qualifications for work and regenerating our urban and rural environments.

The strategy focuses on the following six priority areas:

- Sustainable Consumption and Production
- Natural Resource Protection and Environmental Enhancement
- Sustainable Communities
- Climate Change and Energy
- Learning and Communication
- Governance and Sustainable Development

Strategic Fit:

Maximising access is particularly relevant to the sustainable communities priority area of this strategy. The aim of which is to create sustainable communities involving working to empower local communities to have a greater say in the decisions that affect them. Maximising access supports this aim, firstly by providing the conditions for improved health and social well-being for individuals and secondly by supporting lead organisations and community groups in building capacity through the recruitment and training of local community enablers and increased collaboration between community / voluntary and statutory stakeholders.

2.3.14 Opening Doors – A Strategy for the Delivery of Voluntary Advice Services to the Community

This Strategy aims to put in place an integrated, quality advice service across Northern Ireland and a proper framework to ensure that services are planned and delivered in a way which matches resources to need, with a particular focus on meeting the needs of the most disadvantaged in society.

Principles and Values
• Access by all people, the disadvantaged in particular, to a level of advice that meets their needs;
• High quality services that are sustainable in the long term;
• Value for money;
• Quality of Provision;
• Integrated services that address gaps and overlaps and can respond to changing needs; and
• The best use of the distinctive approach of the voluntary and community sector.

**Strategic Fit:**
The maximising access project has the potential to contribute to the strategy through the proactive engagement of vulnerable individuals in rural communities who are currently not being fully served by existing statutory and advice sector channels.

The outreach mechanisms are designed to dovetail not only with existing advice and statutory sector arrangements, but fully take into account the planned development of the ‘hubs and satellites’ model of advice delivery envisaged under ‘Opening Doors’ – by extending the range of the client population served. The maximising access project has also supported the social economy by funding key agencies within the advice sector including CAB, Advice NI and Bryson Charitable Group – both in giving advice and processing the referrals received by the project.

### 2.3.15 NIHE Housing & Health Strategy and Action Plan 2008 - 11

The NIHE has a Housing & Health Strategy and Action Plan 2008-11. The purpose of this document is to outline the recommendations for future action arising from the review of the Housing Executive’s strategy “Housing and Health - Towards a Shared Agenda” which was published in 2001.

NIHE’s vision is one in which housing plays its part in creating a peaceful, inclusive, prosperous and fair society. Health and wellbeing is integrated throughout NIHE business and this is reflected in the mission statement:

“Working together to ensure that everyone has access to a decent affordable home in a safe and healthy community”

**Strategic Fit:**
The strategy has six objectives, four of which are directly related to maximising access including addressing energy efficiency and fuel poverty, promoting independent living, fostering urban and rural regeneration and building a stronger community which includes community planning.

### 2.3.16 Partners for Change: An Action Plan for Government and the Voluntary and Community Sector

This Action Plan identifies the work of Government departments with the Voluntary and Community Sector. It is the practical outworking of the commitments given in the Compact, to help build stronger, more inclusive and cohesive communities across Northern Ireland and to enhance the delivery of public services.
• **Building Communities/Promoting Active Citizenship** – encourage voluntary activity and the involvement of communities (both “geographic” and “of interest”) in the planning and decision-making process about matters which affect them;

• **Shaping Policy Development/Working Together** – ensure that the knowledge and expertise of the Sector informs policy development and that policies are sensitive to the needs of those who experience disadvantage; and

• **Investment in the Sector/Capacity Building** – build the capacity of the Sector and ensure sustainable resources necessary to enable the Sector to make an effective, continued contribution to society in Northern Ireland.

**Strategic Fit:**
The maximising access project has supported increased collaboration between the community / voluntary and statutory sector including supporting local community organisations to deliver the project locally. Through the recruitment and training of enablers and the lead organisations working in collaboration with community organisations to identify households the project has the potential to support enhanced capacity and improved local connections.

2.3.17 **Ageing in an Inclusive Society – A strategy for promoting the social inclusion of older people**

This strategy sets out the approach to be taken by Government to promote and support the inclusion of older people in Northern Ireland.

The vision of this strategy is “To ensure that age related policies and practices create an enabling environment, which offers everyone the opportunity to make informed choices so that they may pursue healthy, active and positive ageing”.

Six strategic objectives

1. To ensure that older people have access to financial and economic resources to lift them out of exclusion and isolation.

2. To deliver integrated services that improve the health and quality of life of older people.

3. To ensure older people have a decent and secure life in their home and community;

4. To ensure that older people have access to services and facilities that meets their needs and priorities.

5. To promote equality of opportunity for older people and their full participation in civic life, and challenge ageism wherever it is found.

6. To ensure that Government works in a co-ordinated way interdepartmentally and with social partners to deliver effective services for older people.

**Strategic Fit:**
The maximising access project has the potential to contribute directly across a range of recommendations contained within the strategy including identifying and meeting need, improving access to local services and economic resources and tackling fuel poverty.

2.4 **Context looking forward**

In this subsection we consider key factors affecting the current and forward looking strategic context as illustrated in Figure 2.2 below. These are developed further in this section.
Poverty and Social Exclusion in Northern Ireland

In 2009, the Joseph Rowntree Foundation published an update of its Monitoring Poverty and Social Exclusion in Northern Ireland Study (JRF 2006). The update concluded with the statement: “This update is being written during a recession. Unemployment is rising, and the outlook on child and pensioner poverty is uncertain at best”.

The research found that around 20 per cent of people in Northern Ireland live in low-income households, similar to that in Scotland (19 per cent) but fractionally less than England (22 per cent) and Wales (24 per cent). Since the original research on Northern Ireland in 2006, there has been no change in the overall number of people living in low-income households. However, when considered against age categories, the proportion of pensioners in low-income is, at 20 per cent, slightly higher than the rest of the UK (England 18 per cent, Wales 19 per cent, Scotland 15 per cent). In addition, whilst statistics would indicate that the proportion of children in low-income households is lower in Northern Ireland than in England and Wales (around a quarter in Northern Ireland compared to over 30 per cent in England and Wales) the Northern Ireland population overall is younger. Therefore, children in poverty make up a higher proportion of the Northern Ireland population than elsewhere in the UK.

These statistics are compounded by the higher proportion of working-age adults not in paid work in Northern Ireland than across the rest of the UK. In addition, the rise in unemployment in Northern Ireland has increased at a faster rate than across the rest of the UK over the period.

Continuing challenges in rural areas

Many significant issues continue to face rural communities. Pressures felt by wider society as a result of the economic climate are often exacerbated in rural areas resulting in increasing numbers of rural people finding themselves in positions of poverty and exclusion. These challenges are compounded with many needs and issues hidden as a result of isolation in the rural setting (i.e. multiple barriers / deprivation).

Rural poverty manifests itself differently from poverty in urban areas:

• It is not spatially concentrated and is therefore more difficult to identify. Rural poverty is clearly associated with the remote rural regions although obviously not confined to them. The New Policy Institute\(^2\) found, for example, that disadvantage was more prevalent in western districts of Northern Ireland. Broader research carried out across rural areas in the UK indicates that most rural areas are affluent, with rural poverty scattered and hidden amongst general affluence\(^3\).

• People in rural communities are less likely to identify they are in poverty and there is a culture of making do. This is evidenced in part by the lower than average take-up of benefits in rural areas (see Bramley\(^4\) et al 2000).

• There is also strong presence of ‘rural’ in the top 20 per cent of deprived wards as defined by multiple deprivation indicators with the average across the gross weekly earnings of people in rural areas in Northern Ireland from 2001 to 2006 consistently below those living in urban, with the lowest rate of growth occurring in ‘less accessible rural’ areas where, according to the local government based definition of rural, 32 per cent of the Northern Ireland population live.

• In 2007 – 2008 in Northern Ireland, of those who earned 50 per cent below the UK Mean Income before Housing Costs, almost half (46 per cent of individuals) lived in rural areas\(^5\).

Wider economic environment

Challenges within the wider economic environment (e.g. Government spending cuts, rising unemployment, reduced employment opportunities, etc) means that questions and scrutiny in relation to spend and importantly the ‘value of spend’ are the norm. The wider funding environment is also changing. Within this challenging context, it is becoming difficult to justify spend on innovative and preventative initiatives offering longer term benefits at a time when short-term ‘front-line’ services are under threat. This creates additional pressure for all to ensure efficiency and effectiveness is demonstrated.

The wider economic environment also presents challenges for the target audience of the maximising access project. Clearly many significant issues continue to face disadvantaged rural communities across Northern Ireland. Pressures felt by wider society as a result of the economic climate are often exacerbated in disadvantaged communities resulting in increasing numbers of people finding themselves in positions of poverty and exclusion.

Strategic and Policy development

Key announcements made by the NI Finance Minister during his Draft Budget Statement relevant to this project include:

• DARD – budget cuts anticipated of approximately 18 per cent (£40m) between now and 2015.

\(^3\) Shucksmith, M. Poverty and Social Exclusion in Rural Areas of the UK
\(^5\) Source Family Resources Survey Urban Rural Report Northern Ireland 2007-2008 (DSDNI)
• DHSSPS – whilst a degree of protection has been offered for the ‘health’ element of DHSSPS the proposed provision of cuts for personal social services (PPS) is on a similar level to all other NI departments.

• Arms Length Bodies – there is increasing scrutiny on the value of Arms Lengths Bodies (such as PHA). The Budget Review Group is to review all Arms Lengths Bodies against agreed criteria and bring a final set of recommendations for rationalisation to the Executive.

• Benefit Reform – Northern Ireland has traditionally followed GB benefit practice. The Coalition Government has set out major plans to reduce the benefit budget in helping tackle the overall budget deficit.

In looking forward there are two key strategies / policies relating to a new Programme for Government and new DARD corporate plan, both of which will be relevant to any future phase of maximising access project. In looking forward, questions are asked of the project:

• Firstly, is the model provided by the maximising access project the most effective in engaging with the target groups of both policies?

• Secondly, is the project providing / supporting activities or services which government and other bodies will find most difficult to deliver?

The answer to both questions is fundamental to the continuing development of the maximising access project and its potential scalability. Whilst the current project has a strategic fit with the existing policies developments should continue to be factored into any future phase of the project.

2.5 Summary

In this section we have considered a range of policy and strategy documents, and outlined the strategic “fit” with the maximising access project. The project is aimed at improving the quality of life of rural citizens across Northern Ireland.

The section above has served to highlight the strategic and policy context within which the maximising access project has been operating and the current and future challenges associated with its delivery. The key messages include:

• The maximising access project has the potential to contribute to a number of government polices including those related to health, children and young people, rural development, anti-poverty and social inclusion.

• The current context within the wider economic environment presents challenges for innovative projects to articulate their value as question and scrutiny in relation to spend increase.

• Changing economic conditions also present challenges for the target audience of the maximising access programme in terms of increasing levels of unemployment, poverty and exclusion.

• Developing policy in relation to the new PfG and DARD strategic / corporate plans. It is imperative as these two polices develop that maximising access continues to fit within their developing framework.
3 PROJECT PERFORMANCE

3.1 Introduction

The purpose of this section of the report is to outline the performance of the maximising access project against the output targets identified within the original economic appraisal for the project. This section also presents our findings from the stakeholder consultations and consultations with lead organisations in relation to project processes and presents a series of household case studies.

The wider project impacts in relation to economic impacts and the estimated SROI on households associated with the project are presented in section 4.

3.2 Performance against targets

Table 3.1 provides a summary of the overall project performance against intended output targets in terms of the numbers of referrals made against key indicators. The findings are based on information presented by PHA over the evaluation period.
### Table 3.1 Project performance against intended targets

<table>
<thead>
<tr>
<th>Outputs</th>
<th>Intended Target</th>
<th>Performance (as per project update April 2011)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of households recruited across the project</td>
<td>4,200</td>
<td>4,135*</td>
</tr>
<tr>
<td>Number of local enablers trained</td>
<td>200</td>
<td>244**</td>
</tr>
<tr>
<td>Number of lead organisations procured</td>
<td>13</td>
<td>9</td>
</tr>
<tr>
<td>Number of community groups involved</td>
<td>50</td>
<td>164</td>
</tr>
<tr>
<td>Number of referrals for Home Energy / improvement grants</td>
<td>25 per cent of targeted households (1,050 households)</td>
<td>1,701 (exc. NIE Levy)</td>
</tr>
<tr>
<td>Number of referrals to Home Safety Checks</td>
<td>No specific target set for home safety checks</td>
<td>2,655</td>
</tr>
<tr>
<td>Number of referrals to Disabled Facilities Grants</td>
<td>No specific target set for home safety checks</td>
<td>433</td>
</tr>
<tr>
<td>Number of referrals for Benefit Checks</td>
<td>16 per cent of targeted households (672 households)</td>
<td>2,195 BECs referrals made</td>
</tr>
<tr>
<td>Number of referrals to support services</td>
<td>50 per cent of households linked to a range of targeted households (2,100 households)</td>
<td>1,075</td>
</tr>
<tr>
<td>Number of referrals to local community activities</td>
<td></td>
<td>973</td>
</tr>
<tr>
<td>Number of households given greater access to transport</td>
<td></td>
<td>Translink Smart Pass = 713</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Community Rural Transport = 1,716</td>
</tr>
<tr>
<td>Number of people engaging in new social activities</td>
<td></td>
<td>To be determined using follow-up household survey as indicator</td>
</tr>
</tbody>
</table>

**Notes:**

* More than 6,000 households have been identified across the 13 zones. However, as not every household would want to engage on the project the actual number of visits is less. For the purposes of the evaluation we have included the actual number of visits rather than identified households.

** 244 enablers were trained but approximately 150 went on to form the core teams in each zones who completed visits.

*Source: PHA referral monitoring database / lead organisation referrals*
Overall, in terms of the intended output targets contained within the economic appraisal the project has performed well achieving and exceeding targets across several areas, particularly in relation to the numbers of referrals made across the different categories.

However, as is discussed when we progress through the project impact section (section 4) what is less clear from this information is the quality of referral (i.e. how many of these referrals have proceeded through to an outcome for the household?). Whilst this will be how the overall project is measured in terms of performance it should be recognised that at an operational level it has achieved what it set out to in terms of engagement and referrals.

Further discussion of the performance in relation to impact is contained within Section 4.

3.3 Qualitative discussion of project performance

The subsections that follow present a summary of the overall performance of the project in terms of its management and operation. These sections have been informed through our consultations with lead organisations and project stakeholders. The section is grouped in to the following areas:

- Identification of households and target groups;
- Recruitment and training of enablers;
- Referral processes; and
- Project management arrangements.

3.3.1 Identification of households and target groups

Identification of households

The approach to identifying and engaging with the households involved a community development approach. Lead organisations used resources, knowledge and contacts within the local community in order to identify the most vulnerable individuals. The specific approach in each of the 13 zones varied between the different lead organisations. For example, in some zones, lead organisations used electoral registers and asked community volunteers to identify households who may potentially benefit from the project. In other zones, lead organisations used maps of the local areas, again asking community volunteers to identify the most vulnerable households. Whilst the specific approach may have varied, the overall ethos of using local knowledge through a community development approach remained consistent.

It should be noted that procedures for identification of households were set out and discussed by PHA / DARD with lead organisations at the outset of the project. The lead organisations were advised to identify partner organisations / local community groups within the zones in which they were operating and set up project management groups to take the project forward. Information from the lead organisations would indicate that only in a limited number of cases did this process actually take place. One lead organisation cited during consultation:

“A large number of groups were contacted to set up steering groups, however the general response was that groups were either not interested or did not have the capacity to attend a formal group – as a result we took the decision to have a more informal process and worked on an individual basis with groups.” (Lead Organisation)

In one of the areas where a steering group was set up the lead organisation stated:
“The project team for the area was vital for the project to work. It was an important process in terms of accountability and shared responsibility. In the same way when we went to the lead organisation meetings we were challenged and were able to challenge ourselves the project team meetings gave the opportunity for a similar process at a local level” (Lead Organisation)

In relation to carrying out home visits, the project fractionally missed out on meeting its target by 65 visits in total across the 13 zones. Overall, 4,135 home visits were undertaken against a target of 4,200. The performance in each of the zones against targeted home visits varied significantly as depicted in Table 3.2.

Table 3.2 Household targets by zone

<table>
<thead>
<tr>
<th>Zone</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>450</td>
<td>450</td>
<td>250</td>
<td>250</td>
<td>300</td>
<td>300</td>
<td>350</td>
<td>300</td>
<td>317</td>
<td>317</td>
<td>350</td>
<td>216</td>
<td>350</td>
</tr>
<tr>
<td>Visits</td>
<td>365</td>
<td>459</td>
<td>279</td>
<td>202</td>
<td>308</td>
<td>233</td>
<td>283</td>
<td>336</td>
<td>442</td>
<td>328</td>
<td>352</td>
<td>243</td>
<td>305</td>
</tr>
<tr>
<td>Variance</td>
<td>-85</td>
<td>+9</td>
<td>+29</td>
<td>-48</td>
<td>+8</td>
<td>-67</td>
<td>-67</td>
<td>+36</td>
<td>+125</td>
<td>+11</td>
<td>+2</td>
<td>+27</td>
<td>-45</td>
</tr>
</tbody>
</table>

Source: Public Health Agency

Eight out of the 13 zones exceeded their individual target for household visits. However, of the remaining five zones the target was unmet in each case by between 45 and 85 visits.

A number of variables identified during the consultation process could explain the variance across the project including:

- **The lead organisation was working outside of their usual geographic area**
  - In four out of the five zones where the target was not achieved the lead organisation was working outside of their usual geographic area. Whilst in some cases this meant lead organisations had the opportunity to build new relationships the nature of the programme meant that those with existing relationships and importantly trust were able to move quicker at the outset of the project to identify and engage with community groups and households.
  
  “It did need more effort in the areas we had not worked in before to engage with community groups and build up a network to start the ball rolling with identifying households. This added to the delays at the outset meant we were quite far behind some of the other lead organisations and were constantly playing catch up” (Lead Organisation)

  In three out of the five zones where the target was not achieved the lead organisation was managing the project in at least one other zone. Interestingly in all cases where this was the case the lead organisation exceeded the target set within the geographical zone where they usually operated.

- **Type of organisation** – the specific approach / methodology may have been more consistent with the ethos of some organisations over others (e.g. where the organisation had previous experience of a community development approach). Of the nine organisations who delivered the project, six organisations were rural community networks, two had a more general community / voluntary background and one was classified as a social enterprise. Whilst different types of organisation likely operate in a different way, will have different aims and likely different relationships at a community level analysis of the data does not indicate any specific variance in terms of performance against targets.
• **Delays at the outset and weather conditions** – some lead organisations discussed underestimating the time commitment required at the outset of the project to engage with local community groups and recruit / train enablers. There was also suggestion of initial delays as a result of “teething issues” around agreement on the household questionnaire.

“At the outset of the project we had several delays awaiting agreement on the household questionnaire, the referral database and promotional materials. All of these delays had a knock on effect in terms of when we could actually start household visits and in when we could train enablers.” *(Lead Organisation)*

“I think there was an unrealistic timescale set at the outset. We definitely needed more lead-in time and so when delays did happen they were more damaging. I think the fact that it kicked off entering the summer months (i.e. May / June) was also a bit of a challenge” *(Lead Organisation)*

In addition the weather conditions of late November / early December resulted in a lower number of visits being completed across the zones during this period. However, this was highlighted during lead organisation meetings and PHA / DARD made the decision to extend the time given to lead organisations of engaging with households until the end of January.

During the consultation process lead organisations were asked specifically for their views / opinions on the processes around identifying and engaging households. General themes from the discussion included reference to:

• The need for reminder calls to be made in advance of visits to ensure the householder would be present and they were still happy to participate in the project;

• Challenges in some areas of identifying and engaging households as a result of confidentiality issues (i.e. community groups / agencies not comfortable / reluctant to identify / share names and addresses of potential households);

• Perception of a high level of refusal due to suspicions of the project. This was as a result of negativity of the economic climate fuelled by significant media coverage around issues relating to government cuts (particularly on welfare) and broader fears amongst some individuals of potentially losing benefits as a result of the project;

• Reluctance of some households in sharing some information (e.g. Farmers reluctant to share farming income information etc); and

• Some households despite being identified as vulnerable indicating that they were happy enough with their current circumstances and did not want to “go through the hassle”.

As the project progressed, there was discussion at lead organisation meetings around how best to overcome the challenges. One solution presented included increased advertising and promotion. However, many of the lead organisations noted that in the main the majority of those people identified came through contact with individuals / community groups or through word of mouth as the project progressed (e.g. a number of lead organisations identified cases whereby whilst one household was carrying out a visit they identified a neighbour or relative who was in a similar or worse position to themselves). Whilst all of these issues / challenges were identified by lead organisations there was recognition that many of the issues were related to the fact that individuals identified were “the most vulnerable” and as a result were the “hardest to engage”.
Target groups

As is discussed in section 2.2.2 a number of target groups were identified by PHA / DARD through which lead organisations were anticipated to be prioritising “those most socially excluded.”

In this subsection we summarise results from an analysis of the household survey\(^6\). The findings are able to support an understanding of the types of individuals / households engaged in terms of age, educational background and health. The survey was also analysed in terms of engagement with the target groups of the project (see Section 2.2.2). It should be noted that whilst target groups for the project were identified there were no formal targets for engagement with the groups.

The overall trends of householders summarised below were reflective across the 13 geographic zones of the project.

- The majority of the sample was female (63.1 per cent; \(n = 2,609\)).
- The average age of those interviewed was 60 years.
- The majority of interviewees (71.6 per cent; \(n = 2,960\)) indicated they had no formal qualifications (perhaps indicative of the age profile of those engaged).
- 82.3 per cent (\(n = 3,403\)) indicated they were not currently in employment. Of those not in employment a large minority (38.7 per cent; \(n = 1316\)) were retired or permanently sick / disabled (17.8 per cent; \(n = 605\)).
- Over half of interviewees (56.3 per cent; \(n = 2328\)) indicated they had a long term illness.
- 18.5 per cent (\(n = 765\)) either lived with or were carers themselves.

A summary of the target groups of the project engaged is presented in Table 3.3 below.

**Table 3.3 Representation of target groups amongst the sample**

<table>
<thead>
<tr>
<th>Target Group</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disabled</td>
<td>2421</td>
<td>59.5</td>
</tr>
<tr>
<td>Pensioners</td>
<td>2087</td>
<td>51.8</td>
</tr>
<tr>
<td>Lone Adults</td>
<td>1586</td>
<td>41.8</td>
</tr>
<tr>
<td>Carers</td>
<td>839</td>
<td>20.7</td>
</tr>
<tr>
<td>Farmers and Fishermen</td>
<td>392</td>
<td>9.6</td>
</tr>
<tr>
<td>Lone Parents</td>
<td>345</td>
<td>9.6</td>
</tr>
<tr>
<td>Ethnic Minorities</td>
<td>61</td>
<td>1.5</td>
</tr>
</tbody>
</table>

*Source: PHA Household Survey*

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\(^6\) Note: the household survey is the initial survey undertaken by the enabler upon visiting the household. This includes a broad spectrum of questions relating to home, access to services, health, income and benefits.
The largest proportion of households had at least one disabled household member (59.5 per cent; n = 2421), with pensioners (51.8 per cent; n = 2,087) the only other target group represented by more than half of the sample. A large minority of the sample (41.8 per cent; n = 1,586) were identified as lone adults. One in every five of the households (20.7 per cent; n = 839) had carers, whilst, less than one in ten were made up of Lone Parents (9.6 per cent) or Farmers and Fishermen (9.6 per cent). A very small minority of the households (1.5 per cent) contained a member of the ethnic minority community.

Whilst it is important to note that no specific targets were set across these key target groups the relatively high proportion of disabled and older people combined with the relatively low proportion of farmers / fishermen, lone parents and ethnic minorities does warrant further investigation. As part of the consultation process we asked lead organisations to discuss how households had been prioritised and whether they had any specific challenges in engaging with any of the identified groups. The majority of groups stated they had used the criteria circulated by PHA / DARD to prioritise households. In some cases the lead organisations discussed engagement with community groups in the local areas that worked with one of the targeted groups (e.g. groups who worked with lone parents, older people, people with disabilities etc) and this acted as a mechanism in itself to target / prioritise.

“We used the criteria circulated by project co-ordinator and also discussed the lists with local groups to ensure everyone knew who the specific targets of the project were” (Lead Organisation)

Although the majority of groups indicated they had used the criteria identified, seven of the nine lead organisations also indicated that it was difficult to identify the 50+ households required in each SOA and as a result most people eligible qualified for a visit.

“Yes we tried to use the criteria as supplied. However, it was difficult to get the 50+ houses in some of the SOAs and so we didn’t necessarily need to use criteria to prioritise – basically everyone identified was entitled to a visit” (Lead Organisation)

“The lower than anticipated number of houses being identified and willing to take part resulted in this not being an issue for us” (Lead Organisation)

Lead organisations were also asked to identify any particular difficulties in engaging with any of the identified targeted households. The most common response was that ethnic minorities were the most difficult households to identify and engage and this is perhaps reflected in the lower than expected return of these households within the project.

“We tried to engage with a local ethnic minority group – however there were significant challenges in helping them understand what the project was trying to do and they were very defensive about sharing information. In the end we just couldn’t spend the time needed to build up the trust and relationship” (Lead Organisation)

During the stakeholder and referral organisation consultations we also discussed the targeting of priority groups within the project. In the majority of cases consultees were not surprised that Disabled and Older People were the two largest groups to be identified. Whilst some stakeholders believed ethnic minorities could potentially be under-represented in the sample others recognised this could be because they were “simply not within the targeted zones in any great number”. 
3.3.2 Recruitment and training of enablers

In total 244 enablers were trained across the project. This exceeded the original target set within the contract of 200. However, whilst 244 enablers were trained, fewer numbers actually completed household visits. Anecdotally, the majority of lead organisations stated that whilst they may have recruited and trained up to (and in some cases more than) 20 enablers it was more common for a team of around 6 – 10 core enablers to actually undertake the visits. It should be noted however that the target set for the project was in relation to the recruitment and training of enablers and as such the target has been exceeded. Specific reasons for the lower numbers of enablers actually undertaking visits is presented later in the section.

PHA has recently undertaken a survey with enablers from across the project. Within the survey a series of questions were asked with regards the background of enablers, their reasons for getting involved in the project, views and opinions of training and undertaking household visits. In the subsection below we provide a summary of the results from the survey alongside views of stakeholders and lead organisations.

Recruitment of enablers

In terms of identifying and recruiting enablers, there was again a different approach across zones. Some lead organisations had a base of volunteers themselves who provided a first source of enablers; others used local community networks / contacts to identify prospective enablers whilst others advertised through local publications including newspapers, flyers and posters. Whilst the position of enabler was advertised this tended to be very informal and rarely involved formal details of the tasks / activities likely to be undertaken. This potentially had implications in terms of the numbers of enablers who were recruited and signed up for the training but never actually completed any household visits.

“Having more trained enablers can equally share the workload but the quality of work and the attitude of caring and patience are of ultimate importance in meeting the client’s needs.” (Lead Organisation)

However, some of the lead organisations discussed challenges with maintaining enablers in the period post-training. Challenges included losing enablers because they were not able to commit enough time, others were recruited and trained and their circumstances changed which meant they were unable to commit whilst some went through the training and then believed they were not best place to undertake the visits. In a number of cases lead organisations discussed how they had trained enablers to work in the summer but because in some zones lead organisations were not in a position to begin household visits until September the enablers (many of whom were teachers / students etc) were unable to commit the same amount of time they could have done in the preceding months.

Background / Characteristics of enablers

As would be expected given the different approaches to recruiting enablers across the different zones and the nature of the role itself, enablers came from a wide variety of backgrounds in terms of education and experience. A summary of the survey information indicates that a significant minority of trained enablers had a third level education, and had a background in teaching.

Survey respondents were asked to consider characteristics that are important for the role of an enabler with reliability (98.0 per cent), sensitivity (97.1 per cent), ability to work well independently (97.1 per cent) and dedication (91.4 per cent) all being highlighted by those surveyed as being very important or essential. Interestingly, knowledge of the individual in the household (13.3 per cent) and knowledge of the area (46.7 per cent) were identified by smaller numbers of enablers as being very important or essential.
Lead organisations were also asked for their view on the principles or characteristics of a good enabler. Responses included:

**Principles**

- Good knowledge of the area so that they are able to identify with the specific needs of the area and quickly build trust and rapport with the prospective client;
- Need to fully understand the role; and
- Require appropriate tools for the job.

**Characteristics / Skills**

- Good interpersonal skills;
- Good communication skills;
- Good listening skills;
- Efficient and accurate;
- Flexible when the need arises; and
- Ability to gather and utilise a wide range of information across a variety of areas.

**Enabler Training**

Enabler training was carried out across the 13 zones by CAB, PHA, NEA and A2B. It was an essential requirement that enablers attended two days of training prior to undertaking a household visit. This involved training related to benefits and grants and in relation to customer care and learning skills. The training sessions were delivered in a classroom-style with participants taken through the detail by a representative from the different agencies involved. In some areas representatives from lead organisations who were not training as enablers sat in with the training, however, this was not formally required.

Within the survey enablers were asked a series of questions in relation to training. This included agreeing or disagreeing with a series of statements. Responses in relation to training were varied across the sample. Almost three-quarters of enablers (73.6 per cent; n = 81) either agreed or strongly agreed that training sessions had prepared them for making household visits. However, more than half (53.2 per cent; n = 58) also agreed or strongly agreed that training would be better if it included role playing, whilst just over a third of people agreed or strongly agreed there was too much information during training that was unnecessary. In terms of peer training, just over one third (37.3 per cent; n = 41) also agreed or strongly agreed that training would be better if it was delivered by other enablers.

In relation to the actual content of the training, enablers rated training for the completion of the Household Questionnaire (78.6 per cent) as very or extremely useful. Furthermore, more than half of enablers found completion of the A2B questionnaire (57 per cent), customer care (53.6 per cent) and benefits training (55.4 per cent) very or extremely useful. However, over one third of enablers (37.5 per cent) found the benefits training not useful or only a little bit useful. There was also some uncertainty with regards customer care training with more than a third (34.8 per cent) indicating they did not find it useful or only a little bit useful.

Overall, the majority of enablers (55 per cent; n = 62) did not feel there was a fundamental training issue missing. Of those who said there was something missing from the training (40 per cent; n = 45), the main additional training needs focused on role playing, counselling techniques and support for enablers, more hands on completion of the questionnaire and understanding / contextualising the project.
There was some discussion from lead organisations with regards the content of training. More than half of lead organisations believed that training was very heavily focussed on the technical side of benefits and indicated that in their opinion enablers would have benefitted further with enhanced training in some of the softer skills, such as customer care. A smaller number of lead organisations commented however that they believed the training was too long and unnecessary.

**Enablers and Household Visits**

The enabler survey also asked questions in relation to household visits themselves. Enablers were asked whether they would have liked to have completed more household visits with more than two thirds (67.9 per cent) indicating they would. The most common reason for not completing visits was the project ending (27.7 per cent) or that the enabler did not have the time to do any more visits (22.3 per cent).

When on household visits, half of the enablers surveyed (50.6 per cent, n=83), on average, made one visit to households and a further 38.6 per cent (n = 43) visited a household twice before securing the interview. More than one in every ten (10.8 per cent; n = 12) indicated they had to pay a household more than three visits before they could secure an interview.

In relation to timing of household visits it was expected (based on the pilot) that household visits should take one hour to complete the questionnaire. The majority of enablers (73.3 per cent, n=105) reported that, on average, household visits took 1-2 hours to complete. More people stated it took less than an hour (20 per cent; n = 22) than more than two hours (5.7 per cent; n = 6) to complete.

3.3.3 Referral processes

Within this subsection we consider the referral processes and relationships between lead organisations and referral organisations. This has been informed through our consultation programme.

“The processing of some onward referrals were very time consuming. I spent approximately a full afternoon on one referral to social services”. *(Lead organisation)*

“The referral path for social services was not very clear cut. This is a learning point from the project and one that requires further thought for any possible rollout of the project.” *(Lead organisation)*

Lead organisations were also asked to discuss relationships with referral organisations as well as the actual process for referrals. The majority of the lead organisations commented on the helpfulness of the Processes Manual (developed by PHA) which contained helpful advice and guidance on the process for making the various onward referrals.

In terms of the actual relationships with referrals organisations there was mixed commentary by lead organisations. In some cases, lead organisations were very complimentary with regard to referral organisations and discussed enhanced relationships at a local level as a result of the project. This was cited as having potential benefits to lead organisation, referral agencies and local community groups in “having everyone around the same table to be able to learn and challenge each other”.

In many cases, lead organisations had existing relations but may not have been working directly with referrals organisations and the project had helped to support a more developed and formal relationships.
There were however a number of challenges from lead organisations. In particular, some discussed how “challenging” it was at the outset when referrals started to filter through, with some referral organisations appearing unaware of the project. Others discussed how some referral organisations refused referrals because all of the information they required was not captured on the referrals sent through (e.g. in relation to the Disabled Facilities Grants information is required on the individuals GP which was not originally asked for in the Household Survey). Whilst this was subsequently changed within the household survey, there was a general feeling from some lead organisations that information on the project had not been appropriately filtered down to the local level of all organisations and as a result challenges were presented in building initial relationships. This was something that was recognised by stakeholders of the project. In particular, PHA noted that in looking forward further work should be undertaken to ensure the purpose of the project and potential requirements of referral organisations are appropriately filtered down to the local level to ensure that all stakeholders are aware of their responsibilities.

Issues relating to the capacity of some referral agencies were also highlighted (e.g. in one zone a lead organisations highlighted the challenge with Home Safety Checks. In general in the area two home safety checks were carried out per week by the staff member but in one day alone maximising access had identified 22 referrals). There was some concern that lead organisations would “bear the brunt of raising expectations” from individuals if referrals were not processed in a timely manner. Some of the referral organisations however indicated that part of the responsibility lay with lead organisations themselves in ensuring referrals were made in a “realistic manner”. One organisation stated:

“In one particular area we received referrals as and when they happened and we had no problem dealing with them on this basis. However, across other areas we didn’t get any referrals until a month before the end of the project and then received 40 at a time – this was never going to be manageable with the resource we had” (Referral organisation)

A few lead organisations also expressed some frustration at not finding out details of outcomes on referrals made. In their opinion, feedback on the actual outcomes of the referrals was a useful tool in both advertising the project within the local area but also good potential PR for the lead organisation. Tracking of certain referrals is a key challenge for the project (discussed in more detail in section 5). In some cases, the lead organisation may be delivering activities / services (e.g. South Down Family Health Initiative deliver “silver surfers IT training” etc) whereby individuals have been referred and the lead organisation can monitor the direct link between maximising access and participation in the activity. In other cases however the lead organisation does not deliver any of these types of services and given the broad range of potential activities it is almost impossible to identify whether individuals will actually go further than the initial referral. It is important to contextualise the isolated / vulnerable nature of the target group of the project with regards these activities.

### 3.3.4 Project management arrangements

In this subsection we discuss the overall view of stakeholders, referral organisations and lead organisations in relation to project management arrangements. This includes discussion of the regional project management group, regional operational group, lead organisation meetings and relationships between key stakeholders as a result.
Overall the lead organisations were largely satisfied with the process and management of the project. However, a few lead organisations discussed some specific challenges as the project progressed. This included agreeing the original household questionnaire and in administration around the referral and follow-on processes. The Regional Operational Group and Lead Organisations meetings were viewed as being “efficient” and “supportive” of discussing these issues – this was especially the case when lead organisations discussed the project in comparison with other statutory funded projects which were deemed to be “daunting” or “bureaucratic”.

Statutory stakeholders and referral organisations involved in these forums / structures also valued them as mechanisms to share, learn, challenge and develop the project as it progressed.

“The meetings offered an opportunity for us all to meet, discuss the key challenges / issues and make timely decisions to maintain the project momentum” (Referral Organisation)

“In the absence of these structures the project simply would not have progressed within the timescale” (Referral Organisation)

Lead organisations also discussed challenges in relation to the reluctance of some community groups / agencies to identify households and the “time consuming but worthwhile” time they needed to spend at the outset fully briefing community groups and stakeholders of the project at a local level. Other issues encountered related to data protection / confidentiality and suspicion from households who were “afraid of losing benefits” when not fully informed of the project. These were challenges that lead organisations believed should be identified for the purposes of understanding what was “faced on the doorstep” with the project. Again, lead organisations were complementary of the management structures in place within the project which allowed discussion of these issues in a timely fashion.

All of the lead organisations talked positively about the role of PHA and DARD within the project. In particular, individuals mentioned representatives from both organisations being “engaged on the project” and efficient when dealing with particular issues / challenges. The lead organisation meetings (which included all lead organisations as well as PHA and DARD representatives) were viewed as being a successful mechanism for issues to be addressed and lead organisations welcomed the opportunity to directly engage formally with both agencies regularly which was viewed to be “significantly different to many other projects where the statutory bodies are not always engaged consistently throughout”. The regular monthly meetings were viewed as “keeping lead organisations on track” and also providing an opportunity to network with other lead organisations “learning lessons” and “sharing experiences along the way”. One lead organisation summed up their view of the role of PHA / DARD by stating “I could not have wished for a better or more flexible management team from both Departments”.

### 3.4 Household case studies

In this subsection we present a number of household case studies. These case studies have been developed using information provided by lead organisations, enablers and referral organisations. The case studies are presented anonymously in order to protect the identity of the specific households.

**Case Study One**

Client 1 is a married woman with four children all under 12 years old. She has been diagnosed with cancer, and is currently unable to work due to ill health. On the enabler’s arrival the woman and her four children were in the one room wearing heavy coats. The room had one heating source which was an open fire with no back burner.
Following an initial discussion the enabler identified that the whole family slept in this one room as the house was so difficult to heat and they could not afford to pay for oil. The woman’s husband was working part-time, as a long distance lorry driver but could only work when something was available. He also often had to take time off work to care for the woman and the children. As a result, money was tight and paying for their mortgage was becoming a challenge and compounding the issues of ill health for the woman.

The enabler used the directory developed for the Maximising Access Project, to outline the range of local support services available from listening ear to childcare services. Immediately after making this initial contact and agreeing on potential onward referrals the enabler liaised directly with the lead organisation who was able to fast track the lady’s referrals including through the Warms Homes Scheme provider for the area. Social services were also contacted on behalf of the family who were almost immediately able to provide support vouchers for a local shopping centre and a £200 voucher for heating oil.

Case Study Two

Client 2 lives in a privately rented detached house along with her husband and son, with the house having an open fire as the only source of heating. Through maximising access she was referred to the warm homes scheme. A warm homes surveyor called to the house within weeks of the initial contact by the enabler – following a survey they surveyor was able to confirm entitlement to loft insulation and the installation of a new fully controlled energy efficient oil fired heating system. A heating install team has since arrived and installed the necessary measures.

The client also received a benefit entitlement check through maximising access which identified that she was missing out on Pension Credit, an additional £62.25 per week which equates to £3,237 per annum. The claim is currently with SSA for verification. The client was thrilled with the outcome and in particular the swift installation of the new heating system:

“I was really impressed how quickly it was installed and I am looking forward to being more comfortable when the cold weather hits again”

Case Study Three

Client 3 is a 63 year-old woman. She is in receipt of the Higher Rate Care and Higher Rate Mobility Components of Disability Living Allowance (DLA). Her husband is in receipt of Incapacity Benefit (IB), Pension Credit (PC) and the Middle Rate Care and Higher Rate Mobility Components of DLA. He also receives a private pension from Royal Mail. He also acts as the Client’s carer.

The Client was under the impression that her husband was receiving her pension within his IB/PC monies. Without the engagement with the enabler through maximising access and completion of the A2B screening questionnaire she wouldn’t even have queried what she was receiving. Following referral from the maximising access project a CAB advisor phoned the Pension Service to confirm exactly what the Client was in receipt of. Due to this investigation, the adviser was able to make a correct claim for the Client, and got it back-dated to the Client’s 60th birthday. This meant that, not only was the Client entitled to a further £85 per week, or £4,420 per annum, but also a one-off back-dated payment totalling over £12,000 before tax.

The Client’s husband will still be able receive the Incapacity Benefit until next year, when it will then convert to State Retirement Pension. He will also still be able to receive the top-up of Pension Credit, which will act as a Passport Entitlement, enabling the Client and her husband to receive Winter Fuel payments, Social Fund entitlement, Rates Relief help, etc.

The Client was delighted with the outcome of her visit and was looking forward to receiving the back-dated payment of around £12,000 which is currently being verified by SSA.

Case Study Four
Client 4 is a single lady who lives alone and owns her home outright. She is now retired and receives the State Retirement Pension, based on her National Insurance contributions. The Client is also in receipt of the Middle Rate Care Component of Disability Living Allowance (DLA). The Client has no other income and little in the way of savings or assets, excluding her home. Within engagement through the maximising access project she would never have questioned what she was currently being given in benefits.

As the Client receives State retirement Pension of £89.25 per week, her Pension Credit would be paid at the rate of £97 per week, or £5044 per annum. The Client is also eligible to claim assistance with her rates, to the value of £16 per week, or a further £832 per annum. This additional entitlement is currently being verified by SSA.

Case Study Five

Client 5 is a self employed farmer who was identified as entitled to approximately £50 of Working Tax Credits in September 2010 following a visit from a maximising access enabler.

There was an issue with HMRC not recognising his national insurance number, and refusing to process a claim for tax credits. It took several months, and several home visits, letters and phone calls to resolve this issue. There was also an additional issue with self-employment status, and a Benefit Advice Co-ordinator from Bryson Energy had to attend the Tax Enquiry Office with the client to get it resolved.

Following all of these efforts tax credits were awarded in April 2011 and an appeal has been sent to HMRC claiming backdated tax credits to June 2010 (worth approx. £1,500 - £2,500) when his award should have been payable from if HMRC had recognised his national insurance number. The appeal could take several months to be decided.

Without initial engagement through the maximising access project the client would not have proceeded with this application.

Case Study Six

Following engagement through the project Client 6, who was living in private rented accommodation, was identified as being entitled to Housing Benefit for rents and rates. It was a complicated case where the client had fallen into difficulties following the death of her husband and had not paid rent or rates since 2008.

Through the project the client was assisted with the application process, but the landlord could not be contacted to confirm occupancy and liability for rent, despite numerous attempts. This meant that assistance could not be claimed for the rent. A further claim was submitted to NIHE asking for assistance with rates as the client was liable for these, explaining the unusual circumstances and requesting the award be backdated as the client had made a number of claims since 2008 that had been turned down as a result of the absent landlord. NIHE turned the application down, however following a phone call between Bryson Energy and NIHE to clarify this situation the subsequently overturned the decision and have agreed to award Housing Benefits for Rates (worth approximately £450 per year) and backdate this to May 2008 (worth £1,150).

This is expected to really support the client, as she had recently received a CCJ for the outstanding rates for the past three years, and this can now be stopped. It is highly unlikely that this client would have received this outcome in the absence of the project.
Case Study Seven

Client 7 is a mature single lady who lives with her adult son. She is now retired and the enabler upon making initial contact talked through the maximising access programme and completed a benefits questionnaire. The enabler noticed that whilst the lady was being receptive to the questionnaire she was anxious about something else. Using the directory developed for the programme the enabler outlined the range of support available to the client (i.e. the programme was focussed on more than just maximising benefits but also in enhancing awareness of and access to local services). During the conversation on the broader support available the lady began to talk about her son, who having had a “difficult time” in his life had recently attempted to take his own life. The lady indicated she was not sure how best to support him. In the first instance the enabler provided details for Lifeline and the Samaritans and also provided a telephone number for the lead organisation for her to contact should she need too. Over the next few weeks the enabler received 5 or 6 phonecalls from the lady to talk across a number of issues, one of which was a continued concerned for the welfare of her son. As with the house-visit the enabler directed the lady towards specialist service provision in the form of Lifeline.

Several weeks later the enabler took another call from the lady and from her son, both of whom thanked her for the support she was able to provide and said they did not know “where they would have been” without the support and direction towards Lifeline. As part of the project the client not only got her son back but has also received support through the warm homes scheme and received a Smartpass.

This case study provides an example of how proactive engagement with vulnerable individuals through maximising access had provided an opportunity for the household to receive additional support they would otherwise not have been aware of.

Case Study Eight

Client 8 involves a Polish family. An enabler called at the house after the household was identified by a concerned neighbour however the female’s English was poor and she asked the enabler to come back that evening when her husband returned home from work. Initially the husband was suspicious however when it was explained that his next door neighbour had suggested the enabler called and that she too was taking part in the project he agreed to take part.

As the enabler progressed through the form it was clear that although he was working and was involved in the community his wife was not. The enabler suggested a number of relevant services in particular Homestart as they had young children under the age of five. The husband stated that due to his wife’s lack of English she would not want to attend – however the enabler was able to tell him about a small group that Homestart was organising in a neighbouring village which included other Polish Mums. The enabler agreed to contact Homestart and with his permission made a referral for his wife to attend this group. She has since attended several Homestart meetings and is considering taking an English class at the same centre where it is provided.
Case Study Nine

Client 9 is a single man who lives on his own and is an ex-member of the security forces. When he was first engaged by the project it was identified that his only income was jobseekers allowance of £54 a week. He had previously been on the sick but got boarded. However since then his health had deteriorated and with angina and other health related problems he is not permitted to lift heavy objects. After being referred to CAB for a BEC through the project the client is expected to receive DLA. This is expected to more than double his household income. The enabler was also able to talk the gentleman through other aspects of the project. Subsequently, he has received a pill organiser for his medication, low energy light-bulbs and the ‘third hand/helping hand’ service.

As a result of the project the gentleman also made contact with the lead organisation. Following a number of discussions it was identified that he would also benefit from an employment skills project the organisations was delivering in the local area, which he is currently attending to enhance his employability skills.

The enabler’s original engagement with the gentleman was only made possible through the trust that he (the Enabler) had already built with the individual through his involvement in a local group who was supporting ex-military people. This example highlights the importance of local knowledge and experience of engaging the hardest to reach individuals.

3.5 Summary

This section has presented the performance of the project against the intended output targets set at the outset. Overall, using the numbers of referrals generated as an indicator of success the project has performed well against its original objectives.

The Section has also considered the views / opinion of stakeholders of the project including all of the lead organisations procured to deliver across the 13 identified zones in terms of project processes and operation. Findings would suggest that the majority of stakeholders are positive about the project in terms of its intended aims and how it has performed. There are also a number of challenges that have been identified and things to be considered in looking forward to any future phases of the project.

This section has provided important background for the project impact section identified in Section 4 and evidence for our analysis against specific terms of reference as considered in Section 5.
4  PROJECT IMPACT

4.1  Introduction

In this section we consider the overall impact associated with the project in terms of impacts / outcomes realised to date. This includes consideration of impacts on all stakeholders affected by the wide range of impacts / outcomes created as a result of the maximising access project including:

- Targeted households;
- Local enablers;
- Lead organisations;
- Referral agencies; and
- Other statutory Departments / agencies.

The section also provides a forecast SROI specifically focussed on the impacts / outcomes on the households in receipt of support through the project. A forecast SROI predicts how much social value will be created if the activities of the project meet their intended outcomes. Ideally, a full SROI would consider impacts / outcomes across all of the stakeholder groups, however, due to the complexities in articulating and calculating the financial proxies for SROI this has been restricted to the impacts on households only.

Findings in this section are drawn from a range of sources including consultations and follow-up information provided by key agencies / stakeholders, a follow-up survey undertaken by PHA with more than 280 households visited, case studies with individual households and other quantitative and qualitative information gathered through the project monitoring arrangements.

4.2  Methodological Issues

It is important to highlight some key methodological issues at the outset of this section in terms of the identification and measurement of outcomes / impact. These include:

- Some referrals sent from lead organisations to referral agencies have not yet been processed and as a result the actual outcome / impact of these referrals have not yet been realised;
- Some of the outcomes / impacts anticipated by the project are likely only to materialise in the longer term. Given the profile and characteristics of the target group involved on the project changes may only occur in small steps (e.g. in relation to improved health and wellbeing); and
- Tracking of some of the outcomes / impacts (e.g. participation in Social Clubs etc) are very difficult if not impossible as the person may be undertaking the activity as a result of the project but also independently of it (i.e. they may have contacted a local organisation from the directory of services received as part of the project).

Whilst this section attempts to consider the outcomes / impacts materialised to date it also considers (in terms of the forecast SROI on households) the likely outcomes / impacts based on existing research and assumptions gathered from key agencies and qualitative findings through feedback from stakeholders, lead organisations and householders themselves.

These methodological issues should be considered by the reader as they progress through this section.
4.3 Stakeholders and Impacts

Within this section we provide an overview of the wider benefits associated with project as identified throughout the evaluation. The diagram overleaf provides a summary of the stakeholders and impacts realised. These impacts are further developed in the subsections below.
Increased organisational capacity;
Increased understanding of need within local communities;
New and existing relationships built / sustained within local communities;
Partnership working with Statutory bodies / referral agencies not previously worked with;
Relationships developed with other community / voluntary groups not previously worked with;
Increased uptake and awareness of services provided by lead organisations within the communities;
Increased income through payment for visits;
Personal development:
  • Increased knowledge of local communities;
  • Increased local network;
  • Meeting new people; and
  • Positive experiences of helping disadvantaged / vulnerable people.
Professional development
  • Work experience;
  • Increased understanding of benefits process;
  • Increased understanding / knowledge of range of benefits / grants and services; and
  • Increased skills / knowledge of customer care procedures;
  • Increased IT skills
4.3.1 Impact on Targeted Households

As the scope of the SROI is focused around the targeted households the impact section on targeted households is provided separately in section 4.4. This is to incorporate impacts identified through the consultation process and to proceed through the SROI calculation. Case studies of individual households are also presented in Section 3.4.

4.3.2 Impact on Lead Organisations

As part of the consultation process with lead organisations we asked them to identify the impacts / outcomes that had materialised for them as a result of being involved in the maximising access project. The lead organisations discussed a range of impacts and outcomes. For the purposes of reporting the impacts mentioned regularly during consultations have been grouped as follows:

Increased organisational capacity

Lead organisations discussed increased organisational capacity as a key impact. This included increased staff / volunteer capacity through the recruitment of enablers. One lead organisation stated “in the absence of the maximising access project we simply would not have considered recruiting such a large number of volunteers”. Another lead organisation said in the absence of the project “we would never have had the resource to reach as far out into the community as we were able to as a result of the volunteer base the project gave us”. Many of the lead organisations also discussed maintaining this volunteer base as a positive sustainable aspect of the project. For example, one organisation stated “we now have more than twenty new people to call upon as volunteers if we ever need them in the future”. Whilst some of the lead organisations used their existing volunteer bases in the first instance to recruit enablers a number indicated during the consultation process that all of the enablers recruited during the project were “new to them”.

Two organisations discussed increased organisational capacity in terms of an increase in full-time employed staff. In both cases an enabler recruited through the project went on to take up a full-time post in the period when the project finished. In one case the lead organisation said “the project provided an opportunity for us both to find out about each other a role became available and it’s worked out very well for both of us”. One other organisation also discussed using the maximising access project as an opportunity for existing staff’s professional development. In the case of this organisation a member of staff who previously had worked in an administration capacity was able to take on a project management role. This not only supported her to increase skills and experience but also “kept her in employment at a difficult time”.

Increased understanding of need with local communities

The majority of lead organisations identified their increased understanding of need within the communities in which they had worked. One organisation confirmed this by saying “we knew there were challenges out there for people but we certainly didn’t expect to find some of the housing conditions experienced”.

Other lead organisations talked about identification of specific issues. For example, as a result of the maximising access project in one area the need for more childcare facilities was identified and the lead organisation was able to work with other local groups to provide a solution. The lead organisation stated “it was in one particular community where a local community group had supported us to identify a number of households who may have needed support. The enabler who was working in that area came back following the visits and had identified that many of the households were in dire need of childcare facilities. This is something we were able to work through with the local community group and these families are now being supported as a result”.

In another area, a lead organisation stated “following household visits in our zone we identified an interest in Art classes. As a result we put some arrangements in place for the delivery of a class and it was completely filled in no time at all”. Other groups also mentioned needs in relation to employment / training courses, befriending services, out of school clubs, support for carers etc. In some cases this increased awareness of need was viewed as being a motivator to seek further funding in order to better meet the need in their local area.

**Financial Leverage**

Following on from the identification of need and motivation for potential further funding we are aware of at least one lead organisation who following maximising access has been successful in leveraging funding from another source to deliver a range of services in the local community.

The lead organisation firmly believed that without involvement in the project, and the resultant understanding of need as well as the relationships developed at a community level it was “very unlikely” that this application would have been successful.

**Relationships / Partnerships developed**

All of the lead organisations discussed the development of existing and new relationships at different levels as another important impact of the project. This included relationships at a local level within communities, regionally with other lead organisations and also between the lead organisations and different Departments / agencies.

At a local level lead organisations discussed how the project had helped them “re-engage with community / voluntary groups” who they may have had a relationship in the past. In other areas where lead organisations had not worked in the specific communities the project has afforded them the chance to develop new relationships. This was expressed by one lead organisation who stated:

“We certainly looked on reaching out to community groups and trusting in their local knowledge as a tremendous opportunity to engage with them and the individuals they indicated”.

In terms of the communities themselves, many lead organisations talked positively about the project offering them the opportunity to re-engage with communities as a whole.

Lead organisations were also complimentary with regards local relationships with referrals organisations as a result of the project. In many cases, lead organisations had existing relations but may not have been working directly with referrals organisations and the project had helped to support a more developed and formal relationships. During their project evaluation one lead organisation said “we are indebted to our local partners in CAB, Warm Homes etc for making this project and the outcomes happen”: 
Lead organisations also discussed enhanced relationships with statutory bodies including DARD and PHA. One lead organisation stated “this project has supported us to be more confident when sitting in the same room with statutory bodies but it has also let them see what we are capable of”. All of the lead organisations talked positively about the role of PHA and DARD within the project. In particular, individuals mentioned representatives from both organisations being “engaged on the project” and efficient when dealing with particular issues / challenges. The lead organisation meetings (which included all lead organisations as well as PHA and DARD representatives) were viewed as being a successful mechanism for issues to be addressed and lead organisations welcomed the opportunity to directly engage formally with both agencies regularly which was viewed to be “significantly different to many other projects where the statutory bodies are not always engaged consistently throughout”. The regular monthly meetings were viewed as “keeping lead organisations on track” and also providing an opportunity to network with other lead organisations “learning lessons” and “sharing experiences along the way”. One lead organisation summed up their view of the role of PHA / DARD by stating “I could not have wished for a better or more flexible management team from both Departments”.

PHA also carried out a partnership links survey with lead organisations in a follow-up consultation after the project had completed. Seven lead organisations (out of eight organisations who complete the survey) said they had formed new working relationships with other organisations as a result of working on the Maximising Access project. Within the community sector, lead organisations had developed new working links with learning centres, pharmacy groups, healthy living centres, community development centres, the British Legion and the Ulster Farmers’ Union. Within the statutory sector, lead organisations had developed new links with local councillors and councils, primary schools, and social services. Within the voluntary sector, lead organisations had developed new links with St. Vincent DePaul and local churches. Three lead organisations indicated they had continued their working links with organisations when the project had ended. Qualitative feedback from two organisations includes:

“We have continued to work with the local primary school who recently hosted a health fair for parents and children and we are planning their involvement in future health fairs and community events. We will continue to work with the pharmacy group to engage with and support the work of the group mainly with targeting older people in that area. St Vincent DePaul conferences are keen to continue their engagement with us for all aspects of support to disadvantaged people in that area. This project brought us into contact with the British Legion and Farmers Union which has rarely happened. We hope to maintain these links and develop them”.

“We are working now with the co-operation and working together project (CAWT) for older people in West Fermanagh and a number of agencies including Warm Homes, Access to benefits, Fermanagh district council, Western health and social services trust, CAB, are all on the project steering group. The area targeted by the project includes some of the SOAs included in the Maximising Access Project”.

**Increased uptake and awareness of services / activities provided**

In some cases, lead organisations also discussed impacts relating to an increase in demand for their own services. For many lead organisations this meant that phone calls and enquiries had increased, in one organisation’s opinion because “their name had been able to get out their again”.

Other organisations however talked about increased referrals to their own projects / programmes. For example, in South Down 60 individuals through maximising access had been directly referred to community education programmes they were providing. Whilst Dennet Interchange discussed increased demand for their ‘meals on wheels’ and ‘handyman service’ as a direct result of maximising access.
4.3.3 Impact on Local Enablers

In this subsection we consider the benefits / impacts on local enablers of being involved in the maximising access project. In total 244 enablers were recruited and trained across the project over the lifetime of the initiative. Whilst the actual number of enablers who became core to the project in terms of undertaking visits may be significantly less than that (i.e. estimated between 6 – 10 enablers in each zone) the fact remains that 244 community representatives went through a 2-day training course and as a result likely had their capacity raised in terms of understanding aspects of the project including benefits. Whilst individuals may not have went on to complete visits there is now a significant number who may be in a position to signpost / refer others to key agencies outside of the operating environment of the project.

In terms of estimated economic value it is also important at this stage to recognise that 4,135 household visits were undertaken over the lifetime of the project with enablers receiving £50 per visit. This amounts to £206,570 which is likely to have multiplier effects within the local areas targeted by the project. This is relevant during a period of economic recession when additional income for many is significant. Additional income therefore for enablers is an initial positive impact associated with the project. However this impact is also a broader impact for the local economy and communities within which this spend is likely undertaken.

During the consultation process with lead organisations a range of other positive impacts were identified for enablers including:

- **Personal development:**
  - Increased knowledge of local communities;
  - Increased local network with other enablers / lead organisation and local community groups / influencers;
  - Meeting new people; and
  - Positive experiences of helping disadvantaged / vulnerable people.

- **Professional development:**
  - Work experience;
  - Increased understanding of the benefits process;
  - Increased understanding / knowledge of a range of benefits / grants and services; and
  - Increased skills / knowledge of customer care procedures; and
  - Increased IT skills.

4.3.4 Impact on Referral Agencies

As part of the consultation process we also held discussions with referral organisations in which we discussed project impacts in relation to their own organisations. The findings from the consultations with NIHE, CAB, Advice NI, Bryson Energy, Easilift Community Transport and A2B are presented in the subsections below.
Access to clients who may not otherwise have been identified / engaged

The majority of stakeholders indicated that whilst they were aware of other initiatives attempting to maximise benefit uptake and accessibility to services for vulnerable households none of them provided the breadth of offering of maximising access or specifically “reached into the homes” of the households.

The majority of referral organisations were of the opinion that referrals provided by the project were likely ‘additional’ to referrals they would have received over the same period in the absence of the programme.

“As an organisation we tried lots of ways to raise the profile of the services. However, in my opinion we always missed the most vulnerable – we never had the resource to go house to house and so missed out on this target group. I am convinced that maximising access has supported us to get to those ‘hardest to reach’ and we now have significant numbers of people getting a service they would never have been getting if it wasn’t for this project” Easilift Community Transport

“We have always had difficulties getting to the hardest to reach groups. After this project we have recognised that the maximising access model of going out to people’s houses is the best way of doing so. Across the three zones we worked in the project identified people we had never been in contact with before” Advice NI

“Our main way of promoting the schemes is through more general marketing – I firmly believe that every referral we received whether for Warm Homes or Benefit Check we would struggled to get in the absence of maximising access” Bryson Energy

“The additionality question is difficult to measure in terms of increased numbers on the system / patterns of usage of the questionnaire. Anecdotaly, absolutely yes but the evidence is difficult to identify” Access 2 Benefits

One referral organisation did question how “additional” the activity being funded under maximising access was to other interventions. In particular, there was a suggestion that some of the benefits work provided a “cross-over” with other services (e.g. SSA Benefit Uptake). The same referral organisation also believed their own organisation’s outreach service would likely have been able to access the clients regardless of whether maximising access was in operation or not. However, the same referral organisation also suggested that this would likely have taken a much longer timeframe to do so and also indicated that whilst they believed the clients would likely have been engaged eventually much of the outreach service was still reliant on individuals coming forward themselves rather than the organisation proactively engaging them in the way maximising access was able to do. Another point to note is that the referral organisation was discussing benefit uptake specifically and was not considering the holistic / broad ranging engagement for households provided by the maximising access project which they did recognise as being valuable.

Contributes to strategic / policy objectives

Referral organisations also indicated impacts in terms of maximising access supporting them to fulfil their own strategic and policy objectives.

One organisation indicated that a key strategic objective that had been identified was to engage deprived rural areas.

“We knew through maximising access that we were definitely hitting under-represented rural areas – this was a strategic theme that the organisation was wanting to hit and we know from the types of profile of people being accessed through the project that we have hit this theme” Access 2 Benefits
Another talked more broadly about the aim of the organisation.

“Our core aim as an organisation is to provide affordable transport services to individuals and community / voluntary groups. This project supported us in doing this” Easilift Community Transport

Increased uptake and awareness of services provided within targeted communities

Whilst this is connected to the impact in relation to accessing a target audience who may otherwise not have been engaged by the referral organisations a separate impact identified relates to the increased uptake and awareness more general of the services that they can provide within the targeted communities.

“Whilst it’s difficult to put an accurate figure on this we know that in general the best spread of word about the business is through word of mouth - nearly every person engaged will bring along a friend or family member and news of our services will have spread even further” Easilift Community Transport

In addition, one of the referral organisations discussed being able to provide services to a broader audience than it usually engaged with as a result of the project.

“A2B was primarily focussed on older people – this project was a suitable driver to target a broader / wider range of individuals” Access 2 Benefits

Overall in terms of the sheer volume of referrals made through the project, referral organisations were positive in relation to the general awareness within local communities targeted of the services that they offered.

New and existing relationships built / sustained

Referral organisations also talked positively about the new and sustained relationships they have been able to develop within local communities, lead organisations and other agencies as a result of the project.

“From a customer perspective we now have significantly more than we would have had without being involved in the project. Whilst we did have a very strong relationship with Strabane DCN previously this project has helped to strengthen it further” Easilift Community Transport

“We worked across three zones and had good relationships with the lead organisations in all three areas. Whilst the referral process was inconsistent in terms of timing and volume which created some challenges in project delivery the actual relationships were good and we have continued to have relationships with the organisations following the project completion” Advice NI

“In some cases we continue to have relationships with lead organisations who continue to contact us with queries and follow-up work with other clients. There are others however where there is no legacy of relationship as the staff who were involved in the project have moved on. It is important to note that all the relationships we developed with lead organisations during the project were new relationships at a professional level to me although they may have had some form of previous relationship with Bryson Energy or certainly would have known the organisation” Bryson Energy

In terms of being involved within the project structures Advice NI, Bryson Energy and A2B all talked very positively about their roles within the Regional Project Management Forum and the Regional Operational Group.
“We have a long standing relationship with both PHA and DARD. This project helped sustain that relationship and we can only say positive things about how committed and driven both organisations were in driving the project forward and getting things done” Bryson Energy

“We were involved at both Strategic and Operational level in the project from the outset and found the process valuable in supporting relationships across the range of stakeholders involved in the project” Advice NI

“The structures were an effective way for all agencies to keep on top of the project. This also helped all of us maintain professional contact and the relationships across the board during these meetings were harmonious” Access 2 Benefits

4.3.5 Impact on Statutory Bodies / Agencies

DARD funds the project through the Rural Anti-Poverty and Social Inclusion Policy Framework. The framework seeks to identify where gaps exist in the fight against poverty and exclusion in rural areas, and sets out how they might be addressed through innovative, partnership-led approaches with other government departments and stakeholders. In addition to this framework as is discussed in section 2 the project also contributes to a range of other government polices including those related to health, children and young people, rural development, anti-poverty and social inclusion. A key impact therefore is that the project contributes to multi-policy objectives.

The role of the project in providing a reach into the most vulnerable households was highlighted by the majority of Statutory consultees as being a key mechanism in encouraging and accessing those “most in need”. This was viewed as supporting those who were likely to not avail of services offered through mainstream support or services which asked for people to “come to them”. Many consultees discussed the importance of the project having “a degree of flexibility” which allowed it to operate slightly differently in different zones (i.e. in terms of identifying households, enablers etc). As discussed previously this was viewed to be reflective of the “one size does not fit all” in meeting the needs of the different areas.

When asked about the value of the roles of the lead organisations / community groups many of the stakeholders recognised the key value of having local knowledge / experience in identifying and engaging households. In some cases consultees suggested that the rural community groups involved in the project were “often better placed on the ground to offer support than larger bodies” who individual households “may not connect with or share information”. In addition, a number of consultees suggested that there was a value with the project able to offer a more resource intensive level of service / support than statutory services would have the resources too with individuals.

The Welfare Benefits System is controlled and funded by the UK Treasury. This means that additional benefits secured by Maximising Access are additional monies to the Northern Ireland economy that are not otherwise ring fenced for Northern Ireland. Therefore unclaimed benefits for households are a significant potential loss to both those households and the wider Northern Ireland economy. On a macro-economic level, the additional household expenditure resulting from increased household income has a multiplier effect on the economy.
4.4 Impact on households

This section includes consideration of outcomes / impacts of the project to date against outcome targets contained within the original economic appraisal. The subsection is structured against the key outcome targets as follows:

- Improved health and wellbeing;
- Increased access to energy efficiency measures and housing grants for at least 25 per cent of households;
- Increased access to benefits for at least 16 per cent of households; and
- Increased access to a range of services in the community for at least 50 per cent of households.

Improved health and wellbeing

Improved sense of health and wellbeing is perhaps the most difficult outcome to measure within this project as it is potentially linked to several other outcomes (e.g. previous research has considered how wider social determinants such as increased income, improved house condition, reduced fuel poverty etc can support improvements in physical and mental health and wellbeing and reduce potential negative health outcomes such as falls, winter illness etc). It also is by definition very personal to the individual and could be impacted by many external factors outside of the scope of the project itself (e.g. an individual may be suffering from a long-term illness). Given the timescales involved it is also likely that an individual’s circumstances may potentially have changed in the period since the original household visit, this could be change for the better or worse. As a result assessment of direct health related impact and evidence of linkage to the project has not been possible within the short evaluation timeframe.

One potential method of measuring progress against the health and wellbeing target has been to complete a follow-up survey with households engaged in the early stages of the project (i.e. households who had their initial interview prior to December 2010 were interviewed). This survey was undertaken by PHA in April 2011 parallel with this research as part of the overall project evaluation process. It should be noted that whilst the survey targeted those from the early stages of the project it still took place less than six months after the original visits. Therefore, a number of caveats should be considered with these findings including:

- many of the health and wellbeing related impacts may occur over a longer timeframe and so might not necessarily show within this time period;
- given the profile of many of the households (e.g. older age groups and longer term illnesses) there is potential for health to get worse over the period unrelated to the project impacts;
- many of the impacts anticipated (e.g. related to home improvements or benefit uptake) may not have occurred within the timescales due to delays in the referral process; and
- particularly in relation to the warm homes scheme impacts such as reduced fuel bills and warmer homes may not be easily identified by the targeted households as the weather is milder over the months of the survey compared to later in the year. Therefore response to the household survey in December could be different to that in April as individuals can identify the benefits of better insulation etc.

Note: Calls to zones 4 – 7 have not yet taken place, therefore these zones are excluded from this preliminary analysis.
In total a follow up survey was undertaken with 381 individuals including questions on their current general health and wellbeing. The findings from the follow-up survey have been compared with those from the initial household survey undertaken with householders to understand how this position had changed. Across the nine zones used in the preliminary analysis, four zones indicated a reduction in general health problems, whereas five of the zones actually showed an increase in general health problems suggesting that individuals’ general health had deteriorated in the period since the original visit. The overall picture across all of the zones in the sample would suggest there is no significant change in either direction in the participants’ general health and wellbeing.

In relation to mental health and wellbeing the follow-up survey (using the same Warwick-Edinburgh Mental Well-being Scale (WEMWBS) as in the initial household survey) assessed the positive mental health and wellbeing of participants. The overall position again highlights no change in the participants’ mental health wellbeing compared to their position during the initial household survey.

Finally in relation to health, individuals were also asked questions in relation to friendship and social connectedness. These questions included those on relations with others, isolation, getting in touch with others and feelings of being alone and friendless. The overall trend against these indicators showed a positive difference for households in relation to social connectedness in the period before and after intervention by the programme. An upward trend was visible in seven of the nine zones surveyed.

Overall therefore the picture in relation to improved health and wellbeing outcomes is varied. In terms of general health and mental wellbeing the follow-up survey undertaken to date shows no overall change. However, in relation to social isolation (using the social connectedness questions) the results are statistically significant, although less clarity surrounds the actual significance (e.g. Do individuals now have improved social relationships / contact? etc)

Whilst it is too early within the longer term framework of potential outcomes from the project to be conclusive with regards health and wellbeing it is important to contextualise what we do know. Looking at the wider social determinants on health and wellbeing impacted upon by the project (i.e. improved income, house conditions, reduction in fuel poverty etc) improvements in health and wellbeing are likely to materialise, however, many of these impacts may only materialise over a longer period of time (e.g. improvements to energy efficiency may not be recognisable to a householder until into the winter months). It is also important to remember the context of the project when considering outcomes – for example, the findings from the follow-on survey suggest that significant numbers of people continue to have some or extreme problems in relation to Pain / Discomfort (60.8 per cent), Mobility (60.2 per cent), Anxiety / Depression (42.4 per cent) and undertaking usual activities (40.6 per cent). Whilst the project may not (and could not) assist directly in improving these areas, increased access to benefits, services and grants resulting from the project may improve other aspects of their life and make some of the challenges they face more manageable. Longer term tracking of project participants may support identification of these potential impacts / outcomes in the future.

**Increased access to energy efficiency measures and housing grants for at least 25 per cent of households**

As is discussed in Section 3 energy efficiency measures and housing grants cover a number of areas within the maximising access project including warm homes, disabled facilities grants, the NIE levy scheme and Home Safety Checks. In total, more than 4,000 referrals (excluding NIE levy scheme) have been made across these categories by lead organisations during the project timeframe. As with many of the categories the actual processing of referrals are at different stages and so an absolute understanding of outcomes / impacts is not available at this stage.

However, we do have some information from the follow-up household survey completed to date, monitoring data captured by PHA and information captured by referral organisations which can be used to understand outcomes / impacts associated with increased accessibility to these measures. Each of the measures are now considered in turn.
Warm Homes Scheme

According to monitoring information captured by PHA, to date:

- 395 insulation installations have taken place (with a further 293 in progress and 522 recommended);
- Twelve heating and insulations have taken place;
- Two heating only installation currently in progress (with a further five recommended); and
- A further 14 referrals have still to be processed by H&A.

Financial Savings to Householders - Using statistics provided by the Energy Saving Trust on the average financial savings of installing various energy efficiency measures we can estimate the potential savings to the householder of these various installations. The statistics on savings are presented in Table 5.1 below.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Annual saving (£/yr)</th>
<th>Annual saving (CO2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Replace old G-rated oil boiler with new A-rated gas boiler, plus full heating controls</td>
<td>Up to £335</td>
<td>Up to 2.6 tonnes</td>
</tr>
<tr>
<td>Replace old G-rated oil boiler with new A-rated oil boiler, plus full heating controls</td>
<td>Up to £250</td>
<td>Up to 1.5 tonnes</td>
</tr>
<tr>
<td>Loft Insulation (0 - 270mm)</td>
<td>Around £150</td>
<td>730kg</td>
</tr>
<tr>
<td>Loft Insulation (top up)</td>
<td>Around £45</td>
<td>210kg</td>
</tr>
<tr>
<td>Cavity Wall Insulation</td>
<td>Around £115</td>
<td>560kg</td>
</tr>
<tr>
<td>Hot water tank jacket</td>
<td>Around £35</td>
<td>170kg</td>
</tr>
</tbody>
</table>

*Assumptions
Savings are based on a 3 bedroom semi-detached house with oil-fired central heating, an oil cost of 3.98p/kWh and a gas price of 3.53p/kWh. (Oil prices as at November 2010).
Source: Energy Saving Trust

Therefore, using the estimated savings of work undertaken or in progress across the project the following calculations can be made:

- 688 insulations (estimated savings between £30,960 and £103,200 per year);
- Twelve heating and insulations (estimated savings between £3,540 and £5,820 per year); and
- Two heating only installation (estimated savings between £500 and £770 per year).

Adding these figures together we get an overall estimate of savings for households through maximising access within the range £35,000 and £109,790 per year. This amounts to an estimated range of between £50 and £156 savings per year for each household receiving support through the Warm Homes Scheme as a result of maximising access. This figure does not include recommended installations or factor in the referrals yet to be processed by H&A which could increase these figures further.
**Value of grants for installation**

As part of the evaluation we have also received grant information for the various types of support available for the Warm Homes Scheme. This information was prepared by Bryson Energy.

- For insulation, households have a grant level of £850; and
- For heating, households have a grant level of £6,500.

Using the figures presented in terms of the volume of activity completed to date (i.e. undertaken already or in progress) we can estimate the potential spend on households across the project as follows:

- 688 insulations (estimated grant value of £584,800);
- 12 heating and insulations (estimated grant value of £78,000); and
- Two heating only installation (estimated grant value of £13,000).

As with the potential annual savings for households this figure does not include recommended installations yet to be processed which again would significantly increase this figure.

It is also important to note these figures do not include wider social savings for households. This includes potential savings on health of having a warmer home (e.g. the main health conditions associated with cold housing are circulatory diseases, respiratory problems and mental ill-health. Other conditions influenced or exacerbated by cold housing include flu and cold, as well as arthritis and rheumatisms (Marmot 2011).

**Estimated Economic Value**

Estimated economic value in terms of the Warm Homes Scheme can be applied across two levels.

Firstly, the estimated total savings to households on an annual basis as a result of the energy efficiency installation (estimated savings range between £35,000 and £109,790 per year across all households who have received / in progress of receiving support). This amounts to between £50 and £156 savings per year for each household.

Secondly, the estimated value of the grants available for households for each of the energy efficiency measures. In total, using figures presented by Bryson Energy this could amount to approximately £675,800 in expenditure as a result of the installation of the various measures.

**Disabled Facilities Grants**

The actual process for carrying out a Disabled Facilities Grant check varies across the zones. In some areas, Council officials who carry out Home Safety Checks will also carry out a minor adaptation process where they assess whether any adaptations required could be satisfied by the local authority themselves or whether a full assessment is necessary with a view to having such cases referred to the appropriate Grants Office for Disabled Facilities Grants. In other areas referrals will have been made directly to a local Grants Office for the Disabled Facilities Grant by the lead organisation.
Information provided by PHA within their monitoring records indicates that 433 referrals have been made for households to be taken through the Disabled Facilities Grant process. However, in addition to the inconsistent process of referral there are other factors that make attempting to measure the actual impact of these referrals difficult. Firstly, an application for a Disabled Facilities Grant is dependent on the willingness of the disabled person to register their interest (i.e. there may be a drop off rate between initial referral and willingness to proceed with an application). Secondly, whilst referrals will have been made to a local Grants Office for Disabled Facilities Grants they have not been systematically identified as directly relating to maximising access and NIHE have been unable to verify the total number of referrals that have resulted in Disabled Facilities Grants as a result. Therefore it has not been possible at this time to provide financial outcomes associated with the 433 referrals to the Disabled Facilities Grant.

### Estimated Economic Value

Figures provided by NIHE do provide an indication of the average Disabled Facilities Grant that is provided in Northern Ireland based on the 2010 / 2011 figures across the overall programme. A total of 1,143 Disabled Facilities Grant approvals were issued by overall programme with an overall value of £11,494,000. The average Disabled Facilities Grant therefore amounts to £10,056. However, during consultation NIHE representatives believed that any grants given to date in relation to the project are likely to be of much smaller value (e.g. less than £500 for minor adaptations in the households for handrails etc).

Other benefits associated with the Disabled Facilities Grant include helping people remain independently in their own homes, decreasing the need for residential care, decreasing the number of hospital admissions through the prevention of accidents. Research has also shown major improvements in quality of life and independence for recipients\(^8\). Carers suffer less stress and have reduced likelihood of back injury again with likely knock on effects in terms of reduced pressure on social services and HSCT budgets.

### Home Safety Checks

According to monitoring information captured by PHA to date more than 200 referrals have been made to the Home Safety scheme with a further 1,000 on waiting lists. Given the level of referrals made overall (i.e. more than 2,000) it is clear there are major capacity issues for Home Safety Officers in processing the referrals generated by the maximising access project. As with many of the other areas of the project, impacts associated with the home safety scheme can be multi-stranded and range from the comfort for householders in knowing that their home is safe through to avoidance of accident / injury as a result of the safety check.

In recent years a number of evaluations of Home Safety checks have been carried out in Scotland and England\(^9\) which also highlight significant potential outcomes including changed safety habits amongst households, specifically those associated with fire including reduced fire casualties and dwelling fires. In addition, consultation with the regional home safety officer for Northern Ireland indicated that outcomes are also apparent in terms of an increased sense of comfort and wellbeing for householders as a result of a home safety check taking place.

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Estimated Economic Value

Setting economic costs against potential outcomes for Home Safety checks are not straightforward. However, previous work undertaken on the economic cost of fire estimate values of £1.5m per fatality, £170k for a serious injury, £13k for a slight injury and property damage for domestic households estimated at £40k\(^{10}\). Other costs could include costs to the NIFRS in responding to a fire, dealing with false alarms caused by faulty equipment etc. It should be noted the figures highlighted above do not include other environmental costs (e.g. water and energy consumption) and social costs (e.g. the wider impact on families / communities) that would increase these figures further. In addition, home safety checks are broader than just fire, they include advice and support for other home safety measures (e.g. safety gates, chain for doors / windows) which could potentially have values in reducing accidents / theft etc.

Using the figures however as a proxy highlights that if a home safety check undertaken as a result of the project results in even one fire being avoided the economic value is substantial.

As part of the follow-up survey undertaken with householders by PHA a series of questions were asked in relation to energy efficiency measures and housing grants. Out of the 286 households engaged, 68 per cent (n = 195) had been referred for home energy and / or home improvements. Of the 170 respondents who went on to answer a series of other questions 43.5 per cent (n = 74) had received loft insulation, 3.5 per cent (n = 6) cavity wall insulation, 18.2 per cent (n = 31) a hot water tank jacket and 2.9 per cent (n = 5) a new heating system. Finally, survey respondents were asked to indicate what difference the project had made to the quality of their lives. More than two-thirds (67.4 per cent) stated that it had made a huge or a lot of difference with less than one in every five (19.6 per cent) stating no difference.

Summary of energy efficiency measures and housing grants

Information provided by PHA through the monitoring data has highlighted significant numbers of households being referred and accessing energy efficiency measures and housing grants. However, as with other parts of the project the actual number of referrals processed across the category and being pulled through to impact on the household is more difficult to quantify. Where information is available (e.g. Warms Homes Scheme) financial value realised to date both in terms of annual savings to the household and in terms of the value of the grants received by the household for the installation appear positive. In addition, across all of the categories the wider social impacts on the households are likely to include improved health and wellbeing, comfort and quality of life. There are also potential wider benefits to society as a result of reductions in accidents, injuries and hospital visits as a result of safer homes.

Increased access to benefits for at least 16 per cent of households

As is discussed in Section 3 a key aspect of the maximising access project is to increase access to benefits for rural dwellers in locations where there may be a differential uptake of benefits. This may stem from a lack of awareness of entitlements, inadequate access to information and a culture of self-help and lack of awareness of entitlements\(^{11}\).

As part of the household visits, enablers completed A2B screening tools to identify whether individual households could potentially be entitled to further benefits. Following completion of a screening questionnaire referrals were made to CAB, Advice NI and Bryson Energy for completion of BECs. BECs are carried out by trained staff across the three organisations offering a full benefit assessment which examines a client’s eligibility for all social security benefits and other payments, for example, the Social Fund.

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\(^{10}\) The economic cost of fire: estimates for 2006 – DCLG (2011)

\(^{11}\) Rural Isolation & Poverty. Southern Investing for Health Partnership (2007)
In total, 1,722 referrals were made for BECs, of which (according to information presented by PHA) 1,329 BECs have been completed. Final additional benefit entitlement will not be confirmed until they have been processed by the Benefit Entitlement Unit, Social Security Agency. However, using figures confirmed by Advice NI and Bryson Energy we have estimated the number of households likely to be entitled to claim additional benefits and the average additional benefit entitlement per week for zones to understand potential outcomes from the project.

- Bryson Energy – 178 households likely to be entitled to claim additional benefits at an average additional entitlement of £38.84 per household per week. This equates to £359,503.04 per annum in unclaimed benefits.
- Advice NI - 184 households likely to be entitled to claim additional benefits at an average additional entitlement of £38 per household per week. This equates to £363,584 per annum in unclaimed benefits.
- CAB – CAB are currently unable to provide this information. However, conservative estimates based on averages of the information provided by Bryson Energy and Advice NI would result in additional benefit entitlement for 180 households claiming an additional £38 per household per week. This equates to approx. £355,680 per annum in unclaimed benefits.

**Estimated Economic Value**

Therefore maximising access is estimated to have supported vulnerable households to identify an additional £1,078,767.04 in benefits per annum. Using information provided by A2B’s independent evaluators, Economic Research and Evaluation on the ‘value-of-benefits-over-lifetime-of-claim’ this figure could eventually amount to £2,718,492.94 over the average length of the claims.

It is important to highlight that these figures are estimates and will be confirmed by the Benefit Entitlement Unit, Social Security Agency in due course. However, if accurate they are significant both for the individual household but also for the local economy as the additional benefit entitlements do not come from the Northern Ireland block grant. It is also important to note that these figures do not include the wider benefits for households (e.g. increased well being of knowing they have full entitlement etc) and also the potential impact on other members of the household as a result of increased income.

**Increased access to services to support health benefits**

Information presented by PHA through the follow-up survey has identified a range of health service benefits including access to meals on wheels, the home help scheme and day care support and activity centres.

In total, 138 referrals were made to the meals on wheels service with more than half of these referrals expected to access support based on the follow-up survey. More than 200 referrals were made to the home help scheme with over three-quarters expected to access support based on information captured by PHA during the follow-up survey. 77 individuals also requested information on day care support with 50 per cent of those surveyed in the follow-up survey availing of support available.

The benefits associated with each of the health services are wide ranging from improved mental health, diet and ability for the individuals in receipt of services to stay in their homes for longer.

**Increased access to a range of services in the community for at least 50 per cent of households**
As is discussed in Section 3 local support services and community activities cover a broad range of categories including statutory support services (e.g. GP, Dentist, Social Workers etc), local community activities (e.g. leisure activities, luncheon clubs, Sure Start, Home Start etc) and Transport services. These areas are considered separately in the subsections below.

Statutory Services and Local Community Activities

Monitoring information from PHA would indicate that performance in terms of output in these areas has been positive with 1,075 referrals to Support Services and 973 referrals to Local Community Activities.

However, what is less clear is the quality of the referrals under these categories (e.g. has a referral been classed as such by the lead organisation if the person was interested in further information on an activity?). In addition, given the broad nature and range of services / activities classed under this category and subsequently the broad range of agents / organisations who will be providing the end service / activity (some of whom are likely not directly involved in the project) how can outcomes be identified?

One mechanism for identifying outcomes under this indicator is potentially through the follow-up survey completed by PHA. However, a summary of the preliminary analysis across nine zones surveyed to date indicates that only limited numbers of respondents have joined or attended local services across a range of categories. In total only ten survey respondents indicated that a householder had joined / attended activities. Whilst, these figures appear disappointing it is important to consider them in the context of the wider project and specifically in the context of the target groups of the project (i.e. targeted at the most vulnerable and socially isolated rural dwellers that may not be able or willing to avail of these opportunities).

Transport Services

The information available in relation to transport services provides more clarity in terms of the actual outcomes associated with referrals made to this aspect of the project. In terms of the output, PHA data indicates that 713 Smart Pass referrals have been made, whilst 1,823 referrals have been made to Community Rural Transport. Using further information available from PHA, of these referrals 431 individuals have signed up as members of the Community Rural Transport scheme with approximately 8,000 trips being undertaken already as a result. It is important as with many other areas of the evaluation that consideration be given to the social value of transport services (i.e. in terms of reduced isolation, improved health and wellbeing from being able to access local health services etc) as well as the potential economic value in terms of the savings made to the householder who will be saving the cost of other public or private transport arrangements.

Estimated Economic Value

Information from CRT highlights that more than 8,000 trips have already been undertaken by signed up members of the programme through referrals made by maximising access. Using the average cost of a Translink journey (approx. £3.20) as a proxy would place an economic value on these journeys of more than £25,000. A recent value for money assessment has been undertaken on CRT in Northern Ireland. This identified that CRT also had clear impacts in terms of VFM and benefits for local communities across economic, social and environmental areas including the use of local operators and the resultant boost to local employment. Improved quality of life and accessibility for users were also highlighted which would increase the economic value significantly if applied.
4.5 Social Return on Investment - Households

4.5.1 Introduction

To assess a project of this kind in purely economic terms fails to acknowledge the wider benefits to society. Social Return on Investment (SROI) is a method for measuring and communicating a broad concept of value that incorporates social, environmental and economic impacts. It is a way of accounting for the value created by our activities and the contributions that make that activity possible. It is also the story of the change affected by the activities, told from the perspective of the stakeholders.

SROI measures change in ways that are relevant to the people or organisations that experience or contribute to it. It tells the story of how change is being created by measuring social, environmental and economic outcomes and uses monetary values to represent them.

4.5.2 SROI Types and Scope

There are two types of SROI;

- Evaluative - which is conducted retrospectively and based on actual outcomes that have already taken place; and
- Forecast, which predicts how much social value will be created if the activities meet their intended outcomes.

This SROI analysis is a forecast SROI as a result of the challenges and timing issues identified in relation to the measurement of outcomes to date on the project (i.e. in the absence of final outcomes). The SROI has been carried out according to the methodology defined by the New Economics Foundation in their publication “Measuring value: a guide to Social Return on Investment (SROI)”.

As agreed with the evaluation sub-group at the outset of the research the scope of the SROI will be on the households in terms of the impact and value of the project directly on them. This includes uptake of additional benefit entitlement, referrals for energy efficiency measures and housing grants, referrals to local support services and activities and referrals to rural transport schemes.

4.5.3 The investment in the activity

This report is an evaluation of the social return from maximising access as a result of the intervention on households visited. Total investment in the project over its lifetime was:

- £707,000 from DARD through the Rural Poverty and Social Inclusion Framework; and
- £103,875 from PHA and A2B in-kind support and additional funding.

Other stakeholders do provide additional inputs that support project delivery. This includes community organisations / individuals who have supported the identification of the vulnerable households. However, input beyond service purchase is not materially significant and so have not been included.

Total investment therefore over the lifetime of the project is £810,875.
4.5.4 Theory of change

The theory of change is a key aspect of SROI. The explicit aim of maximising access is to:

“facilitate a co-ordinated service to maximise access to benefits, grants and local services in targeted rural areas in Northern Ireland to support rural dwellers living in or at risk of poverty and social exclusion. The project will proactively target the most vulnerable in identified rural communities using a community development approach”

In addressing this aim as is identified in Section 4.4 many direct financial outcomes are generated (e.g. increased benefit entitlement, savings as a result of energy efficiencies etc) and the themes of physical and mental health and wellbeing, social connectedness are also prevalent. Increasing access to local services supports the aims of many stakeholders and improves community cohesion, reducing social isolation of vulnerable households who may not generally be proactive in seeking services or know how to go about finding out about services. For example, increasing household income reduces potential fuel poverty, which in turn has a positive impact on long term health conditions and demand on health services.

In this section we use findings from across the evaluation to consider the theory, or story of change for households as a result of the intervention. The objectives of the project are presented in section 2.2.3 and represent the overall aim of the project in maximising access to a range of benefits, grants and services.

A range of measures and information sources were used to find out if these objectives were being achieved and to get a clearer picture of the full outcomes materialising from the project. These are discussed in more detail in the preceding sections of the report but include consultations with key stakeholders, evaluation information captured by PHA and information presented and captured from referral organisations. The proportional importance of outcomes is considered in the Impact Map and in justification for decisions on attribution, deadweight, duration of outcome etc.

4.5.5 Outcomes and Evidence

In the Impact Map shown in Table 4.3 we have taken the householders as the main stakeholders and captured the intended objectives and outcomes against each of the key indicators of the project. Ideally, a full SROI would consider impacts / outcomes across all of the stakeholder groups, however, due to the complexities in articulating and calculating the financial proxies for SROI this has been restricted to the households. We begin this process by considering the household input, output and outcomes associated with the project – this information is contained in Table 4.2 overleaf.

Within the impact map for each outcome, a direct financial measure or financial proxy has been established in order to provide a measurement of the value of each outcome on monetary terms. Where possible we have identified the sources and assumptions that underpin the calculation of value. Not all outcomes can be monetised at this stage; some outcomes are difficult to predict or set targets for – for example, while some of the intended households to be targeted will have health problems, we cannot readily predict or target the type of health problems they may possess and thus it is difficult to reasonably estimate the impact the program will have on their outcomes. However we have included them in order to recognise that they do have social value.

For the purposes of this forecast SROI we have tried to be deliberately conservative in our estimates and not include those items that are hard to evidence or place too much emphasis on the outcomes specifically attributable to the project.
### Table 4.2 Household input, output and outcome

<table>
<thead>
<tr>
<th>Input</th>
<th>Output</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time – not materially significant as all visits carried out at the clients home</td>
<td>6,319 households identified for the project</td>
<td>Increased awareness and uptake of entitlement to benefits, grants and services</td>
</tr>
<tr>
<td></td>
<td>4,135 home visits undertaken</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2,195 referrals made for benefit entitlement checks</td>
<td>Increased income for the household</td>
</tr>
<tr>
<td></td>
<td>1,701 households referred for energy efficiency and housing grants</td>
<td>Improved health and wellbeing</td>
</tr>
<tr>
<td>Provision of information – verbal and paperwork – not materially significant</td>
<td></td>
<td>Households able to make energy efficient home improvements</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Improved quality of life from being able to afford a better diet</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Improved home environment therefore preventing cold-home related illness and (reduction in excess winter deaths)</td>
</tr>
<tr>
<td></td>
<td>433 referrals for disabled facilities grants</td>
<td>Improved safety and security in the home as a result of aids and adaptations</td>
</tr>
<tr>
<td></td>
<td>2,655 referrals for Home Safety checks</td>
<td>Increased ability to stay in own home for longer as a result of installation of appropriate aids and adaptations</td>
</tr>
<tr>
<td></td>
<td>1,075 referrals to local support services</td>
<td>Increased access to support services</td>
</tr>
<tr>
<td></td>
<td>138 referrals to meals on wheels</td>
<td>Improved quality of life from getting more help in the home</td>
</tr>
<tr>
<td></td>
<td>229 referrals to home help scheme</td>
<td>Improved quality of life through access to day care support and activity centres</td>
</tr>
<tr>
<td></td>
<td>77 individuals requesting information on day care support</td>
<td>Improved mental health as a result of respite support</td>
</tr>
<tr>
<td></td>
<td>42 individuals requesting respite support</td>
<td></td>
</tr>
<tr>
<td></td>
<td>973 referrals to local community activities</td>
<td>Improved quality of life from reduced social isolation</td>
</tr>
<tr>
<td></td>
<td>1,873 referrals to Rural Community Transport</td>
<td>Improved quality of life from increased access to transport</td>
</tr>
</tbody>
</table>
Table 4.3 overleaf shows the description of the indicators, direct financial measures and financial proxies that represent the value of the outcomes for the households engaged on the project, the estimated quantities achieved for each outcome based on the project evaluation, consultations, follow-up activity etc and the value of each financial proxy used. For the purposes of this study four types of financial proxy have been used:

- Actual increased income through benefit maximisation;
- Cost savings; and
- Spend on services/activities.
Table 4.3 Impact Map

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Indicators</th>
<th>Quantity</th>
<th>Data Source</th>
<th>Financial Proxy</th>
<th>Source</th>
<th>Value £</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased awareness and uptake of entitlement to benefits, grants and</td>
<td>Number of households receiving a visit</td>
<td>4,135</td>
<td>PHA database</td>
<td>Cost of alternative targeted promotion of services through targeted mail-out and (1hr) one-to-one interview by consultant</td>
<td>Royal Mail Website, CPD Framework Rates for Consultancy Services</td>
<td>£6,000 mailshot to 10,000 people</td>
</tr>
<tr>
<td>services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>£500 per day for consultant (c. £66 per hour) = £272,910</td>
</tr>
<tr>
<td>Increased income for the household</td>
<td>Previously unsecured benefits gained (annualised and back dated lump sum)</td>
<td>1 overall lump sum based on calculations in Section 5.4</td>
<td>PHA database</td>
<td>Likely additional benefit entitlement secured - backdated and annualised</td>
<td>Bryson Energy, CAB Advice NI</td>
<td>£1,078,767.04</td>
</tr>
<tr>
<td>Improved health and wellbeing</td>
<td>Number of households reporting improvement in health conditions</td>
<td>Difficult to predict and no specific target set</td>
<td></td>
<td>Reduced spend on health services</td>
<td>ONS Family Spending 2010 Edition</td>
<td>£275.60 pa per household</td>
</tr>
<tr>
<td></td>
<td>Difficult to predict and no specific target set (207 households) based on case studies and household follow-up survey</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>£11,409.84</td>
</tr>
<tr>
<td>Improved quality of life from being able to afford a better diet</td>
<td>Number of households reporting improved health / nutrition</td>
<td>Difficult to predict and no specific target set</td>
<td></td>
<td>Additional spend on healthy food</td>
<td>ONS Family Spending 2010 Edition</td>
<td>£2,714.40 pa per household (additional 20% = £542.88 per household) £224,752.32</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Indicators</td>
<td>Quantity</td>
<td>Data Source</td>
<td>Financial Proxy</td>
<td>Source</td>
<td>Value £</td>
</tr>
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<td>------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Improved quality of life from referrals to meals on wheels</td>
<td>Number of referrals to Meals on Wheels</td>
<td>138 referrals with 50 per cent (n = 69) expected to access Meals on Wheels services based on household follow-up information</td>
<td></td>
<td>Additional spend on Meals on Wheels</td>
<td>Department reference cost £2.94&lt;sup&gt;12&lt;/sup&gt;</td>
<td>£73,841.04 - £221,523.12 (mean = £147,682.08)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 meal per day = Per day - £202.86 Per week - £1,420.02 Annually - £73,841.04</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2 per day = Per day - £405.72 Per week - £2,840.04 Annually - £147,682.08</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3 per day = Per day - £608.58 Per week - £4,260.06 Annually - £221,523.12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improved quality of life from being able to get more help in the home</td>
<td>Number of referrals to home help scheme</td>
<td>229 referrals with 80 per cent (n = 183) expected to access help based on household follow-up information</td>
<td></td>
<td>Additional spend on home help</td>
<td>Information provided by PHA on average hours (10 hrs p/week) and cost (£12.01 p/hour) of a Home help in NI</td>
<td>£1,142,871.60p.a</td>
</tr>
<tr>
<td>Households able to make energy efficient home improvements providing annual savings on heating bills and indirectly increasing household income</td>
<td>Number of households in receipt of grants for energy efficiency and housing grants</td>
<td>702 received or in progress</td>
<td>PHA database</td>
<td>Energy efficiency household saving</td>
<td>Energy Saving Trust</td>
<td>Between £35,000 and £109,790 pa (mean = £72,395)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Value of grants for installation of measures</td>
<td>Bryson Energy</td>
<td></td>
</tr>
<tr>
<td>Improved home environment therefore preventing cold-home related illness and falls (reduction in excess winter deaths)</td>
<td>Number of households reporting reduction in</td>
<td>Difficult to predict and no specific target set Estimated 10 per cent of households reporting reduction in</td>
<td></td>
<td>Savings to the health service of reduced</td>
<td><a href="http://www.lancashire.gov.uk/">http://www.lancashire.gov.uk/</a></td>
<td>£2,563,500 – reduced health service costs estimated at</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Liddell identified that for every</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Conservative figure – e.g. BBC news reports (December 2010) on costs of meals on wheels increasing to £4.25 (reference costs for dhsspsni figures shown as £3.54): [http://www.bbc.co.uk/news/uk-northern-ireland-11886090](http://www.bbc.co.uk/news/uk-northern-ireland-11886090)
<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Indicators</th>
<th>Quantity</th>
<th>Data Source</th>
<th>Financial Proxy</th>
<th>Source</th>
<th>Value £</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>illness / falls etc</td>
<td>receiving energy efficiency home improvements (100 households)</td>
<td></td>
<td>cold-home related illness falls</td>
<td>£1 spent on fuel poverty grants schemes, health service costs reduced by 42p. Some 41% of the health savings related to physical conditions associated with excess cold, and 24% to mental health.</td>
<td>£1,076,670</td>
</tr>
<tr>
<td>Improved mental health as a result of respite support</td>
<td>Number of requests for respite support</td>
<td>2.5 per cent of 1,701 respondents (n = 42) within the Household survey requested respite support</td>
<td></td>
<td>Proxy: Costs of CBT: £67 per session £36 admin per hour £73 per hour face-to-face (approx 50/50 time spend on FTF and other e.g. CBT) Counselling in primary care: Admin £34 p/h £44 ph client contact</td>
<td>Information provided by PHA</td>
<td>Counselling in primary care = £468 for 6 sessions X 42 = 19,656 CBT &amp; Counselling = Face-to-face = £109 p/h X 3 = 327 CBT = 103p/h X 3 = 309 6 sessions = 636 X 42 = 26,712 Counselling range from 19,656 to 26,712</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Indicators</td>
<td>Quantity</td>
<td>Data Source</td>
<td>Financial Proxy</td>
<td>Source</td>
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</tr>
<tr>
<td>Improved safety and security in the home as a result of aids and adaptations installation reducing number of falls and accidents in the home</td>
<td>Number of signposted referrals for Disabled Facilities Grants</td>
<td>433</td>
<td>PHA database</td>
<td>Cost saving of aids and adaptations themselves – median cost of aids and adaptations</td>
<td>NIHE</td>
<td>£500 per grant</td>
</tr>
<tr>
<td></td>
<td>Number of referrals for home safety checks</td>
<td>2,655</td>
<td>PHA database</td>
<td>Reduced costs associated with injuries as a result of fire / falls / accident</td>
<td>The economic costs of fire – DCLG</td>
<td>£43,300 overall (Est.)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NHS Cost Book/ Scuffman 2003</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>NICE (2011)</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>70,000 to 75,000 hip fractures occur each year in UK costing £2 billion (including medical and social care). Cost per hip fracture: £26,667</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Of those referred:</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>9.9% (n=184) under 5</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>48.4% (n=901) over 65</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0% (n=1) both under 5 and over 65</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>41.7% (n=776) aged 6 to 64</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number of householders able to stay in</td>
<td>Difficult to predict and no specific target set</td>
<td></td>
<td>Cost of private residential care</td>
<td>Internet search</td>
<td>£15k pa per householders</td>
</tr>
</tbody>
</table>


14 Number of referrals received by home safety (excluding duplicates) (n=1862) lower than recorded on database (n=2665): % of age groups used to approximate age categories for home safety recorded numbers (due to lack of information on householder demographics for their sample)
<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Indicators</th>
<th>Quantity</th>
<th>Data Source</th>
<th>Financial Proxy</th>
<th>Source</th>
<th>Value £</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased access to support services</td>
<td>Number of signposted referrals for primary care / social support services</td>
<td>1,075</td>
<td>PHA database</td>
<td>Cost of provision of community health services</td>
<td>NHS Cost Book</td>
<td>£35</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number of signposted referrals for local support services</td>
<td>973</td>
<td>Project Targets</td>
<td>Additional spend on recreation and culture</td>
<td>Average social club membership</td>
<td>£20</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number of households accessing CRT</td>
<td>8,000</td>
<td>PHA database</td>
<td>Cost of transport</td>
<td>Translink</td>
<td>£3.20</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
|                                                                        | Day care support and day activity centre                                   | 4.5 per cent of 1718 = 77 individuals requesting information on day care support with 50 per cent of those surveyed in the follow-up survey availing of support | PHA database | Learning Disability p/w = £38.67 Geriatric Medicine p/w = £245.76 | Department Reference costs 2007/08\(^{15}\) | If taken as 31 of those who received help were over 65 (80%) & 8 individuals who received help were learning disabled (20%):
|                                                                        |                                                                            |          |                      |                                                 |                                     | £7,927.92 per week                  |

\(^{15}\) [www.dhsspsni.gov.uk/reference_costs_community_services_unit_costs_2007-08.pdf](http://www.dhsspsni.gov.uk/reference_costs_community_services_unit_costs_2007-08.pdf)
<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Indicators</th>
<th>Quantity</th>
<th>Data Source</th>
<th>Financial Proxy</th>
<th>Source</th>
<th>Value £</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>7.5% of 1727 = 129</td>
<td></td>
<td>(40.8% of those referred for day care support were over 65 years. 7.5% were learning disabled. No costs provided for individuals not categorised as learning disabled/over 65 which may account for the 50% approx who actually received help [i.e. those who received help were either elderly or learning disabled because other categories of individuals do not qualify]).</td>
<td></td>
<td>£412,251.84 annually</td>
</tr>
</tbody>
</table>

(40.8% of those referred for day care support were over 65 years. 7.5% were learning disabled. No costs provided for individuals not categorised as learning disabled/over 65 which may account for the 50% approx who actually received help [i.e. those who received help were either elderly or learning disabled because other categories of individuals do not qualify]).
4.5.6 Impact: Attribution, Deadweight and Displacement

In order to calculate the overall impact, these values have to be reduced to take account of deadweight (what would have happened anyway), attribution (who else creates these outcomes) and displacement (where there are negative outcomes for stakeholders not included in the impact map).

Attribution, deadweight, and displacement were all examined for each of the monetised outcomes for the impact on the calculated social return. The detailed assumptions and sources for each area are contained in Appendix II.

Deadweight

Deadweight is a measure of how many of the outcomes listed would occur without the project (i.e. how many of the households would have accessed the benefits, grants and services anyway in the absence of the maximising access project?). In deciding on deadweight, consideration must be given to the project being specifically designed to target those households that have not been reached by other methods using the community development model.

Displacement

Displacement was carefully considered during the creation of the economic appraisal for the project. Displacement occurs when the benefits claimed by a project participant are at the expense of others outside the project.

During the design of the project, the community development model and engagement with broad range of stakeholders meant that displacement effects were minimised and thus maximising benefits, grants and services to the target population.

Attribution

Attribution takes account of the fact that outcomes will also be influenced by other organisations and factors, especially where the stakeholders' objectives can only be achieved through the combined efforts of more than one organisation. We recognise that the various partners we have engaged play an important role in this project, however since their involvement has only come about because of the unique approach of this particular project, the vast majority of credit for achieving a given outcome must go to the project itself.
### Table 5.4 Deadweight and Attribution

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Value (£)</th>
<th>Deadweight</th>
<th>Attribution</th>
<th>Impact (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased awareness and uptake of entitlement to benefits, grants and services</td>
<td>272910.00</td>
<td>5</td>
<td>5</td>
<td>246301.28</td>
</tr>
<tr>
<td>Increased income for the household</td>
<td>1078767.04</td>
<td>0</td>
<td>0</td>
<td>1078767.04</td>
</tr>
<tr>
<td>Improved health and wellbeing</td>
<td>11409.84</td>
<td>50</td>
<td>20</td>
<td>4563.94</td>
</tr>
<tr>
<td>Improved quality of life ability to afford better diet</td>
<td>224752.32</td>
<td>27</td>
<td>20</td>
<td>131255.35</td>
</tr>
<tr>
<td>Improved quality of life from referrals to meals on wheels</td>
<td>147682.08</td>
<td>5</td>
<td>5</td>
<td>133283.1</td>
</tr>
<tr>
<td>Improved quality of life from being able to get more help in the home</td>
<td>1142871.60</td>
<td>5</td>
<td>5</td>
<td>1031441.62</td>
</tr>
<tr>
<td>Households able to make energy improvements providing annual savings on heating bills and indirectly increasing household income</td>
<td>748195.00</td>
<td>10</td>
<td>5</td>
<td>639706.7</td>
</tr>
<tr>
<td>Improved home environment therefore preventing cold-home related illness and falls (reduction in excess winter deaths)</td>
<td>283836.00</td>
<td>20</td>
<td>0</td>
<td>227068.8</td>
</tr>
<tr>
<td>Improved mental health as a result of respite support</td>
<td>23184.00</td>
<td>50</td>
<td>20</td>
<td>9273.6</td>
</tr>
<tr>
<td>Improved safety and security in the home as a result of aids and adaptations installations reducing number of falls and accidents in the home</td>
<td>4349587.00</td>
<td>10</td>
<td>20</td>
<td>2440503</td>
</tr>
<tr>
<td>Increased ability to stay in home for longer as a result of installation of appropriate aids and adaptations</td>
<td>960000.00</td>
<td>10</td>
<td>20</td>
<td>691200</td>
</tr>
<tr>
<td>Increased access to support services</td>
<td>37625.00</td>
<td>10</td>
<td>20</td>
<td>27090</td>
</tr>
<tr>
<td>Improved quality of life from reduced social isolation</td>
<td>19460.00</td>
<td>10</td>
<td>20</td>
<td>14011.2</td>
</tr>
<tr>
<td>Improved quality of life from increased access to transport</td>
<td>25000.00</td>
<td>5</td>
<td>10</td>
<td>21375</td>
</tr>
<tr>
<td>Improved quality of life through access to day care support and activity centres</td>
<td>412251.84</td>
<td>10</td>
<td>20</td>
<td>296821.32</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>9737531.72</strong></td>
<td></td>
<td></td>
<td><strong>6992661.95</strong></td>
</tr>
</tbody>
</table>
4.5.7 Calculation of SROI

Before we are able to calculate the SROI of the project the issues of duration of outcomes and drop off also have to be considered.

Duration

Clearly the effect of some outcomes will last longer than others and some will depend on the activity continuing and some not. When calculating the Social Return we project the value of the outcomes achieved into the future depending on what we believe the duration to be. This issue is under review by the Measuring Social Value consortium, and the aim is to produce further guidance on discounting in due course.

In the case of the maximising access project, we have taken a conservative view on duration, in the light of lack of research evidence to draw on. For the purposes of this SROI report we have considered only the first year after completion of the project.

Drop off

We need to take into account how long outcomes last. It is considered that in future years the amount of outcomes directly attributable to the maximising access project is likely to diminish. As a consequence, over time it is likely that changes experienced by people will be more influenced by other factors external to the project. Drop off is used to account for this. Since this SROI concentrates on outcomes that can be readily evidenced and is not considering beyond the first year after completion drop off has been determined as zero.

SROI Calculation

*Summing the right hand column in Table 5.4 gives the total impact from maximising access for the period under analysis as £6,992,661.95. The total invested to generate the total impact was £810,875.*

*The SROI index is a result of dividing the total present value for the investment. This gives a social return of £8.62 for every £1 invested in the project.*

4.6 Value for Money

Value for Money (VFM) has long been defined as the relationship between the three key indicators of economy, effectiveness and efficiency sometimes known as the ‘value chain’. Traditionally, value for money has been interpreted as ‘cost efficiency’ however; increasingly the concept of perceived value for money (i.e. quality, accessibility, satisfaction etc) is included. This creates complexities associated with measurement as these values tend to be more ‘qualitative’ and as a result harder to measure.

1. Economy – the cost paid for providing a service;
2. Effectiveness – measure of the impact (both qualitative and quantitative); and
3. Efficiency – is a measure of productivity (i.e. cost reduction to achieve the same level of outcome, or improvements in the outcomes achieved from the same level of expenditure).

VFM is high when there is an optimum balance between all three indicators, relatively low costs, high productivity and successful outcomes.
It is important to highlight at the outset of this analysis that given the complexities around measurement as well as the timing issue in terms of anticipated outcomes (as identified within the methodological issues section in 5.2) it is very difficult to be definitive with regards VFM. However, subject to this caveat we have presented our analysis of VFM against indicators in the sub-sections below.

**Economy**

Overall spend on the maximising access project has amounted to £810,875 over the lifetime of the project. In the absence of this investment it would not be possible for the project to be sustainable, certainly not at the same scale, or with the same unique community development approach, without this funding.

Against original output targets contained within the economic appraisal the project has performed well with significant engagement in the 88 targeted rural super output areas. This engagement has been at a broader community level as well as with the households themselves. This in itself should be viewed as a success factor for the project, not least given the multi-agency approach and partnership working developed between statutory and non-statutory providers.

In addition to output targets a detailed VFM study should consider the outcomes / impacts realised. Subject to the caveat with regards realisation of outcomes (e.g. health and wellbeing outcomes are likely to materialise over a much longer timeframe / some of the referrals have not yet been processed etc) performance would suggest significant positive gains across the broad spectrum of stakeholders as portrayed in Figure 5.1. These have included:

- **Impact on households** – increased income, improved quality of life, reduced fuel poverty, increased awareness and uptake of services and improved safety and security in the home;

- **Lead organisations** – increased organisational capacity, improved / sustained relationships, increased uptake of services / activities delivered, financial leverage and increased understanding of local need;

- **Local enablers** – increased income, personal skills / network development and professional development;

- **Referral Agencies** – fulfilling strategic / policy objectives, increased uptake and awareness of services, access to clients who would otherwise not have been engaged and improved local and regional partnerships / relationships; and

- **Statutory bodies** – multi-policy objectives fulfilled, additional income generated for the local economy, maximised uptake of services / activities and access to / support of disadvantaged rural communities who otherwise may not have availed of mainstream processes.

At a more strategic level using the proxy figure for benefits alone the project has been able to contribute potentially more than £1m through maximising benefit uptake to the Northern Ireland economy. It should be remembered that this money is additional to the Northern Ireland economy from the UK Treasury.

Estimates on the broader outcomes would indicate the project has the potential to lever in as a minimum £3.7m for the households alone. This figure is a conservative estimate based on the information available on outcomes to date and does not include the many social benefits which can also be attributed to the project. Overall spend on the project amounts to £810,875 which indicates:

- A minimum leverage of £4.56 for every £1 spent by DARD /PHA based on the direct financial information available on the project.

- Using the SROI methodology this figure would increase to £6,992,661.95. This gives a social return of £8.62 for every £1 invested in the project.
These figures represent significant value for money for the investment of the project.

Effectiveness

Additionality levels whilst difficult to measure would appear to be quite high with many of the lead organisations / stakeholders and householders suggesting that services / activities provided through maximising access would simply not have happened to the same level without the funding. As a result, the volume of individuals would not be availing of the activities / services on offer. This could be quantified through more in-depth counterfactual assessment over a longer period of time – however given the majority of referral organisations stated they would not otherwise have had the capacity to undertake this engagement to the same scale or speed in the absence of the community development model we are confident that additionality levels are high.

Our analysis in relation to outcomes and the performance of the project against output targets contained within the economic appraisal indicate progress has been made in terms of effectiveness. Whilst some challenges / issues have been experienced with project processes in terms of household identification, some target groups not being accessed in sufficient numbers, referral processes and referral agencies resource / capacity to deal with the volume of referrals the fact the project has performed so well would indicate that it has been effective and importantly in looking forward could be more effective. These areas should be considered in looking forward to ensure VFM is maximised.

Efficiency

In total more than 4,000 households have been visited by over 200 trained enablers across the 13 zones of the project managed by nine lead organisations. Whilst a useful indicator of efficiency would be to assess the cost per visit, cost per referral etc we do not have a full summary of costs in relation to the project. In addition, household targeting and engagement, referral processes etc varied across the zones and therefore an overall assessment of efficiency would not be possible using this method.

There is also a tendency with regards these types of initiatives to measure performance in terms of output (i.e. how many people have been engaged?). However, equally if not more important than the number of people engaged, is the ‘quality’, and connection to wider society, societal processes and activities. In this respect our analysis is positive as we are confident of outcomes across many areas both economic and social.

4.7 VFM Summary

The evidence presented in the preceding section and within the project impact section of the final report indicates that the services / activities provided under maximising access are additional to the services / activities that would be provided in the absence of funding.

Significant impacts have been identified across a broad range of stakeholders. For many households the project appears to be serving individuals who may not be willing (or able) to avail of mainstream provision and addressing gaps in accessibility to mainstream provision. The project has provided an opportunity for stakeholders to ‘think outside the box’ to provide activities that otherwise would not have been funded, and to deliver a ‘unique community development approach’ to engagement with the targeted households.

Overall, our assessment would indicate that the project has provided value for money.
5 ANALYSIS AGAINST TERMS OF REFERENCE

5.1 Introduction

Bringing together the project performance, consultation findings and outcomes associated with the project this section presents our analysis of findings. The analysis specifically addresses the terms of reference for this evaluation and is presented in the following subsections:

- the effectiveness of the project (qualitatively and quantitatively) and evaluate the effectiveness of delivery;
- the effectiveness of the project in terms of maximising access to benefits, grants and local services to support rural dwellers living in or at risk of poverty and social exclusion;
- the success of the project in accessing the hardest to reach groups; and
- quantify in local and regional terms what are (and can be) the economic and social impacts of the project.

The recommendations are drawn from this analysis in section 6.

5.2 Effectiveness of the project and its delivery

"Assess the effectiveness of the project and evaluate the effectiveness of delivery"

It is important to recognise the context within which the project has been developed and managed. The breadth of offering of services and the number of key partners both at a community and strategic level are significant. The fact that the project was able to move from a ‘pilot’ in one area to a ‘regional’ project without any significant challenges (albeit with some teething challenges) is notable of its effectiveness.

The project has supported local community organisations, key referral organisations and statutory stakeholders to develop their knowledge and understanding of the needs within disadvantaged rural communities. Based on feedback from lead organisations and stakeholders the delivery of the project has been maintained with good relationships between key partners. Lead organisations regularly talked of the accessibility, trust and rapport they had with project delivery partners (specifically those from PHA and DARD). This gave lead organisations the opportunity to be more open, as they were speaking to individuals during lead organisation meetings, whom they believed understood the context and needs and supported on addressing any challenges experienced in a timely fashion.

The consultation with stakeholders and lead organisations would also indicate that the project has allowed identification and engagement with a range of vulnerable rural households, who would otherwise be left isolated and in receipt of limited generic support. Anecdotally at least, additonal levels would appear to be quite high with many of the stakeholders discussing the added value of the community development model in terms of identifying those most in need and building trust and empathy with the households. Albeit there are some issues which could be addressed and support improved additonality (e.g. an increased challenge function within the tendering process with lead organisations to ensure effective early connection with knowledgeable community activists in support of the identification process). In the absence of funding for the project, levels of households being referred through to key agencies / organisations would not be happening at minimum on the same scale. The result is that households would not be accessing the benefits, grants and services on offer to them. This could be quantified in the longer term through more in-depth counterfactual assessment.

In terms of delivery the project has afforded an inter-agency and cross-sectoral approach to tackle issues within the rural context. Access, co-operation and expertise has been apparent at the bottom level through the community development model across the 13 zones and using the experience, knowledge and networks of community activists and voluntary / community
groups. At the top level, right through to the Minister in DARD and senior officials within PHA in providing strategic direction to the overall project. The actual delivery model of the project is cited by all stakeholders as “best practice” in terms of a project approach. The regional project management forum provided opportunities for senior engagement and strategic direction, the regional operational group played an important role in co-ordination across the different agencies and included representation from the lead organisations. The lead organisation meeting were important in terms of both delivery of the project and in facing challenges in delivery. Often both lead organisations and stakeholders during consultations discussed the “flexibility and responsiveness” of this approach.

The evaluation has found positive examples, through these forums of well developed working relationships between the lead organisation and statutory partners. However, there have also been challenges with regards some aspects of the project. In particular, at an operational level in terms of referrals there appears to have been some challenges at the outset in relations between some lead organisations and some referral organisations. Whilst involvement of the “strategic” stakeholders provided good opportunities for increased knowledge and agreement of the project procedures, it appears that in some cases the messages may not have been effectively filtered down to the regional and operational arms of these organisations. As a result, some lead organisations had to spend time at the outset of the project building relations, explaining the project and agreeing referral protocols. Whilst in the main these challenges appear to have been worked through it is important that for any future phase of the project these issues are considered. One potential avenue for this is to involve organisations at a local level in project delivery groups across the zones. Some of the lead organisations worked in this capacity and where it did happen was viewed to be beneficial to the project. As part of the project PHA developed a process manual for the referral procedures which developed as the project progressed. This manual was viewed positively be lead organisations and in looking forward should be developed and agreed with all partners at the outset of the project clearly articulating timings and processes for referrals. This could help to maximise the efficiency of the referral process. We understand that an IT system will also be developed which will support a smoother referral process, this is welcomed and will support the new process manual in clearly supporting understanding on all sides of responsibilities.

5.3 Effectiveness in maximising access to benefits, grants and services

“The effectiveness of the project in terms of maximising access to benefits, grants and local services to support rural dwellers living in or at risk of poverty and social exclusion”

What is delivered and who delivers it are two features of the project which contribute most to its overall effectiveness in maximising access. In terms of the sheer volume of referrals produced through the project, performance has at minimum delivered what had been ambitiously targeted within the original economic appraisal for the project. As is discussed in Section 5, of the 4,135 households visited, 92.7 per cent (n=3,833) of households engaged by the project were signposted / referred for at least one service across the range of benefits, grants and services available. This included significant figures in relation to energy efficiency and housing grants, home safety checks, benefit entitlement checks and transport. Using referrals as a proxy for accessibility to each of these areas suggests that the project has been effective in maximising access.

From an economic perspective effectiveness is a consideration of what changes would have improved or increased the final outcomes associated with an intervention. Overall the project identified more than 6,000 households across the 13 zones who potentially could have benefitted from the project using a bottom-up community development model. From this overall figure, 4,135 household visits were completed and more than 10,900 referrals were made across the various strands of the project as identified in Sections 4 and 5.

The direct impact of the funding is continuing to be monitored as referrals across the agencies are processed. However, as is discussed within Section 6 these impacts / outcomes have the potential to be significant. However, this may only be a first step. We recognise the tracking of an individual households ‘journey’ will likely realise other outcomes, beyond the most obvious
(and often medical model) targets. As is discussed in Section 2 the needs associated with the
target groups of the project are challenging and in some cases still not fully understood. It is
therefore important to apply a flexible approach to ensure other outcomes beyond set
indicators are both captured and appropriately valued. This likely requires further study and
consideration, and could help provide a more meaningful framework of outcome indicators in
looking forward to phase II of the project.

The practical aspects of the project in terms of identifying households using the ‘bottom-up’
community development model and engagement at all levels through the different forums
were appreciated by stakeholders and lead organisations. The other feature of the project
which differentiates itself from other interventions designed to increase access to benefits,
grants and services is the fact that enablers engage directly with the individual households
identified within their household (i.e. the enabler goes to them).

Whilst findings are positive in relation to maximising access there are some challenges which
if addressed would support an improvement in looking forward. This is important in the
context of a second phase which potentially aims to target the 198 “next most deprived” SOAs
away from the 88 most deprived SOAs. This includes, identification and targeting of
households, recruitment and training of enablers and the ongoing and monitoring of referrals
following engagement with the households. These are considered in more detail in Section 6.

5.4 Success of the project in accessing the hardest to reach groups

“The success of the project in accessing the hardest to reach groups”

Evidence and experience indicates that to access the most difficult to reach and those
suffering greatest inequalities and disadvantage requires a more innovative, extensive and
personal approach to that traditionally used. Addressing issues as sensitive as poverty and
exclusion requires a supportive and sympathetic approach that will build trust and
commitment. The maximising access project has attempted to do this using a community
development model to engage directly with households by:

- Identifying vulnerable people in their community using local knowledge; and
- Recruiting and training members of the local community to become enablers so as to
carry out home visits and signpost people to local services.

The actual definition of “hardest to reach” is a challenge in itself. Not least in rural areas, as is
discussed in Section 2, where the scale, breadth and dispersed nature of some areas may
make it even more difficult to identify those groups.

At the outset, it is important to note the project set out to prioritise the 88 most deprived rural
SOAs using the NISRA 2009 deprivation ratings. Secondary to this initial prioritisation, the
project approach also sought to provide guidance to the lead organisations on the key groups
who were potentially most vulnerable in terms of poverty and social exclusion within these
areas. These groups included older people, lone parents, farm families, ethnic minorities,
disabled and carers. This guidance highlighted that if an individual or a family living in a rural
area fell into one of these more vulnerable groups they were doubly disadvantaged.

Our analysis of the household survey indicates that the largest proportion of households had
at least one disabled household member (59.5 per cent; n = 2421), with pensioners (51.8 per
cent; n = 2,087) the only other target group represented by more than half of the sample. A
large minority of the sample (41.2 per cent; n = 1,586) were identified as lone adults. One in
every five of the households (20.7 per cent; n = 839) had carers, whilst, less than one in ten
were made up of Lone Parents (9.6 per cent) or Farmers and Fishermen (9.6 per cent). A
very small minority of the households (1.5 per cent) contained a member of the ethnic minority
community. As a minimum what we can say is that some of all of these groups have been
engaged in all areas. However, it is important to note these groups were identified for
guidance rather than targets. Anecdotally, during the lead organisation consultations some
groups actively used these target groups in prioritising and targeting households (e.g. through
engagement with representative organisations including those with disabilities, ethnic
minorities etc). In other areas however lead organisations discussed specific challenges with engaging with particular representative organisations or had so many targeted households identified that they did not need to specifically target in areas. Consideration of how best to engage with target groups in looking forward and perhaps setting specific targets for numbers may be worth consideration for future phases of the project.

5.5 Economic and social impacts

“Quantify in local and regional terms what are (and can be) the economic and social impacts of the project”

From our analysis of monitoring data, consultations / case studies and review of feedback / evaluation work undertaken by PHA we have identified economic and social impacts on individual households and on the lead organisations involved in the project delivery.

Economic and social impacts on households:

- **Increased awareness** – this includes increased awareness of entitlement as well as increased awareness of local services / activities available. Whilst only slightly more than a quarter (26.2 per cent; n = 75) of participants in the PHA follow-up survey indicated use of the directory of services in finding local groups or services, 79.7 per cent (n = 228) remembered the enabler spending time to go through the directory, 76.4 per cent (n = 219) still have the booklet and more than half (59.7 per cent; n = 171) stated they found the directory useful to some degree;

- **Improved access to benefit entitlement** – In total more than half of households engaged (53 per cent; n = 2,195) have been referred for a BEC. Using estimates (see Section 5) this has identified an additional £1,078,767.04 in benefits per annum across the 13 zones;

- **Reduced social isolation** – The PHA follow-up survey indicates a positive change in terms of the social connectedness of project participants. Anecdotally, through consultations with lead organisations and case studies with households the project has afforded vulnerable individuals with opportunities to “get out of the house” either in attendance at local groups / activities or as a result to improved access to transport through CRT;

- **Improved health and wellbeing** – Whilst the follow-up survey did not indicate any measurable improvements in the general health and well-being of participants there are likely longer term impacts as a result of increased access to benefits, warmer homes, safer homes and improved access to transport for many of the households engaged on the project;

- **Improved living conditions** – in total more than 900 households have received / or are in the process of receiving support through installation of a range of energy efficiency measures. Using figures provided by the Energy Saving Trust this has the potential to save each household between £121 and £252 per year.

- **Reduced social exclusion** – in total, 92.7 per cent of households engaged (n = 3,833) were signposted / referred for at least one service across the across the range of benefits, grants and services available.

Impacts on lead organisation:

- **Increased understanding of need** – working directly with key influencers within communities and direct engagement with householders through enablers has supported lead organisations in understanding needs within the communities and increasing awareness of these needs with the broader stakeholders involved in the project;
• **Networking / relationship building** – lead organisations discussed building relations at several levels across the project. This included relationship building with local community groups at the outset of the project in recruiting enablers and identifying households. In some cases this had supported the development of new relations whilst in others relationships had been sustained or continued. Networks have also developed amongst lead organisations with some organisations discussing sustained relations in the period post-project – the lead organisation meetings were highlighted as opportunities to network and share best practice;

• **Evidence for future funding** – some lead organisations discussed ‘leveraged’ benefits associated with being involved in the project. This is partly linked to the relationships developed and an increased understanding of need leading to opportunities for future funding. We are aware of at least one lead organisation who has already been successful with a funding application developed directly as a result of their involved in maximising access;

• **Increased demand for services** – some lead organisations discussed increasing demand for their own services as a result of the project – this was specifically for those organisation who may deliver local services / activities but other organisations also discussed increasing volumes of calls / contact from local residents as a result of the project.

**Other impacts**

• **Improved community capacity** – In total 244 individuals were recruited and trained as enablers on the project supporting enhanced skills, knowledge and capacity within local communities. This knowledge is likely retained after the project and the skills developed (i.e. interview skills etc) are potentially transferable to other initiatives. In addition, relations developed between lead organisations and key referral agencies are positive developments in capacity / understanding of each other in looking forward.

• **Strategic Impacts** – involvement of key agencies in the regional project management forum and the supported learning from the project in terms of methodology, approach to identification and engagement of households and the actual outcomes can all be used to influence policy and practice in participating organisations and within both local and regional Government across the region.

In total, as identified in Section 5 in terms of purely economic outcomes the project has the potential to lever in as a minimum £3.7m for the households. This figure is a **conservative** estimate based on the information available on outcomes to date and does not include the many social benefits which can also be attributed to the project. This would suggest a minimum leverage of £4.46 for every £1 spent by DARD /PHA.

Using the SROI methodology this figure would increase to £6,992,661.95. This gives a social return of £8.62 for every £1 invested in the project.

### 5.6 Summary of key messages from the analysis

• It is important to recognise the context within which the project has been developed and managed. The breadth of offering of services and the number of key partners both at a community and strategic level are significant. The fact that the project was able to move from a ‘pilot’ in one area to a ‘regional’ project without any significant challenges (albeit with some teething challenges) is notable of its effectiveness.

• The project has supported local community organisations, key referral organisations and statutory stakeholders to develop their knowledge and understanding of the needs within disadvantaged rural communities.

• The project has allowed identification and engagement with a range of vulnerable rural households, who would otherwise be left isolated and in receipt of limited generic support. Anecdotally at least, additionality levels would appear to be quite high with many of the
stakeholders discussing the added value of the community development model in terms of identifying those most in need and building trust and empathy with the households.

- In terms of delivery the project has afforded an inter-agency and cross-sectoral approach to tackle issues within the rural context. Access, co-operation and expertise has been apparent at the bottom level through the community development model across the 13 zones and using the experience, knowledge and networks of community activists and voluntary / community groups. At the top level, right through to the Minister in DARD and senior officials within PHA in providing strategic direction to the overall project. The actual delivery model of the project is cited by all stakeholders as “best practice” in terms of a project approach.

- What is delivered and who delivers it are two features of the project which contribute most to its overall effectiveness in maximising access. In terms of the sheer volume of referrals produced through the project, performance has at minimum delivered what had been ambitiously targeted within the original economic appraisal for the project. Using referrals as a proxy for accessibility to each of these areas suggests that the project has been effective in maximising access.

- The direct impact of the funding is continuing to be monitored as referrals across the agencies are processed. However, as is discussed within Section 6 these impacts / outcomes have the potential to be significant.

- The practical aspects of the project in terms of identifying households using the ‘bottom-up’ community development model and engagement at all levels through the different forums were appreciated by stakeholders and lead organisations. The other feature of the project which differentiates itself from other interventions designed to increase access to benefits, grants and services is the fact that enablers engage directly with the individual households identified within their household (i.e. the enabler goes to them).

- Evidence and experience indicates that to access the most difficult to reach and those suffering greatest inequalities and disadvantage requires a more innovative, extensive and personal approach to that traditionally used. Addressing issues as sensitive as poverty and exclusion requires a supportive and sympathetic approach that will build trust and commitment. The maximising access project has attempted to do this using a community development model which has been, anecdotally at least, largely effective.

- As a minimum what we can say is that some of all of these groups have been engaged in all areas. However, it is important to note these groups were identified for guidance rather than targets. Anecdotally, during the lead organisation consultations some groups actively used these target groups in prioritising and targeting households (e.g. through engagement with representative organisations including those with disabilities, ethnic minorities etc). In other areas however lead organisations discussed specific challenges with engaging with particular representative organisations or had so many targeted households identified that they did not need to specifically target in areas.

- From our analysis of monitoring data, consultations / case studies and review of feedback / evaluation work undertaken by PHA we have identified economic and social impacts on individual households and on the lead organisations involved in the project delivery across a broad range of areas including improved access and awareness of entitlement, strategic linkages between community / voluntary groups and statutory bodies and increased understanding / awareness of need.
6 LOOKING FORWARD

6.1 Introduction

"Make recommendations as to the scalability of the initiative and how PHA / DARD could / should maximise this”

This section details our recommendations to support the development of the next phase of the project. These are drawn from the findings and analysis presented in previous sections of the report.

6.2 Recommendations

Based on our analysis of findings, we have identified a number of recommendations for PHA and DARD in terms of the strategic and operational direction of the project for phase II.

6.3 Strategic Recommendations

Continued Need

It is evident from the evaluation that the project has engaged with a significant number of rural dwellers. The households engaged on the project have been identified with local knowledge as vulnerable and in need of support. Many of those engaged may not otherwise have been supported in accessing the range of benefits, grants and services.

The project continues to fit with a range of Government strategies and policies at a regional and local level across rural areas in Northern Ireland. As is discussed in Section 2 there is also potential growth in demand for interventions of this nature as a result of the impact of the economic downturn and the potential implications of this on the hardest to reach communities, specifically those who may continue to be hidden in rural areas.

Recommendation 1:

The rationale for maximising access to those “most in need” in rural areas remains and it is recommended that DARD through the Rural Anti-Poverty Strategy and Social Inclusion Framework should continue to provide a specific intervention to meet this need.

Identifying Need

Identification of those “most in need” should continue to be a focus for the project in looking forward. Findings from the evaluation would suggest that use of the community development approach has supported vulnerable households to be identified by the local community and encouraged to participate in the initiative.

This approach is particularly relevant if the project were to move out of the “most deprived” SOAs into more affluent areas where deprived / disadvantaged households may be hidden within more affluent neighbourhoods / communities.

Recommendation 2:

It is recommended that in consideration of a future phase of the project the community development approach to engaging those most in need should continue to be applied.

Local knowledge / experience and links with the communities targeted are vital in maximising the impact of project. We recommend that a procurement process should be established to identify local community organisations with the capacity, expertise and skills to deliver across a full zone. In particular, this should include consideration of how potential lead organisations can demonstrate existing links / networks across the zone(s) they intend to work across.
Recommendation 3:
Further to recommendation 2 we would also recommend that lead organisations through the tendering process are asked to establish / identify a plan to establish local zone-based steering groups to identify and target households. This group should include individuals and local organisations from across the zone who have knowledge and access to information on vulnerable households. This should include special interest groups at a local level (e.g. those specifically working with target groups, for instance, ethnic minorities etc) and could also include individuals with specific knowledge of the local areas (e.g. local clergy, postmen, local councillors etc).

This group should then be tasked with identifying the most vulnerable households across the zones and creating a database who will then be contacted and asked if they wish to take part.

Management / Operational considerations
The management and operational structures of the project have been described as “best practice” by key stakeholders of the initiative. This includes strategic direction provided by the Regional Project Management Forum, a Regional Operational Group overseeing project implementation and a Lead Organisations Forum to exchange learning and addressing risks / challenges.

Recommendation 4:
It is recommended therefore that for any future phase of the project consideration be given to continuing these overall management structures. In addition, in line with recommendation 10 we would also recommend inclusion / engagement of regional bodies representing the identified targeted groups of the project within these management structures. This could include for example, bodies working with Ethnic Minorities, Disabled persons, Lone Parents etc.

Referral organisations / agencies
Buy-in to the process by referral agencies and particularly at a local level agency staff is essential if maximum benefits, grants and service uptake is to be realised. Within the evaluation we have identified some challenges with moving households through the referral process to actual outcome in terms of timing, local differences in approach and local relationships between lead organisations and key referral agencies.

Recommendation 5:
We recommend that further work is undertaken at both a strategic and operational level for any future phase of the project to ensure that all key stakeholders are fully aware of their roles and responsibilities and “buy-in” is ensured across the key agencies in support of maximising the outcomes.

In line with recommendation 3 and the establishment of local steering groups for identifying households we would also recommend consideration of partnerships between lead organisations and referrals agencies at a local level to ensure consistency in referrals across the zones and to support the monitoring of referrals from point of referral to outcome. Potentially this could include signed Partnership Agreements both at a strategic level and at a local level to ensure consistency in relationships across the operational areas of the project.
Strengthening collaboration

Collaborative working between the community and voluntary sector and the statutory sector remains desirable in meeting the needs of vulnerable rural dwellers, particularly given the increased pressure to demonstrate that resources are used in the most efficient and effective way. It is important however that funding provided through maximising access is not used to replicate statutory services or duplicate other efforts within the local communities engaged.

The first phase of the project has demonstrated positive collaboration both at a strategic and operational level across the project. However, it also indicated some continued challenges, particularly at a local level which highlights the importance of continuing to develop and facilitate understanding (and trust) between the statutory sector and the community and voluntary sector of the benefits of working collaboratively to maximise impact through referrals between the sectors. In particular, processes for sustaining relationships into the longer term between stakeholders of the project could be an important legacy of the maximising access project.

**Recommendation 6:**

In relation to improved and continued collaboration we have recommended through recommendations 2, 3 and 5 areas for continuation from the first phase into the second phase to support the positive elements of collaboration experienced and evidenced through the evaluation.

A further area to consider is in marketing the most positive aspects of collaboration within the project. In particular, how can the positive message and lessons of collaboration be shared with agencies / organisations outside of the project for them to integrate the learning into future practice and support broader collaboration between the sectors? We recommend that consideration be given to taking opportunities to share best practice with agencies when opportunities are available.

Finally, as is discussed the evaluation has evidenced positive collaboration for the purposes of the project. However, we would also recommend as phase II develops consideration of how relationships across all levels of the project can be sustained into the longer period in support of meeting need within the rural community over the longer term.

### 6.4 Operational Recommendations

**Enablers**

The position of enabler is a key role within the project, from supporting household identification, through persuading / encouraging participation and effective referral of households to ensure maximised impact. Recommendations for enablers have been considered across a number of dimensions below.

**Recommendation 7:**

**Enabler selection**

Consideration should be given to the development of more robust selection criteria for enablers to include, for example, motivation to become an enabler, previous training experience, previous knowledge of working with vulnerable households, interview skills and agreement to the time commitment required for the project.

In addition, the development of enhanced and consistent formal support structures for enablers through monitoring, post-visit supervision should support the enhanced recruitment and retention of enablers.

**Enabler training**

Feedback from lead organisations and enablers captured through the evaluation indicates support for more focus on some aspects of the training and potentially a more interactive training experience.
This could include role plays of potential incidents that may be experienced in households (e.g. how to overcome a particularly difficult household in partaking in the project) and support enhanced understanding of the day-to-day nature of the role.

**Enabler quality**

It is imperative that structures are introduced to monitor the quality of enablers and ensure that enablers are delivering the core aspects of the project consistently.

We understand that phase II of the project may include lead organisations employing an “enabler team” as part of the contract. We would welcome this approach. However, we would also recommend that individual contracts / agreement are developed between lead organisations which consider all aspects of the role and include details of ongoing monitoring and supervision of enablers through regular reviews to ensure consistencies in the longer term across the project. This should include commitment from the lead organisations to monitor enabler quality at a local level and bring details of challenges / issues and progress to the Lead Organisation Forum.

**Enabler forum**

Consider the establishment of an enabler networking forum that enablers from across the project can use to contact and network with other enablers. This network should encourage greater sharing of best practice and lessons learned in training but could also provide a peer network of support for enablers to discuss issues, share experiences thus supporting wider project objectives.

**Marketing the project**

The promotion and awareness of the project should be an area of focus at both a strategic and operational level of the project. Evidence from the evaluation has largely been positive in terms of economic and social value and individual case studies.

**Recommendation 8:**

We recommend that consideration be given to the development of a full marketing plan for the project which considers how the project should be promoted at both strategic and operational levels. The success of the first phase of the project could potentially encourage vulnerable households to come forward and the information could also be used at a local level to support those identified to participate in the project.

In line with strategic recommendation 5 and sharing lessons / best practice with other key stakeholders outside of the project we would also recommend sharing information where possible on the community development model approach and operational / management arrangements with key agencies.

We recognise that phase II of the project will be branded as the “MARA” project and we welcome this approach in ensuring consistency in marketing / promotion of the project across the region.

Finally, we would recommend that any potential marketing plan would include a more proactive effort with various local and regional media outlets to inform, promote and raise awareness of both the aims of the project and its impacts when they materialise.

**Sharing and learning best practice**

One of the key benefits associated with the Lead Organisation Forum was the ability for lead organisations to share best practice and learning lessons with each other. Whilst this is welcome and a valuable aspect of the project further consideration should be given to building on this to find effective ways to share knowledge, experience and good practice and sustain these relationships into the longer term.
Recommendation 9:
Consideration should be given to development of a formal mechanism for sharing / learning across the project. Potentially this could include an intranet for all stakeholders to engage / share knowledge with each other from project inception, through the targeting / engagement process to referral.

Targeting the hardest to reach
Some lead organisations mentioned the difficulties of reaching specific groups within their zones. This is perhaps reflected in the smaller number of households engaged outside of the traditionally defined vulnerable (i.e. older people and those with disabilities).

Recommendation 10:
In line with strategic recommendations 2 and 3 the project should directly engage with a range of regional representative organisations across the key target groups to develop a dialogue with particular hard to reach groups (e.g. why the project needs their help, explain the project and what it aims to achieve, and ask for advice / support in engaging with particular groups / communities). This could include groups who represent ethnic minorities, disabled, lone adults, etc.

Referral Tracking
Through our analysis of management information the tracking of referrals towards outcomes was highlighted as being a key difficulty.

Recommendation 11:
We recognise that the new IT system is planned for phase II and training will be provided for this. However we recommend that all stakeholders continue to work in this area to ensure referral tracking is consistent and that opportunities for inconsistency across different zones is minimised.

Householder Feedback
The case studies undertaken has part of the project have provided positive examples at an individual household level of the impacts / outcomes associated with the project.

Recommendation 12:
We recommend that a systematic approach to collecting householder feedback over the longer term should be introduced and the findings from the feedback should be addressed on an ongoing basis by potential contractors and PHA / DARD during contracted meetings.

This could take the form of case studies, with a mandatory focus on the projects role. There could also be an opportunity for households to feedback through more informal mechanisms such as internet / websites etc.

Strengthening quality
Our analysis has highlighted a lack of consistency in terms of quality controls relating to enablers across the zones. When quality controls were in place, they had been developed as a result of the individual lead organisation rather than the project (e.g. this included capturing details of communications between enablers, lead organisations and households where particular issues arose). Whilst no serious incidents occurred as a result of the project, further consideration should be given to consistent protocols across the zones in terms of dealing with specific incidents requiring follow-up support by enablers, lead organisations and others.
Recommendation 13:
We recommend that quality standards are increasingly project driven. In doing this PHA / DARD should consider ‘best practice’ for quality controls in working directly with “vulnerable individuals”. This could involve enhanced training around key areas of client interviewing, interaction and protection and should be made consistent across all of the zones.

Building Links / Relationships early
A key aspect of the project is the important role played by lead organisations in engaging and utilising key individuals / influencers and groups at a local level to identify the most vulnerable households. As is discussed in the analysis of findings there was a different response in some areas to the project when enablers were engaging with different households.

Recommendation 14:
If similar projects are being implemented in rural areas in the future it is important to take time to identify the key people who have extensive local knowledge and also to ensure a representative spread of people across the geographic area. This is necessary if those who would benefit most are to be identified. Individuals in occupations such as postmen / local clergy etc can have considerable knowledge with regards the personal circumstances of potential beneficiaries of the project. It is important that relationships are developed in advance of going into the community to ensure appropriate targeting at the “most in need”.
### Appendix I – Steering Group Members

<table>
<thead>
<tr>
<th>Name</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gerard Treacy</td>
<td>DARD</td>
</tr>
<tr>
<td>Colette Brolly</td>
<td>PHA</td>
</tr>
<tr>
<td>Naomi McCay</td>
<td>PHA</td>
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<tr>
<td>Teresa McGarvey</td>
<td>PHA</td>
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<tr>
<td>Catherine O’Neill</td>
<td>PHA</td>
</tr>
<tr>
<td>Elizabeth Bird</td>
<td>North Antrim Community Network</td>
</tr>
<tr>
<td>Orla Ward</td>
<td>Bryson Energy</td>
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<tr>
<td>Patrick Minne</td>
<td>Access 2 Benefits</td>
</tr>
<tr>
<td>Barry Boyle</td>
<td>Fermanagh Rural Community Network</td>
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Appendix II – SROI Assumptions

Sources, references and assumptions in calculating the Social Return for Households from the maximising access project
## Table 1 – Quantities

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Indicators</th>
<th>Quantity</th>
<th>Assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased awareness and uptake of entitlement to benefits, grants and services</td>
<td>Number of households receiving a visit</td>
<td>4,135</td>
<td>No assumption actual figure</td>
</tr>
<tr>
<td>Increased income for the household</td>
<td>Previously unsecured benefits gained (annualised and back dated lump sum)</td>
<td>1 overall lump sum based on calculations in Section 5.4</td>
<td>No assumption actual figure</td>
</tr>
<tr>
<td>Improved health and wellbeing</td>
<td>Number of households reporting improvement in health conditions</td>
<td>Difficult to predict and no specific target set</td>
<td>Based on PHA questionnaire response of the number of households who indicated an improvement in general health conditions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Estimated 5 per cent of households engaged (207 households)</td>
<td></td>
</tr>
<tr>
<td>Improved quality of life from being able to afford a better diet</td>
<td>Number of households reporting improved health / nutrition</td>
<td>Difficult to predict and no specific target set</td>
<td>Conservative estimate based on research undertaken by the Food Standards Agency</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Estimated 10 per cent of households engaged (414 households)</td>
<td>Question should be factored into future follow-up survey</td>
</tr>
<tr>
<td>Improved quality of life from referrals to meals on wheels</td>
<td>Number of referrals to meals on wheels</td>
<td>138 referrals with 50 per cent expected to access meals on wheels services based on household follow-up information</td>
<td>No assumption actual figure</td>
</tr>
<tr>
<td>Improved quality of life from being able to get more help in the home</td>
<td>Number of referrals to home help scheme</td>
<td>229 referrals with 80 per cent expected to access home help services based on household follow-up information</td>
<td>No assumption actual figure</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Indicators</td>
<td>Quantity</td>
<td>Assumptions</td>
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<td>------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Households able to make energy efficient home improvements providing annual savings on heating bills and indirectly increasing household income</td>
<td>Number of households in receipt of grants for energy efficiency and housing grants</td>
<td>991 received or in progress</td>
<td>No assumption actual figure</td>
</tr>
<tr>
<td>Improved home environment therefore preventing cold-home related illness and falls (reduction in excess winter deaths)</td>
<td>Number of households reporting reduction in illness / falls etc</td>
<td>Difficult to predict and no specific target set</td>
<td>Stakeholder conversations with Bryson Energy in relation to the Warm Homes Scheme</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Estimated 10 per cent of households receiving energy efficiency home improvements (100 households)</td>
<td>Question should be factored into future follow-up survey</td>
</tr>
<tr>
<td>Improved safety and security in the home as a result of aids and adaptations installation reducing number of falls and accidents in the home</td>
<td>Number of signposted referrals for Disabled Facilities Grants / minor adaptations</td>
<td>433</td>
<td>No assumption actual figures</td>
</tr>
<tr>
<td></td>
<td>Number of referrals for home safety checks</td>
<td>2,655</td>
<td>No assumption actual figures</td>
</tr>
<tr>
<td>Increased ability to stay in own home for longer as a result of installation of appropriate aids and adaptations</td>
<td>Number of householders able to stay in home for longer as a result of installation of appropriate aids and adaptations</td>
<td>Difficult to predict and no specific target set</td>
<td>One research study found that almost one in ten randomly-selected adult recipients of adaptations had been kept out of residential care as a direct result of adaptation¹⁶</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Indicators</th>
<th>Quantity</th>
<th>Assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved mental health as a result of respite support</td>
<td>Number of requests for respite support</td>
<td>42 within the household survey</td>
<td>No assumption actual figures</td>
</tr>
<tr>
<td>Increased access to support services</td>
<td>Number of signposted referrals for primary care / social support services</td>
<td>1,075</td>
<td>No assumption actual figures</td>
</tr>
<tr>
<td>Improved quality of life from reduced social isolation</td>
<td>Number of signposted referrals for local support services</td>
<td>973</td>
<td>No assumption actual figures</td>
</tr>
<tr>
<td>Improved quality of life from increased access to transport</td>
<td>Number of households accessing CRT</td>
<td>8,000 trips undertaken by members</td>
<td>No assumption actual figures prepared by CRT</td>
</tr>
<tr>
<td>Improved quality of life through access to day care support and activity centres</td>
<td>Uptake of day care support</td>
<td>77 individuals requiring information with 50 per cent availing of support</td>
<td>No assumption actual figures</td>
</tr>
</tbody>
</table>
Table 2 – Financial Proxies

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Financial Proxy</th>
<th>Value</th>
<th>Assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased awareness and uptake of entitlement to benefits, grants and services</td>
<td>Cost of alternative targeted promotion of services through targeted mail-out and (1hr) one-to-one interview by consultant</td>
<td><strong>£6,000 mailshot to 10,000 people</strong>&lt;br&gt;<strong>£500 per day for consultant (c. £66 per hour) = £272,910</strong></td>
<td>Cost of 10,000 mailshots to general population using Royal Mail&lt;br&gt;Average cost of consultant to undertake questionnaire on face-to-face basis with households</td>
</tr>
<tr>
<td>Increased income for the household</td>
<td>Likely additional benefit entitlement secured - backdated and annualised</td>
<td><strong>£1,078,767.04</strong></td>
<td>No assumption actual figure</td>
</tr>
<tr>
<td>Improved health and wellbeing</td>
<td>Reduced spend on health services</td>
<td><strong>£275.60 pa per household</strong>&lt;br&gt;<strong>£11,409.84</strong></td>
<td>ONS Family Spending Survey 2010 – average spend on health services £275.60 pa per household. 20 per cent reduction on spend = £55.12 pa per household = savings of £11,409.84</td>
</tr>
<tr>
<td>Improved quality of life from being able to afford a better diet</td>
<td>Additional spend on healthy food</td>
<td><strong>£2,714.40 pa per household</strong>&lt;br&gt;(additional 20% = £542.88 per household&lt;br&gt;£224,752.32)</td>
<td>ONS Family Spending Survey 2010 – average spend on food = £2,714.40 pa per household. 20 per cent additional spend = £542.88 per household = increased spend on food £224,752.32</td>
</tr>
<tr>
<td>Improved quality of life from referrals to meals on wheels</td>
<td>Additional spend on meals on wheels</td>
<td><strong>£73,841.04 - £221,523.12</strong></td>
<td>Department reference cost £2.94&lt;sup&gt;17&lt;/sup&gt;&lt;br&gt;1 meal per day = Per day - £202.86</td>
</tr>
</tbody>
</table>

<sup>17</sup> [www.dhsspsni.gov.uk/reference_costs_community_services_unit_costs_2007-08.pdf](http://www.dhsspsni.gov.uk/reference_costs_community_services_unit_costs_2007-08.pdf).<br>Conservative figure – e.g. BBC news reports (December 2010) on costs of meals on wheels increasing to £4.25 (reference costs for dhsspsni figures shown as £3.54): [http://www.bbc.co.uk/news/uk-northern-ireland-11886090](http://www.bbc.co.uk/news/uk-northern-ireland-11886090).
<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Financial Proxy</th>
<th>Value</th>
<th>Assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved quality of life from being able to get more help in the home</td>
<td>Additional spend on home helps</td>
<td>£1,142,871.60p.a</td>
<td>Information provided by PHA on average hours (10 hrs p/week) and cost (£12.01 p/hour) of a Home help in NI</td>
</tr>
<tr>
<td>Households able to make energy efficient home improvements providing annual savings on heating bills and indirectly increasing household income</td>
<td>Energy efficiency household saving</td>
<td>Between £120,255 and £249,955 pa</td>
<td>No assumption actual figure</td>
</tr>
<tr>
<td></td>
<td>Value of grants for installation of measures</td>
<td>£2,563,500</td>
<td>No assumption actual figure</td>
</tr>
<tr>
<td>Improved home environment therefore preventing cold-home related illness and falls (reduction in excess winter deaths)</td>
<td>Savings to the health service of reduced cold-home related illness and falls</td>
<td>£2,563,500 = reduced health service costs estimated at £1,076,670</td>
<td>Estimated that for every £1 spent on measures savings of 42p to the health services. Estimated health saving costs of £1,076,670</td>
</tr>
<tr>
<td>Improved safety and security in the home as a result of aids and adaptations installation reducing number of falls and accidents in the home</td>
<td>Cost saving of aids and adaptations themselves – median cost of aids and adaptations</td>
<td>£500 per grant Est. £39,900 overall</td>
<td>NIHE estimate on the average costs of minor adaptations</td>
</tr>
<tr>
<td></td>
<td>Reduced costs associated with injuries as a result of fire / falls / accident</td>
<td>1x Death = £1.5m 5 x Serious = £850k 10 x Minor = £130k £2,810 x 50 = £140,500</td>
<td>Work undertaken for fire authorities in England indicates that for every 1,000 home safety checks completed a dwelling fire is prevented.</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Financial Proxy</td>
<td>Value</td>
<td>Assumptions</td>
</tr>
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</tr>
<tr>
<td>Increased ability to stay in own home for longer as a result of installation of appropriate aids and adaptations</td>
<td>Cost of private residential care</td>
<td>£254,240</td>
<td>Direct unit cost of private residential care is the fee – approximate to the social cost of the service. Age NI figures on cost of residential care</td>
</tr>
<tr>
<td>Improved mental health as a result of respite support</td>
<td>Reduced spend on counselling services</td>
<td>£645,000</td>
<td>Proxy: Costs of CBT: £67 per session £36 admin per hour £73 per hour face-to-face (approx 50/50 time spend on FTF and other e.g. CBT)</td>
</tr>
<tr>
<td>Increased access to support services</td>
<td>Cost of provision of community health services</td>
<td>£37,625</td>
<td>NHS Cost Book 2010 Average – Cost per community health nurse visit</td>
</tr>
<tr>
<td>Improved quality of life from reduced social isolation</td>
<td>Additional spend on recreation and culture</td>
<td>£19,460</td>
<td>Average cost of membership to luncheon club for Dennet Interchange</td>
</tr>
<tr>
<td>Improved quality of life from increased access to transport</td>
<td>Cost of transport</td>
<td>£25,000 overall</td>
<td>Average cost of Translink journey – conservative estimate which does not consider the costs associated with private taxis etc</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Financial Proxy</td>
<td>Value</td>
<td>Assumptions</td>
</tr>
<tr>
<td>----------</td>
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<td>-------------</td>
</tr>
<tr>
<td>Improved quality of life through access to day care support services</td>
<td>Reduced spend on day care facilities</td>
<td>If taken as 31 of those who received help were over 65 (80%) &amp; 8 individuals who received help were learning disabled (20%): £7,927.92 per week £412,251.84 annually</td>
<td>Learning Disability p/w = £38.67 Geriatric Medicine p/w = £245.76 46.8% referred for day activity also referred for day care support (n=30) leaving 35 referred for day activity centre only 40.8% of those referred for day care support were over 65 years. 7.5% were learning disabled. No costs provided for individuals not categorised as learning disabled/over 65 which may account for the 50% approx who actually received help [i.e. those who received help were either elderly or learning disabled because other categories of individuals do not qualify].</td>
</tr>
</tbody>
</table>

This could be refined based on information from Easilift.
### Table 3 – Deductions

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Deadweight benchmark or assumption</th>
<th>Attribution estimate</th>
<th>Displacement estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased awareness and uptake of entitlement to benefits, grants and services</td>
<td>Low-level of self referral to services offered by maximising access due to limited awareness / reluctance / ability to proactively seek services out 5 per cent</td>
<td>Each of the providers will undertake marketing activities etc however the maximising access project is the only project which targets the population using the community development approach 5 per cent</td>
<td>Maximising access additional to other service providers - no negative impact on other service providers</td>
</tr>
<tr>
<td>Increased income for the household</td>
<td>Targeted households are hard to reach group with identified benefit under claiming issue according to previous research. The figures presented have already considered a 45 per cent drop-off on uptake and as a result we estimate deadweight is zero/ 0 per cent</td>
<td>Maximising access directly responsible for increasing housing income – referral agencies part of partnership approach to the project 0 per cent</td>
<td>Maximising access additional to other service providers - no negative impact on other service providers</td>
</tr>
<tr>
<td>Improved health and wellbeing</td>
<td>Improvement in health and wellbeing correlates with ability to manage existing conditions, return to work, generally feel better 50 per cent</td>
<td>Medium attribution to maximising access as other factors influence health such as service provision and support from health services, family support, personal habits etc 20 per cent</td>
<td>Some negative outcomes from the follow-up household survey although inconclusive in terms of the overall outcomes for the project – likely as a result of changing circumstances. Not materially significant</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Deadweight benchmark or assumption</td>
<td>Attribution estimate</td>
<td>Displacement estimate</td>
</tr>
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<td>-------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Improved quality of life from being able to afford a better diet</td>
<td>Proportion of people aged 65+ in most deprived categories (large proportion of the maximising access project in this category) who eat a healthy diet (i.e. containing fruit etc) Health Education Population Survey 2007 update 27 per cent</td>
<td>Medium attribution to maximising access as other factors influence diet such as personal preference, education, health conditions, family etc 20 per cent</td>
<td>Some research suggests that when income reaches a significant level there is a deterioration in health eating – however whilst income has increased for households it has not done so to these levels and so no negative impact</td>
</tr>
<tr>
<td>Improved quality of life from referrals to meals on wheels</td>
<td>Limited number of households may have sought these services themselves – therefore deadweight minimal 5 per cent</td>
<td>Limited number of households may have sought these services themselves 5 per cent</td>
<td></td>
</tr>
<tr>
<td>Improved quality of life from being able to get more help in the home</td>
<td>Limited number of households may have sought these services themselves – therefore deadweight minimal 5 per cent</td>
<td>Limited number of households may have sought these services themselves 5 per cent</td>
<td></td>
</tr>
<tr>
<td>Households able to make energy efficient home improvements providing annual savings on heating bills and indirectly increasing household income</td>
<td>Bryson energy staff suggest that very few households would have self-referred to the Warm Homes Scheme in the absence of the project – therefore deadweight minimal 5 per cent</td>
<td>A limited number of households may have sought these services directly through Bryson Energy etc 5 per cent</td>
<td></td>
</tr>
<tr>
<td>Improved home environment therefore preventing cold-home related illness and falls (reduction in excess winter deaths)</td>
<td>Fuel poverty a result of ratio of household income to energy consumption – while household income and home efficiencies would unlikely have increased there may have been fuel price rises which may also</td>
<td>100 per cent attributable to maximising access</td>
<td></td>
</tr>
<tr>
<td>Outcomes</td>
<td>Deadweight benchmark or assumption</td>
<td>Attribution estimate</td>
<td>Displacement estimate</td>
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</tr>
<tr>
<td></td>
<td>What would have happened anyway</td>
<td>Who else creates these outcomes</td>
<td>Where there are negative outcomes for stakeholders not included in the impact map</td>
</tr>
<tr>
<td>Improved safety and security in the home as a result of aids and adaptations installation reducing number of falls and accidents in the home</td>
<td>have impacted on fuel poverty 20 per cent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased ability to stay in own home for longer as a result of installation of appropriate aids and adaptations</td>
<td>Low level of self-referring to support services such as care and repair and aids and adaptations due to limited awareness of services and reluctance/ability to proactively seek services out. 10 per cent</td>
<td>Maximising access directly responsible for referrals. Services offered by Home Safety Check then provide the outcome by delivery of the service / activity 20 per cent</td>
<td></td>
</tr>
<tr>
<td>Improved mental health as a result of respite support</td>
<td>Improvement in health and wellbeing correlates with ability to manage existing conditions, return to work, generally feel better 50 per cent</td>
<td>Medium attribution to maximising access as other factors influence health such as service provision and support from health services, family support, personal habits etc 20 per cent</td>
<td></td>
</tr>
<tr>
<td>Increased access to support services</td>
<td>Low level of self-referring to support services such as care and repair and aids and adaptations due to limited awareness of services and reluctance/ability to proactively seek services out.</td>
<td>Maximising access directly responsible for referrals. Services offered then provide by support services provide the outcome by delivery of the service</td>
<td></td>
</tr>
<tr>
<td>Outcomes</td>
<td>Deadweight benchmark or assumption</td>
<td>Attribution estimate</td>
<td>Displacement estimate</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
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<td>----------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Improved quality of life from reduced social isolation</td>
<td>Statistical significance with the number of households who report improvement in social connectedness as result of maximising access 10 per cent</td>
<td>Medium attribution to maximising access as ability to get out and about related to household income, health conditions, mental health etc. However the target group is vulnerable and isolated therefore improvement in social connectedness can largely be attributed to maximising access 20 per cent</td>
<td></td>
</tr>
<tr>
<td>Improved quality of life from increased access to transport</td>
<td>Easlift Community Transport indicated during consultation that none of the people referred to their service would have accessed in the absence of the project – therefore deadweight minimal 5 per cent</td>
<td>Ability to use other forms of transport such as taxis / cars / bus etc related to income, health conditions and affordability 10 per cent</td>
<td></td>
</tr>
<tr>
<td>Improved quality of life through access to day care support and activity centres</td>
<td>Low level of self-referring to support services due to limited awareness of services and reluctance/ability to proactively seek services out. 10 per cent</td>
<td>Maximising access directly responsible for referrals. Services offered then provide by support services provide the outcome by delivery of the service 20 per cent</td>
<td></td>
</tr>
</tbody>
</table>