Ms Naomi McCay and
Dr Catherine Millman
Health Intelligence

MARA

Summary Evaluation Report

October 2015

Improving your health and wellbeing

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Glossary of terms

1st visit	This was the first time an enabler called to a client's home to see if they were eligible for a range of services, grants and benefits. The 1st visit took approximately 1½ hours to complete the full assessment.
2nd visit	This was the second (and final) time an enabler contacted a client. The enabler either visited the client's home for the second time
BEC(s)	Benefit Entitlement Check(s)
DARD	Department of Agriculture and Rural Development
Enabler	A paid member of staff within lead organisations who visited clients in their households and facilitated referrals and follow up support.
HIPA	Household Identification Partnership Agreement
HP	Hewlett-Packard
IRPMF	Interdepartmental Regional Project Management Forum
Lead organisation	An organisation located in rural communities that was tendered to deliver MARA in their local area.
LOF	Lead Organisation Forum
MARA	Maximising Access in Rural Areas
MIG	MARA Implementation Group
NISEP/levy	Northern Ireland Sustainable Energy Programme
OT	Occupational Therapist
PHA	Public Health Agency
Phase I	This refers to an early version of MARA conducted between 2009 and 2011 which included nine lead organisations with 4,135 households participating and resulted in more than 11,000 referrals.

Phase II	This refers to the current MARA project.
RCTP	Rural Community Transport Partnership
SOA	Super Output Area
TRPSI	Tackling Rural Poverty and Social Isolation

1. Introduction

The Maximising Access in Rural Areas (MARA) project was delivered in rural areas across Northern Ireland between April 2012 and December 2014 using a community development approach. MARA is delivered at a local level by a number (12) of rural organisations. Enablers from these organisations visit clients' homes to conduct a needs assessment. MARA uses a 'personal touch' to encourage people to avail of a range of services, benefits and grants which they would not otherwise have known about or been able to apply for (eg Benefit Entitlement Checks (BECs), Warm Homes, Northern Ireland Sustainable Energy Programme (NISEP), Home Safety, Local Services, Rural Community Transport Partnerships (RCTP), boiler replacement grants (NIHE), occupational therapy assessments, social services, flexicare and Translink Smartpass). Clients are also provided with follow up support regarding their referrals.

MARA is funded by the Department of Agriculture and Rural Development (DARD) and the Public Health Agency (PHA). MARA is included in DARD's Tackling Rural Poverty and Social Isolation (TRPSI) programme[1] of work. Ultimately, MARA aims to improve the health and wellbeing of rural dwellers by increasing their access to a range of services, benefits and grants. The PHA oversees implementation of the MARA.

This is a summary of the evaluation of MARA and forms part of a series of reports. This report focuses on overall attainment of objectives, resultant outcomes and impacts for clients, and summarises the external consultant's report which independently reviewed MARA impacts and examined the value of MARA from the perspective of social return on investment and value for money.

1.1 MARA aims and objectives

The overall aim of MARA is[2]:

> *To improve the health and wellbeing of rural dwellers in Northern Ireland by increasing access to services, grants and benefits by facilitating a coordinated service to support rural dwellers living in, or at risk, of poverty and social exclusion. The MARA project will proactively target the vulnerable households in identified rural communities using a community development approach.*

To achieve this aim, the project objectives were:

1. To provide a home visit to 50 households per Super Output Area (SOA) by November 2014 using local knowledge with outcomes referred and/or signposted to local services, grants and benefits.
2. To increase access to home improvement schemes, particularly energy efficiency grants for at least 20% of targeted households.
3. To increase access to full Benefit Entitlement checks for at least 35% of targeted households.
4. To increase access to a range of local services for at least 20% of targeted households.
5. To increase access to a range of regional/universal services for at least 15%.
6. To increase access to community transport for at least 25% of targeted households.

1.2 Background

MARA is a regional roll out of a programme previously developed and implemented by DARD and PHA *Maximising access to services grants and benefits in rural areas* (2009 –11, Phase I).[3] Phase I facilitated a cross departmental coordinated service to maximise access to benefits grants and local services to support rural dwellers in or at risk of poverty. Vulnerable households were proactively targeted in identified rural communities using a community development face-to-face approach.

After the evaluation of Phase 1, several changes were made to the community development model to develop MARA Phase II. The main changes included a regional roll out to all Super Output Areas in rural areas, a bespoke IT system, enablers were formally employed rather than informally recruited, and some additions to the services, grants and/or benefits available. The new MARA model was piloted in the Fermanagh area (with 100 households) primarily to test the changes made to Phase II. The pilot was evaluated and recommendations were incorporated into full implementation (see main report[3] Section three for more detail).

1.2.1 Strategic context

The MARA project provides a direct link to the current Programme for Government (PfG 2011–2015)[4] through its potential to contribute to priority 2: creating opportunities, tackling disadvantage and improving health and wellbeing. MARA also supports the strategies and polices of

several government departments including DARD, Department of Health (DoH), and Department for Social Development (DSD).

MARA is one of the key projects in DARDS Tackling Rural Poverty and Social Isolation Framework[1]. It supports DARD in meeting the aims of its strategic plan by promoting accessibility to services within disadvantaged vulnerable rural communities and addresses the aims of the DARD rural development programme by contributing to the development and improvement of rural areas.

By working to address inequalities in the rural population MARA also addresses many cross government policy and strategies including Lifetime Opportunities - Government's Anti-Poverty and Social Inclusion Strategy for Northern Ireland[5], and health strategies; A Healthier Future - A Twenty Year Vision for Health and Wellbeing in NI, 2005 – 2025[6], Investing for health[7] and Making life better[8]. MARA also addresses several aims of DSD strategies including, NIHE rural action plan[9], and Warmer Healthier Homes – A new Fuel Poverty Strategy for Northern Ireland[10] and Opening doors, A strategy for the Delivery of Voluntary Advice service to the community.[11]

1.2.2 MARA model

All rural Super Output Areas (SOAs) in Northern Ireland were grouped into 13 geographical zones (excluding the pilot) with 12 lead organisations tendered to deliver MARA (see Table 6, Appendix A). Within each lead organisation, there was resource allocation for a project manager, administrative staff and a set number of enablers (dependent on the number of households to be targeted).

The lead organisations used the community development approach deemed successful in Phase I. Lead organisations had to identify and visit a target number of households in each of their zones. Initially, lead organisations were to draw on partners with whom they had a Household Identification Partnership Agreement (HIPA) to form steering groups. Steering groups were also to include key people within local communities who could help to identify households who may benefit from the intervention. When identified, households were issued a letter to raise their awareness of the project and inviting participation. When a client contacted the lead organisation to express an interest in participation, a suitable time was arranged for an enabler to call to the client's home.

1.2.3 The 1st visit – initial assessment

Enablers were required to help clients complete an initial assessment during the 1st visit. The assessment was to be completed by all adults over 18 years providing they were able to provide consent. The assessment screened for eligibility for 11 different types of referrals (noted at 1.2.5).

1.2.4 The 2nd visit – follow up

Approximately 12 weeks following the 1st visit, 80% of clients who consented were contacted to complete a second assessment either face-to-face or via telephone. The 2nd visit was an opportunity to further some referrals (eg those requiring extra information or forms to be completed), to chase the progress of referrals with referral partners, and to encourage clients to attend local services.

1.2.5 Referral process

Following the visits, the IT system automatically forwarded eligible clients to referral partners including:

- Warm Homes;
- NI Sustainable Energy Programme (NISEP)/Levy;
- Home Safety;
- Benefit Entitlement Checks (BECs);
- Local Services; and
- Rural Community Transport Partnerships (RCTP).

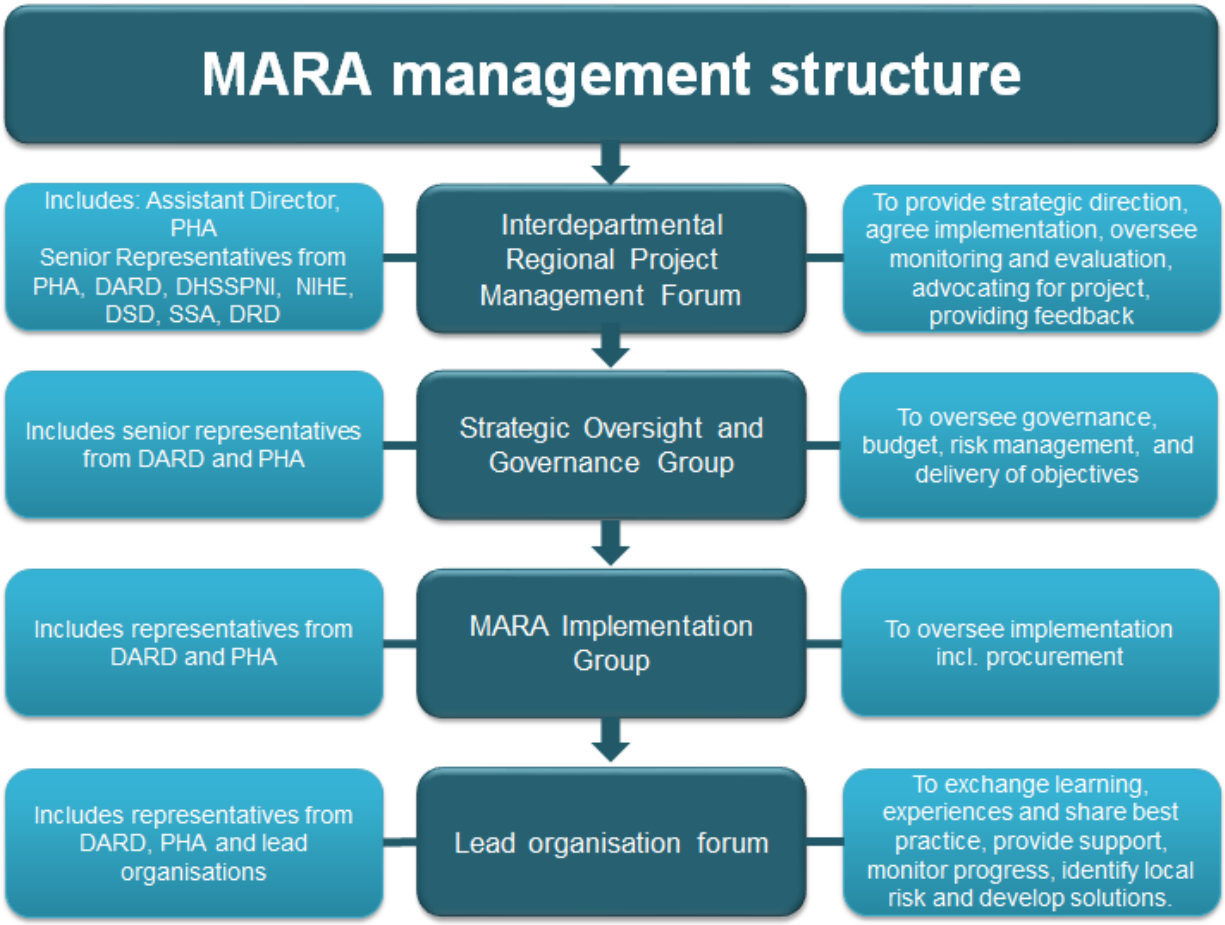
However, some other referrals could not be sent automatically as they required some other action before the referral could be made (eg, completion of paper-based forms, visiting a GP, obtaining a passport photograph, etc). Manual referrals were processed manually by lead organisations and included:

- boiler replacement grants;
- occupational therapy assessments;
- flexicare;
- social services; and
- Smartpass.

1.2.6 MARA management

Figure 1 outlines the management structure for MARA with the groups involved being responsible for overseeing, and accountable for project delivery.

Figure 1: MARA management structure



2. Evaluation approach and methodology

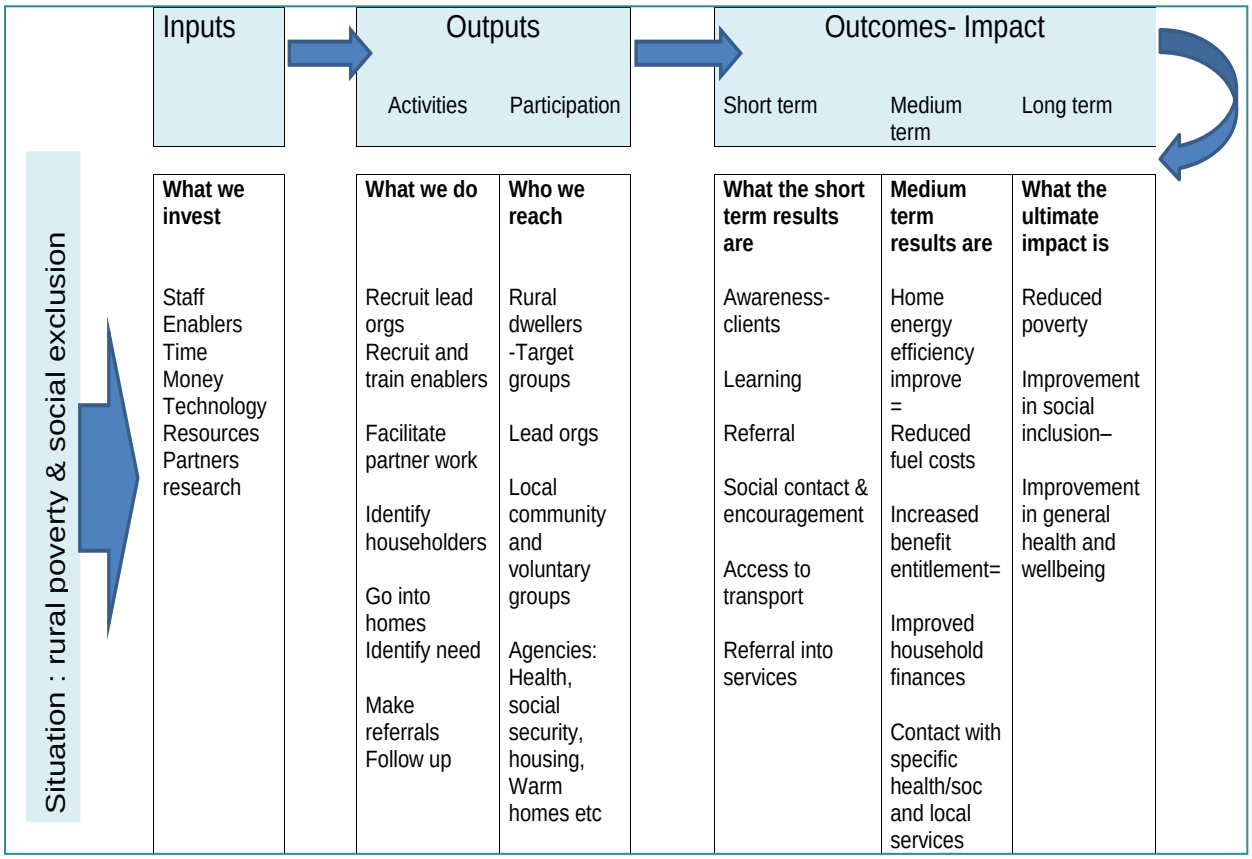
The evaluation of MARA Phase II has been both process and impact focused. An evaluation framework was designed before MARA commenced to both formatively test aspects of the MARA model (eg IT) and to examine processes to make recommendations for improvement at an early stage. The evaluation was also designed to assess outcomes. Further detail on the evaluation approach can be found in the main report.[12]

2.1 Evaluation framework

Figure 2 shows the logic model for MARA which describes the situation, the project inputs and outputs with expected short term medium term and long term outcomes and impacts. As long term outcomes (eg reduced poverty, improved health) take a longer time to materialise, the MARA evaluation focuses on evidence relating to the short-term and

medium term outcomes and impacts. This is based on the assumption that there is a relationship between medium term and longer term outcomes: if the short and medium term outcomes and impacts are realised, it is assumed the long-term impacts will also be realised.

Figure 2: Logic model for MARA Phase II evaluation



2.2 Evaluation aims and objectives

The aim of the evaluation is:

To evaluate the effectiveness of MARA in improving client health and wellbeing by increasing access to services, benefits and/or grants.

To address this aim, the objectives were:

1. To assess the effectiveness of the new IT system.
2. To assess identification and uptake of households by area and vulnerable groups.
3. To evaluate the impact of MARA on clients' access to services, grants and benefits.
4. To assess changes in the health and wellbeing of rural dwellers associated with their participation in MARA.

5. To calculate and evaluate the economic value of MARA and the social return on investment.

Note: Please see pilot and interim evaluation reports[13,14] for evaluation work relating to Objective 1.

2.3 Evaluation approach

Table 1 illustrates the approaches used to address each of the evaluation objectives and the source of information used. A variety of data sources were used including the MARA IT system, referral system, a survey of lead organisations, surveys of enablers and a 12 month follow up survey with clients to assess changes to their quality of life as a result of MARA.

In addition, the PHA commissioned Deloitte to conduct an independent review of evaluation information. They also conducted work with stakeholders and examined the look at the MARA in terms of economic value (value for money) and social return on investment (SROI).[15]

Table 1: MARA Phase II evaluation approach used to address each objective

Evaluation objectives	Approach	Source
Effectiveness of the new IT system	MARA and new IT system implemented in one zone (Fermanagh) to test IT system and assess processes	Analysis of new MARA IT system data
Assess identification and uptake of households by area and vulnerable groups	Qualitative work/proforma work with lead organisations and analysis of data on MARA IT system – analyse data by key demographic groupings and by zone	Interviews with project managers in lead organisations Analysis of MARA system data
The impact on access to services, grants and benefits	Analysis of MARA system data – referral data and evaluation follow up survey data	MARA IT system referral data evaluation follow up survey data
Changes in	Analysis of MARA system	MARA IT system

determinants health/ measures of wellbeing of rural dwellers	data and evaluation follow up survey data	and follow up survey
Impact on mainstream organisations delivery of assistance to rural households	Analysis of referral data Interviews with referral partners	MARA IT system and follow up Interviews with referral partners
Any other impacts	Economic and SROI analysis	Economic and SROI analysis

Notes on the report and statistical references

Throughout the report, results are presented giving mean (average) scores and are often presented as M. Base numbers are included in all tables and figures to indicate the number (n) of respondents on which percentages are based. In all instances, percentages may not add up to 100 due to rounding.

Statistically significant findings are shown where appropriate, and three levels of significance are presented: $p \leq 0.05$; $p \leq 0.01$; $p \leq 0.001$. For instance, if a finding is significant at the $p \leq 0.05$ level, it would be expected in a similar population 95 times out of 100. Significance is an indication of how likely it is that your results are due to chance and a significance level of $p \leq 0.05$ indicates there is a 95% chance that the results are true.

3 Final evaluation findings

3.1 Evaluation objective 1: effectiveness of new IT system

Early evaluation findings from the pilot study and interim report are available as separate reports and are also discussed in the main evaluation report.[12]

- Pilot report[13]: The data from the pilot of 100 households conducted in Fermanagh between January and March 2012 were analysed and presented to the MIG (May, 2012). The report focused on testing the new processes including the new IT system. The data were analysed for data completeness, client profiling, and recommendations for improvement to IT or other aspects of the 1st visit process were made.

- Interim evaluation[14]: A fuller analysis of data was presented in the Interim evaluation report (April 2013) which included referral outcome data. At the time of the report, lead organisations had taken part in qualitative work and a survey of enablers had been conducted to address the following issues:
    - identifying and making household visits;
    - value of steering groups and HIPAs in achieving uptake in vulnerable groups;
    - effectiveness of enablers training;
    - enablers feedback processes and household visits and experience;
    - referral processes; and
    - IT system and issues.

Table 5 in Appendix A lists the main issues for consideration from the interim report and how these were addressed by the MARA implementation group.

3.2 Evaluation objective 2: identification and uptake

In total, 12,085 homes were visited by enablers across all rural areas of Northern Ireland between May 2012 and December 2014 (see Table 7 Appendix A). In those households, 13,784 individuals were assessed for need. The overall profile for clients included in MARA was as follows:

- 40% clients were male and 60% female. The gender breakdown was roughly equivalent across zones.
- Clients were aged 64 years on average (ranging from 18 to 102 years). Over half (55%) of all clients were 65 years or more. Over

half of all clients (57.9%) were retired, less than one fifth (19%) were in employment (full or part time or self-employed).

- The majority (81.7%) lived in households that did not contain children under 18 years.

3.2.1 Reaching vulnerable groups

While MARA attempted to identify and improve access for those most in need, lead organisations were encouraged to focus on a number of vulnerable groups. For these vulnerable groups, their existing vulnerability in combination with rurality makes them more socially isolated. No quantifiable targets were set for these groups as prevalence levels for these groups in the general population are not available. Vulnerable groups included older people (defined as those over 65 years), lone adults, single parents, low income, carers, disabled, ethnic minorities, and identified vulnerable farmers and/or fishermen.

Table 2 shows the proportion of those reached in each of the vulnerable groups. Older people, those on a low household income and the disabled were most frequently reached. This is a similar pattern to Phase I, where disabled, older people and low income were also the top three. Those least likely to be included were single parents (4% proportion of clients) and ethnic minorities (see page 21 of the main report for further discussion on ethnic minority data quality issues[12]).

Table 2: Proportion of clients reached within vulnerable groups (n=13,784).

Vulnerable groups	MARA		Phase I[1]
	n	%	%
Single parent	545	4	10
Older people	7,697	56	52
Lone adult	4,295	31	42
Low household income	4,152	43	47
Carers	2,461	18	21
Disabled[2]	3,729	32	60
Vulnerable farmers and fishermen	1,565	11	10
Ethnic minority	43	<1	2

Note: *column will not total 100% as clients can fall into more than one category.*

3.3 Evaluation objective 3: access to services grants and benefits

Targets were set for the number of referrals for services, grants and benefits. All targets were exceeded except for transport as follows (Table 3):

- 53% of households referred to home improvement schemes (target 20%).
- 51% of clients were referred for home safety checks (no target set).
- 53% of clients were referred for a Benefits Entitlement Check (35% target).
- 28% were referred for local services (including social/physical activity, education/training activities) (target 20%).
- 18% were referred for universal services (Social Services and OT) (target 15%).
- 21% were referred for transport service which included Rural Community Transport or Translink Smartpass (target 25%).

[1] Figures rounded to nearest whole number from Phase I report.
[2] Disabled is limited to only those who completed an assessment after 15/01/2013 due to IT changes so base number is lower for those completing 1st assessments (n=11,739).

Table 3: MARA Phase II performance summary against project targets

Outputs	Performance (referred)	Target	Status
Households recruited	12,085	11,925	Exceeded
Home improvement schemes	53% households (31% Warm Homes 12% Levy 23% Boiler replacement)	20% households	Exceeded
Home Safety[3]	51% clients	No target set	n/a
BECs	53% clients	35% clients	Exceeded
Local services	28% clients	20% clients	Exceeded
Universal services	19% clients (17% Occupational therapists 5% social services)	15% clients	Exceeded
Transport	21% clients (18% RCTP 4% Smartpass)	25% clients	Not exceeded

- 90% of all clients were referred for at least one service. Sixty nine percent of clients were referred to more than one service (up to nine services, Figure 3).
- Over half (55.4%) of all clients achieved a positive outcome from a MARA referral (see Figure 4).

[3] Home Safety referrals were associated with clients and not households. Consequently, home safety was separated from home improvement schemes as limiting analysis to households would have excluded 336 referrals.

Figure 3: Proportion of clients by the number of referrals made (n=13,784)

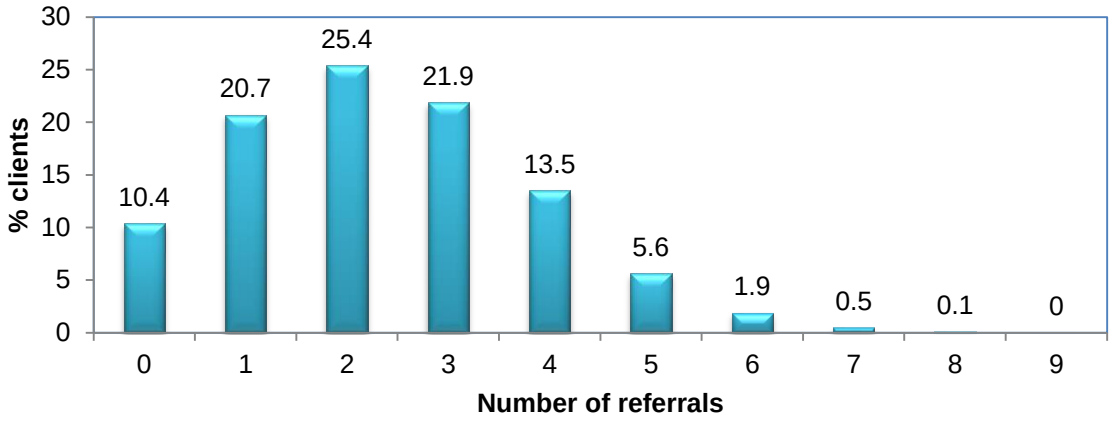
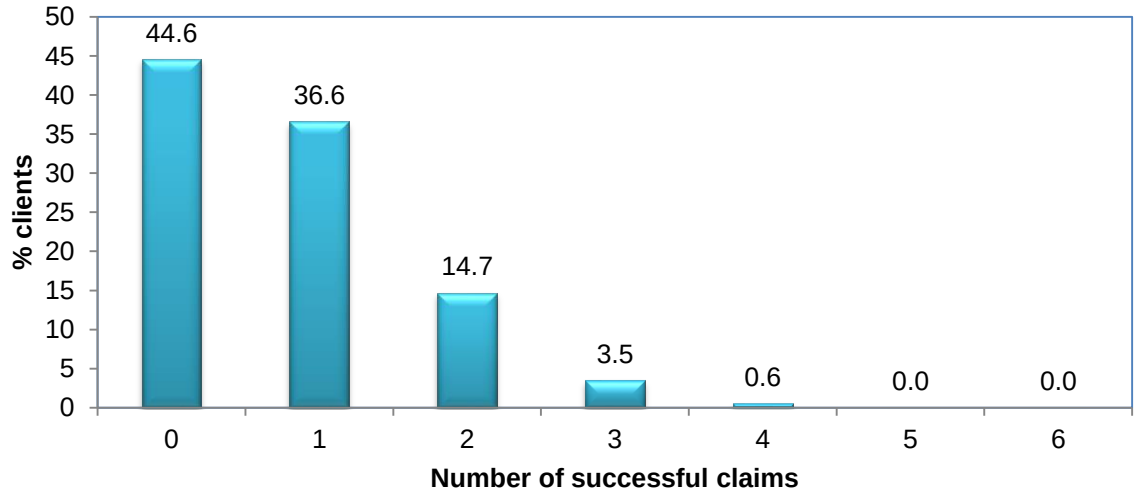


Figure 4: Proportion of clients by the number of successful referrals (n=13,784)



3.3.1 Successful outcomes

As MARA aims to improve access to services, targets were based on referrals made regardless of outcome. However, changes to processes improved the ability to obtain outcome data. The proportion of clients who had successful claims is presented in Table 4:

- 30% of those referred to home improvement schemes were successful (which equated to 16% of all households) and had measures carried out to improve the energy efficiency of their home. The majority (14%) had a successful Warm Homes or Levy claim and 3% were awarded a Boiler Replacement grant.

- 77% of those referred to Home Safety were provided with equipment and/or advice from the Home Safety adviser which equated to 40% of all clients.
- 7% of those referred for BECs were awarded a benefit which equated to 4% of all clients; the average weekly benefit amount for successful claimants was **£63.74**.[4]
- 39% of those referred to a universal service had a successful outcome which equated to 7% of all clients (6% of all clients had a successful outcome from an occupational therapy assessment and 1% had a successful outcome from a social services assessment).
- 42% of those referred for a transport referral were successfully registered with a transport provider which equated to 9% of all clients (6% of all clients were registered with RCTP and 3% with Translink). All but one rural community transport partnership reported on the number of trips taken by MARA clients, this figure was 3,966 (reported April 2015).
- 20% of those referred were sent information about a service they were interested in their local area which equated to 6% of all clients.

[4] It was not possible to obtain entitlement value per client as a result of a MARA benefit entitlement check (BEC). PHA/DARD worked with SSA and Analytical Statistical Unit to obtain the value of award each MARA client obtained. As not all clients would have received an entitlement due to MARA, only those clients who received an award within 6 months of the first MARA visit were counted in calculations.

$$\text{Average per week} = \frac{\text{Total value of weekly award for clients awarded within 6 months of MARA visit}}{\text{Number of clients awarded entitlement within 6 months of MARA visit.}}$$

This may include some clients who received an award not related to MARA but this is balanced with clients who received entitlement due to MARA more than 6 months after their MARA visit.

Table 4: The proportion of those who had successful claims

Outputs	Performance (referred)	Successful claims	
		(% of those referred)	(% of all)
Home improvement schemes	53% households (31% Warm Homes 12% Levy 23% Boiler replacement)	30% (32% Warm Homes 30% Levy 12% Boiler replacement)	16% (10% Warm Homes 4% Levy 3% Boiler replacement)
Home Safety	51% clients	77%	40%
BECs	53% clients	7%	4%
Local services	28% clients	20%	6%
Universal services	19% clients (17% Occupational therapists 5% social services)	39% (36% Occupational therapist 12% social services)	7% (6% Occupational therapists 1% Social services)
Transport	21% (18% RCTP 4% Smartpass)	42% (34% RCTP 14% Smartpass)	9% (6% RCTP 3% Smartpass)

3.3.2 Outcomes success for vulnerable groups

Significant associations between vulnerable groups and successful outcomes following referrals are summarised below:

- Single parents were significantly less likely to have a successful outcome following universal services or transport referrals. Overall, single parents were less likely to be successful following any referral.
- Older people were significantly more likely to have a successful outcome following referrals for BECs, universal services, transport or overall for any referral. Lone adults were significantly more likely to have a successful outcome following a referral for local services, universal services, transport or overall for any referral.

- Those with a low income were significantly more likely to have a successful outcome for BECs and local services but less likely to be successful for universal services.
- Carers were more likely to receive additional benefit entitlement but less likely to receive a universal services referral or a referral for any.
- Disabled people were more likely to receive additional benefits, local services information, universal services, transport or overall, any successful outcome.
- Farmers/fishermen identified as vulnerable were less likely to receive additional benefit entitlement, local services or universal services.

3.3.3 Key points

With the exception of transport referrals, all MARA targets and objectives were achieved.
9/10 clients were referred for at least one service, benefit or grant offered via MARA (with clients being referred for up to 9)
More than half of the clients who participated in MARA were successful in accessing a service following a referral (55.4%)

3.4 Evaluation Objective 4: changes in health and wellbeing of rural dweller associated with their participation in MARA

Client health and wellbeing was measured at 1st visit and the evaluation follow up using items to measure general health, physical health, positive mental wellbeing and social connectedness. While clients were asked directly to rate their general and physical health, positive mental wellbeing and social connectedness were assessed using standardised scales. Positive mental wellbeing was measured using a 7-item short version of the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBs).[16] Social connectedness was measured using a 6-item Friendship Scale.[17] Both scales have been found to be reliable and suitable for use in adult populations.

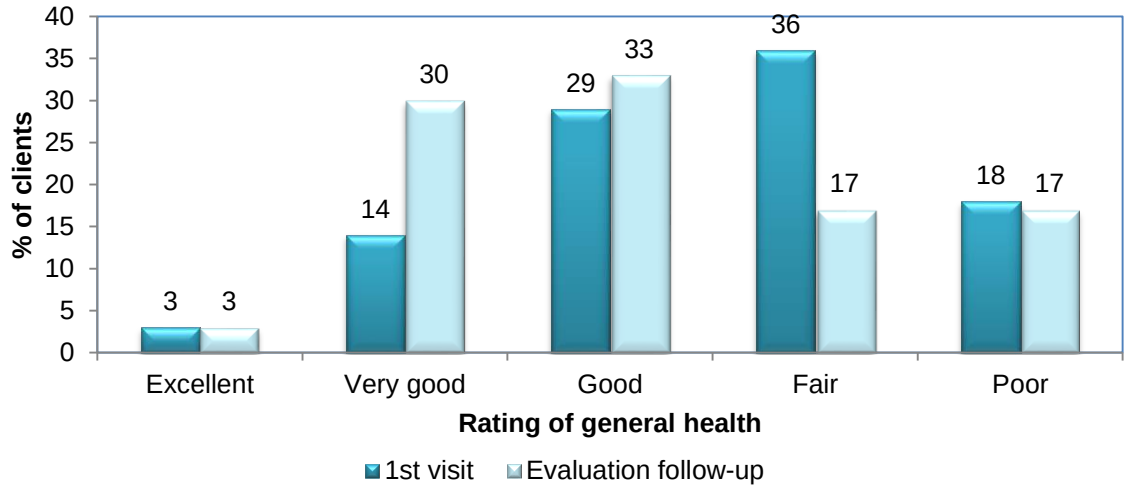
It should be noted that administration of the scales differed between the 1st visit and the evaluation follow up and this difference may have introduced bias. At the 1st visit, the assessment was completed face-to-face with clients and enablers encouraged clients to self-complete the health and wellbeing section of the assessment if possible. However, the evaluation follow up was completed via telephone and clients were unable to self-complete. Limitations in this approach are highlighted in the main report.

3.4.1 General health (self-report)

The mean score for general health increased from 2.5 to 2.9 at evaluation follow up and this increase was statistically significant ($p<0.001$; matched clients, n=935).

Figure 5 shows client ratings of their general health at the 1st visit and at evaluation follow up for the matched sample. The proportion of clients who reported that their general health was 'good' or 'very good' increased. Conversely, there was a decrease in the proportion of clients who reported that their general health was 'fair' or 'poor'.

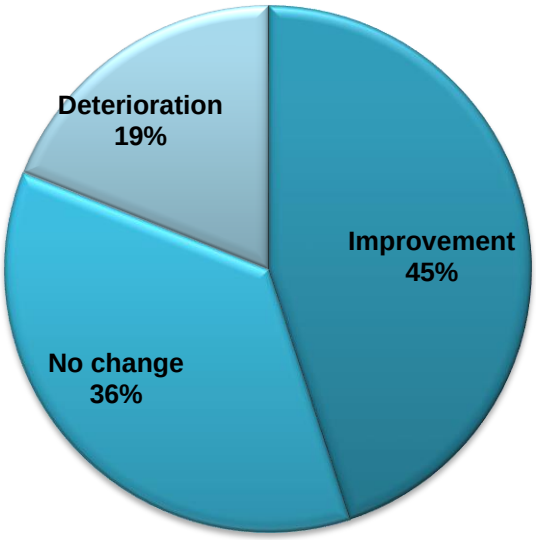
Figure 5: Self-rated general health status at 1st visit and evaluation follow up, matched sample (n=935)



- Figure 6 shows the change in general health according to clients matched response between 1st visit and the evaluation follow up at 12months. Overall, 45% of clients reported an improvement in general health, with 36% reporting no change and 19% showing deterioration (as over half of the MARA clients were 'older people' it would be expected that a proportion would experience a deterioration in health).

- Improvements in general health were statistically related to being successful for any of the services, benefits or grants.

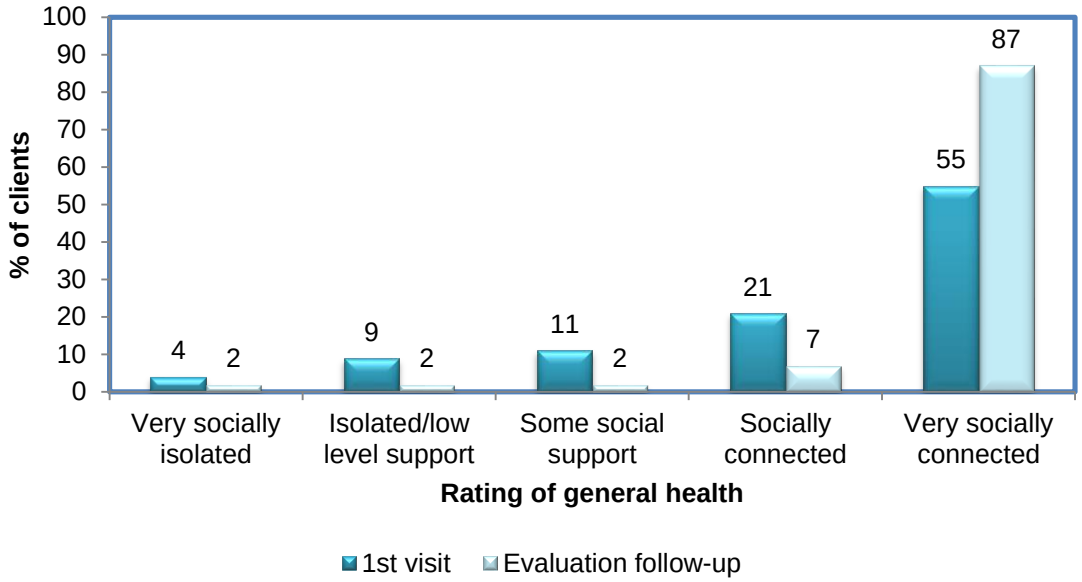
Figure 6: Change in self-report general health between 1st visit and evaluation follow up, matched sample (n=935)



3.4.2 Social connectedness

There was a significant improvement ($p<0.001$) in clients social connectedness at 12 months follow up after the initial MARA visit. Although it is important to note that over half of all clients were already well socially connected at first visit (Figure 7).

Figure 7: Social connectedness at the 1st visit and evaluation follow up



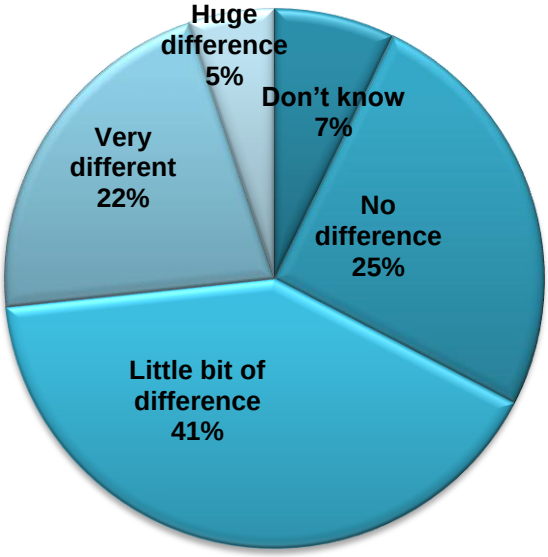
- 40% of clients (clients before and after measures matched and compared) improved social connectedness after MARA. Fifty five percent showed no change and 5% showed deterioration.
- Improvement in social connectedness was statistically related with being referred or successful for BECs and universal services (social services and OT).

3.4.3 Clients self-report on what difference MARA made

At the evaluation follow up, clients were asked to report on the difference they felt MARA made to their lives (Figure 8). More than two thirds (68%) said that MARA had made at least a little bit of difference to their lives with 5% saying a 'huge difference' and 22% saying 'very different'.

Sixty eight percent of clients reported that MARA had made a difference to their quality of life. Clients who had three or more referrals, and those who were successful for at least one referral, were more likely to say that MARA had made a difference to their quality of life ($p<0.001$).

Figure 8: Client ratings of the difference MARA made to their lives (n=1,102)



3.4.4 Key points

Overall, clients' ratings of general health and social connectedness significantly increased between the 1st visit and the evaluation follow up.
Self-report general health significantly increased and this increase was associated with having a disability, being referred to a universal service (social services/OT), or being successful in a transport referral.
Social connectedness increased for lone adults, disabled clients, referrals to and successful outcomes for BECs or universal services

3.5 Evaluation Objective 5: to calculate and evaluate the economic value of MARA and the social return on investment.

An independent evaluation (conducted by Deloitte[15]) of MARA, focusing on value outcomes, concluded that MARA represented value for money and that the project performed well, with significant engagement in rural areas.

> *"The project has performed well with significant engagement in the 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 multiagency approach and partnership working between statutory and non-statutory providers."*

Deloitte's analysis of monitoring data and consultation feedback identified a range of economic and social impacts on individual clients, households, lead organisations and for the public bodies involved in project delivery. These included:

- increased awareness of entitlement and local services, improved access to social security benefit entitlement;
- improved living conditions, reduced social isolation and self-report general health;
- improved organisational and community capacity;
- increased understanding of need; and
- networking and relationship building.

3.5.1 Value

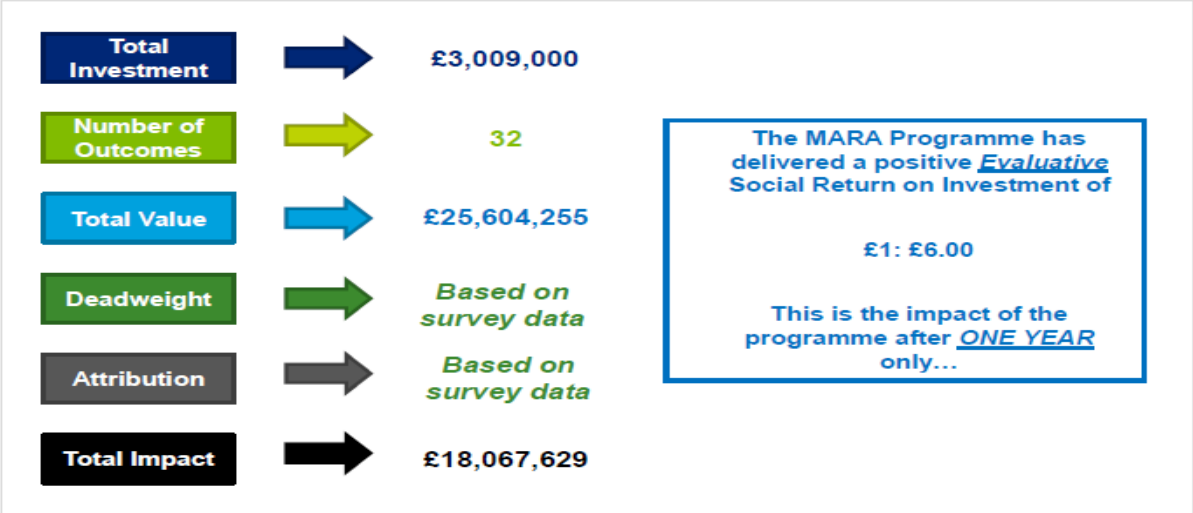
Overall, spend on MARA was £3,009,000; this yielded a total value of £25,604,255, taking into account deadweight[5] and attribution[6], and represented a social impact value from MARA of £18,067,629 (Figure 9).

[5] Deadweight is a measure of how many of the outcomes listed would occur without the project (ie how many of the households would have accessed the services anyway in the absence of the MARA). 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.

[6] 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.

Social Return on Investment (SROI) analysis, focusing on value outcomes just to clients, concluded that for every £1.00 invested in MARA £6.00 was yielded in social return, if the MARA value is forecast over 5 years this figure is £15.52 for every £1 invested (Figure 10). For a full explanation of the SROI model and process please refer to the Deloite report[15].

Figure 9: Evaluative SROI: financial investment and income generated



Note: The number of outcomes showing as 32 referred to the number of variables against which a cost could be applied for the SROI calculation. This included outcomes such as BECs entitlement, cost of works and savings benefits from energy saving schemes, and improved quality of life from being able to afford a better lifestyle (see Deloitte[15] report for full list of outcomes).

Figure 10: Forecast SROI

Other economic impacts noted in the Deloitte report include:

- Lead organisations were procured through competitive process which came in under budget – allowing savings to be later invested in programme extension.
- Enablers employed by lead organisations bore no cost increase on the project when compared to using informal recruitment as in Phase 1 of the programme.

- Investment in an IT system ultimately saved resources (time and effort) and allowed for outcomes to be realised.

3.5.2 Process evaluation

Previous evaluation reports[13,14] focused on process issues for MARA and these were addressed throughout delivery. Other issues to highlight include:

- Lead organisations reported the effort in MARA exceeded their initial expectations and budgets. However, their involvement in MARA improved their credibility, helped them identify local need and increased their capacity. In some instances, funding was obtained from other sources for other strands of work as a result of MARA and some were able to improve their offering within their local rural community.
- A number of elements to the processes greatly improved the efficiency and effectiveness of MARA. This included: the IT system (after early teething problems were resolved); employment of enablers which created a dedicated and highly skilled workforce; and the 2nd visit which helped support clients in achieving referral outcomes.
- There were limitations as to what could be achieved for some clients in need.
- The lack of a regional referral pathway for Health and Social Care Trust based services (eg social services and OT) meant that referrals to these services required a lot of individual input from lead organisations and may have been restricted by local Trust capacity.
- Obtaining referral outcomes through the IT system worked effectively for some services but not for all.
- Deloitte commented that feedback from stakeholders highlighted that management processes were fit for purpose. A notable feature was the consistency of key personnel in core positions in DARD and PHA which allowed development of deep understanding of the programme and strong relationships with a wide range of stakeholders, all of which have contributed to the effectiveness of the programme management, which in turn supports programme performance.
- Referral partners and steering group members reported that MARA contributes to strategic objectives of partner organisations particularly for those with a rural mandate, and provided access to clients who may not have otherwise been identified or engaged. However, some also said that it was just another mechanism for referrals.
- MARA is an example of effective ‘joined up government working’ that contributes to multi-policy objectives.

3.6 Key questions arising for future development

A number of key issues arose from analyses which required further exploration. This was necessary given the increasing financial pressures placed on all statutory agencies as a result of budget cuts.

3.6.1 Is MARA more suited to older people?

The typical client profile for MARA indicated older clients of pensionable age with many living alone. This finding gave rise to the question 'Is MARA more suited to older people?'

Older people were statistically significantly more likely to be referred for home safety checks, universal services and transport. However, home safety checks, transport referrals and social services (one of the universal services) all included an age criteria and these associations were to be expected. However, older people were also significantly more likely than younger people to be **successful for all** referrals, with the exception of local services.

Targets set for MARA to date have focused on referrals rather than outcomes and based on these targets it would not be appropriate to focus on older people. However, if the focus is on successful outcomes, older people are more likely to benefit. For cost effectiveness, it may be more appropriate to limit inclusion to older people in this instance.

3.6.2 Should MARA only target the more deprived geographical areas?

When analysed by the different referral types, again a clear pattern did not emerge. There were a number of findings that indicated that targeting based solely on geographical multiple deprivation levels would not be appropriate going forward. For instance, there was success for universal services in the least deprived quintile. Deprivation was not related to successful outcomes for BECs and home improvement schemes. These findings highlight the effective targeting of clients in need in areas considered to be more affluent. If targeting remains effective in less geographically deprived areas, it would not be appropriate to limit the reach of MARA to the most deprived geographical areas.

3.6.3 Does MARA's holistic approach have a cumulative effect?

MARA takes a holistic approach by offering clients a wide range of services, benefits and/or grants by assessing client need at one time. It is difficult to investigate whether this holistic approach has a cumulative

effect as the effects of one outcome cannot be separated from another. However, analysis focused on client ratings of the difference MARA made to their lives by the number of referrals made and successful outcomes to provide some insight to the question posed:

- There was a significant relationship between the differences MARA made to clients' lives and whether they were referred or successful for the services, benefits and grants offered.
- Clients, who had no referrals or one or two referrals, were more likely to say MARA made no difference to their lives. However, clients who had three or more referrals were more likely to say MARA made a difference to their lives.
- Clients who were not successful for any of the services, benefits or grants were more likely to say MARA made no difference to their lives. Those who were successful for one, two or three claims were more likely to say MARA made a difference to their lives.

3.7 Conclusions

1. MARA has achieved its targets and yielded success, particularly for older rural people. In addition, MARA has achieved good value for money and a good social return on investment. Evaluative SROI looking at the social return only for clients found that for every £1 invested MARA yielded £6 for clients. Forecasting over 5 years this increases to a value to clients of £15.52 for every £1 invested. MARA's holistic multiagency offering helps deliver government in a 'joined up' way and its local community approach helps identify and access those most in need. According to lead organisations delivering MARA, MARA is now an identifiable credible brand, linked with local rural community organisations and, as it is not identified with government it encourages greater uptake from clients.

2. Deloitte, through consultation with stakeholders and review of data, identified a number of economic and social impacts on households and clients. These included:
   - Increased awareness of entitlement and increased awareness of local services.
   - Improved access to benefit entitlement – in total more than half of households engaged (53%) have been referred for a BEC. This has identified an additional £1,965,345 in benefits per annum across the 13 zones for 589 individuals.
   - Improved living conditions – 30% of households received support through installation of a range of energy efficiency measures.

Using figures provided by the Energy Saving Trust, this has the potential to save households as much as £380 p/a in fuel bills.

3. There are also wider benefits of MARA beyond benefits to clients. In addition to the employment and training benefits to lead delivery organisations, their managers and over 100 enablers, there are also wider rural community benefits. MARA has benefited the rural community infrastructure, networks and capacity. Lead organisations have strengthened their skills, forged new links and relationships with other statutory bodies and community and voluntary agencies to improve the overall assets of their rural catchment areas. 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.

4. The level of referrals and successful outcomes even in areas that are being revisited since the earlier Maximising Access project (2009–11) suggest there is still need for this type of intervention within rural communities. Similarly, the MARA delivery organisations believe there is still a need for MARA. However, they emphasise that this would require more resources and some processes to be improved. Other stakeholders suggest that with welfare reform and other public sector savings, the need for a programme like MARA (that goes beyond using the usual means of reaching more vulnerable people) is likely to increase.

5. Findings would also suggest that targeting for MARA should not be limited to geographical areas of multiple-deprivation. Analysis has shown that there are pockets of need in affluent areas but it needs to be acknowledged that identifying and accessing these clients is more resource intensive.

6. The main beneficiaries of MARA were older clients and this is not simply a matter of older people being easier to access. An analysis of outcomes shows that older people are more likely to achieve success via MARA referrals, which indicates that they are a group in most in need. These findings in terms of successful outcomes and efficiency, would suggest that one future option for MARA may be to target older people only. An increased move towards digital access to services by government and others has the potential to further isolate

the rural community, in particular the older population who do not have access to the internet, nor often the confidence to access it.

7. Access to health and social services offered through MARA (OT and social services) showed strong positive outcomes in terms of quality of life improvements for those clients who were successful. However, it was acknowledged that this offering put significant demands on the lead organisations. Positive outcomes for this element would suggest that it is worth retaining and strengthening this aspect if MARA goes forward. However, this would require greater collaboration between MARA and relevant Health and Social Care Trusts to ensure a coordinated approach that is beneficial to all partners.

8. A major item in the MARA holistic package was access to the DSD funded Warm Homes Scheme for energy efficiency measures. This scheme has now been replaced by the Affordable Warmth Grant Scheme which provides a package of energy-efficiency and heating measures to homes identified at risk of fuel poverty and which is delivered by local councils and the NIHE. When developing the Affordable Warmth Scheme, DSD extracted considerable learning from MARA and incorporated a number of the well-established practices that MARA had in place. Currently, referral to Affordable Warmth is not possible meaning that MARA will lose a significant feature of its offering. Consideration needs to be given to whether MARA can retain efficiency and efficacy without a home efficiency element in the programme.

9. The Warm Homes contribution has been valuable in terms of outcomes for clients and return on investment. It is notable that modelling on SROI still indicates a revised impact value of £4.80 (or £12.77 – 5 year forecast) when the Warm Homes outcomes are not included in the model. However, maintaining a wide geography for MARA with no energy efficiency/heating offering potentially means that MARA costs are likely to increase, with the outcome yield decreasing.

10. While there is no evidence to indicate what, if any single aspect of the MARA offering motivates clients to take part, we know that a holistic, broad offering is part of MARA's strength. Apart from reducing outcomes and reducing the SROI value, it may be more difficult to recruit clients in the first place without a home efficiency feature, which in turn will impact on costs.

3.8 Options for consideration on the way forward

The following options are being considered to help develop MARA going forward:

1. To work in tandem with DSD, NIHE and Councils to integrate the lessons from MARA and Affordable Warmth and develop a new integrated approach. This would include increasing links with PHC and HSCTs.

2. To utilise the established rural support network community infrastructure (DARD funded) to provide a MARA assessment as requested and increase links with PHC and HSCTs.

3. To deliver MARA as is (15/16 delivery) and increase links with PHC and HSCTs.

4. Discontinue MARA.

Note: Options one, two and three are subject to budget availability and departmental priorities.

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Appendix A: additional tables

Table 5: Main issues arising from pilot and interim reports discussed and how these were responded to by the MARA implementation group

Issues for consideration	Resultant action
Process issues	
The importance of targeting vulnerable groups should be emphasised and monitored.	This was reiterated to project managers in lead organisations. Client profile now included in monitoring.
Lead organisations should be provided the opportunity to decide whether steering group meetings are beneficial to identifying appropriate households.	Accepted, no further action required.
The importance of efficiently providing client outcome information should be reiterated to referral partner agencies.	This issue is reinforced during quarterly meetings with referral partners and at meetings with lead organisations.
Local directories should be updated to include availability for the most requested services. Enablers who are not using the local directory in the intended way should be provided with further training where necessary.	Lead organisations are advised to update the directories on a regular basis.
A formal recruiting process has ensured that enablers with relevant experience are committed to MARA. It is recommended that enablers continue to be formally recruited and trained to perform the enabler role.	Adhered to, no further action required.
IT problems should be clearly identified and rectified to ensure that serious breaches of information governance and data protection are eliminated as a risk to MARA.	If these matters arise, they are brought to the immediate attention of the IT contractor to resolve.
Outcome issues	
Consideration should be given to the cost-effectiveness of some referrals.	Generally, the issue of cost-effectiveness is discussed with

For instance, for BECs, consideration should be given to filter questions to exclude clients from referral who have had a recent check/ or no change in circumstances since that check.	all referral partners and none have expressed any major concerns regarding the number of referrals they are receiving. For BECs, it was decided this action would not be appropriate as clients' circumstances may have changed from receipt of a previous BEC. It was believed that it was not the enablers' role to refuse a client who wanted a BEC.
Findings illustrated that some clients successfully accessed additional grants, benefits and services despite stating that they did not think they were eligible. Enablers should be advised that clients should be encouraged to consent for referrals regardless of client concern about eligibility.	Enablers have access to the data for the clients they have visited via the IT system. Lead organisations hold regular meetings with their enablers and they are advised to update enablers on the benefits that are accruing as a result of MARA visits.
Further consideration should be given to the referral partner outcome categories to improve the meaningful interpretation of outcomes. This is necessary for any economic evaluations that will occur at the end of the project.	Regular meetings are held with referral partners where the status and outcome categories are reviewed and, if necessary, amended.

Table 6: Lead organisations by zone and geographies covered

Zone	Lead organisation	Geographies covered
1	Tyrone Antrim Down Armagh (TADA)	Banbridge
2	Cookstown and Western Shores Area Network (CWSAN)	Cookstown, Magherafelt
3	County Down Rural Community Network (CDRCN)	Down
4	Rural North West Community Support (RNWCS)	Derry, Strabane, Limavady
5	North Antrim Community Network (NACN)	Moyle, Antrim, Larne, Ballymena

6	Omagh Forum for Rural Associations (OFRA)	Omagh
7	Causeway Rural Urban Network (CRUN)	Ballymoney, Coleraine
8	Community Organisations of South Tyrone and Areas (COSTA)	Dungannon, Armagh
9	Supporting People and Communities Everyday	SPACE
10	County Down Rural Community Network (CDRCN)	Ards, Castlereagh
11	Fermanagh Rural Community Network (FRCN)	Fermanagh pilot
12	Tyrone Antrim Down Armagh (TADA)	Lisburn
13	South Antrim Community Network (SACN)	Carrickfergus, Newtownabbey
14	Fermanagh Rural Community Network (FRCN)	Fermanagh

Table 7: Number of households targeted and achieved and 1st and 2nd assessments completed

Zone	Lead organisation	Household targets	Households achieved	1st assessments	2nd assessments
		n	**n (%)**	**n**	**n (% of 1st assessments)**
1	TADA	425	459 (108)	600	535 (89)
2	CWSAN	1175	1191 (101)	1349	1091 (92)
3	CDRCN	1025	1071 (104)	1206	1052 (87)
4	RNWCS	904	956 (106)	1131	935 (82)
5	NACN	1642	1617 (98)	1892	1530 (93)
6	OFRA	468	471 (101)	477	390 (83)
7	CRUN	922	919 (99)	986	803 (87)
8	COSTA	1316	1316 (100)	1417	1158 (87)
9	SPACE	1360	1357 (99)	1586	1267 (93)
10	CDRCN	820	834 (102)	924	736 (89)
12	TADA	850	873 (103)	1092	960 (87)
13	SACN	350	351 (100)	396	332 (83)
14	FRCN	668	670 (100)	728	583 (80)
	Total	**11,925**	**12,085**	**13,784**	**11,372 (83)**