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Health Intelligence

MARA: Maximising Access in Rural Areas

Evaluation Report
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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 helped/enabled them to complete assessments, facilitated referrals and follow-up support
HIPA	Household Identification Partnership Agreement
HP	Hewlett-Packard
IRPMF	Interdepartmental Regional Project Management Forum
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 9 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

Executive summary

- The Maximising Access in Rural Areas (MARA) project 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 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

- MARA Phase II was delivered in rural areas across Northern Ireland between April 2012 and December 2014. 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 (e.g. Benefit Entitlement Checks, warm homes, home safety, transport, Occupational Therapy assessments, etc.). Clients are also provided with follow-up support regarding their referrals.

Outcomes

- 12,085 homes were visited by enablers across all rural areas of Northern Ireland between May 2012 and December 2014. In those households, 13,784 individuals were assessed for need.
- Targets were set for the number of referrals for services, grants and benefits. All targets were exceeded except for transport.
  - 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% 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%).
- Ninety percent of all clients were referred for at least one service. Sixty-nine percent of clients were referred to more than one service (up to 9 services)
- Out of all clients, 55.4% achieved a positive outcome from a MARA referral:
  - 30% of those referred for home improvement schemes had a successful outcome, representing 16% of all households.
  - 77% of those referred for home safety had a successful outcome representing 40% of all clients.
  - 7% of those referred for BECs had a successful outcome. This represents 4% of all clients. The average weekly benefit amount for successful claimants was £63.74.
  - 20% of those who expressed interest in local services were provided with information about the service of interest, representing 6% of all clients.
  - 39% of all those referred for a universal service (Social services and OT) were successful, representing 7% of all clients.
  - 42% of those referred for a Transport service had a successful outcome representing 9% of all clients. All but one rural community transport

partnership reported on the number of trips taken by MARA clients, this figure was 3966 (reported April 2015).

- There was a significant improvement ($p<0.001$) in clients (self-report) general health at 12 months follow-up after the initial MARA visit.
- Forty-five percent of clients (clients before and after measures matched and compared) improved general health after MARA. Thirty-six percent showed no change and 19% showed deterioration.
- Improvements in general health were statistically related to being successful for any of the services benefits or grants.
- There was a significant improvement ($p<0.001$) in clients social connectedness at 12 months follow-up after the initial MARA visit.
- Forty percent 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).
- 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 ($p<0.001$).

Value

- An independent evaluation (Deloitte) of MARA focussing on value outcomes concluded that MARA represented value for money. Deloitte concluded from their economic appraisal that the project performed well, with significant engagement in rural areas.
- Overall, spend on MARA was £3,009,000; this yielded a total value of £25,604,255, taking into account deadweight and attribution, this represented a social impact value from MARA of £18,067,629.
- Social Return on Investment (SROI) analysis, focussing on value outcomes just to clients, concluded that for every £1.00 invested in MARA £6.00 was yielded in social return, if we forecast MARA value over 5 years this figure is £15.52 for every £1 invested.
- Other economic impacts not included in the SROI calculations but acknowledged were; 12 lead organisation funded to improve community development in rural areas (with 9 out of 10 lead organisations saying that MARA improved their relationships with other agencies), 244 enablers employed, and investment in an IT system. Furthermore, Deloitte noted that the proxy value for benefit entitlement alone brought more than £1.9m to the Northern Ireland Economy from the UK Treasury.

Who MARA impacts on

- The main MARA client profile was 60% female, with an average age of 64 (55% were over 65 years old), 58% were retired and 82% lived in households with no children.
- MARA had key target vulnerable groups to focus on, although there were no set targets for these groups. These groups were, older people (56% of all clients), low household income (43% of households), disabled (32% of clients),

lone adult(31%), carers (18%), identified vulnerable farmers/fishermen (11%), single parents (4%) and ethnic minorities (<1% but issue with quality of data).

- Referrals and successful outcomes favoured older clients and disabled clients.
- A key question for analysis was *'is MARA a service for older people?*' Analysis of uptake of MARA shows that older people are either those most in need in rural areas or easier to access. Comparing referral levels between older and younger people showed there is no difference. However, when we look at successful outcomes, older people show more success in terms of eligibility and achieving extra services, grants or benefits.
- Targets for number of households were achieved in geographically less deprived areas (NISRA, SOA Multiple Deprivation measure). However, lead organisations acknowledged extra effort was required in order to identify households in need in these areas.
- There was no difference in referral level by locality deprivation level. Those in the most deprived areas were more successful in referrals. However, analysis showed that those clients identified in the least deprived areas still yielded successful outcomes for referrals in particular for universal services (social service and OT). Furthermore, there was no relationship between geographical deprivation and successful outcomes for BECs, home improvements and transport.

Process

- Previous evaluation reports focussed on process issues for MARA and these were addressed throughout delivery. Other issues to highlight include:
  - Lead organisations reported that the effort in MARA exceeded their initial expectations and budgets.
  - Lead organisations reported that involvement in MARA has improved their credibility, helped them identify local need and increased their capacity, with some obtaining funding from other sources for other strands of work. Some have also been able to improve their offering to their local rural community.
  - IT system after early teething problems has contributed greatly to efficiency of MARA.
  - Employment of enablers rather than informal recruitment has created a dedicated and highly skilled workforce which again added to the efficiency and effectiveness of MARA.
  - The second follow up visit has been effective in supporting 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 Trust based services (e.g. 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.
- 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 it was just another mechanism for referrals.

- MARA is an example of effective joined up government working that contributes to multi-policy objectives.

1. Introduction

The Maximising Access in Rural Areas (MARA) project 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 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.

MARA Phase II was delivered in rural areas across Northern Ireland between April 2012 and April 2015 using a community development approach. The PHA oversees implementation of the MARA, which is delivered at a local level by a number of local rural organisations. The evaluation team are based in the Health Intelligence Unit, PHA and evaluation work has been on-going from the developmental phases of the project.

This is the final evaluation report for MARA and forms part of a series of reports including a report of the initial implementation based on the first 100 households included in Phase II, an interim evaluation report and an external consultant's report.

This report focusses on overall attainment of objectives and resultant outcomes and impacts for clients. The consultant's report independently reviews MARA impacts and looks at 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 [i]:

To improve the health and wellbeing of rural dwellers in Northern Ireland by increasing access to services, grants and benefits by facilitating a co-ordinated 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 previous programme developed and implemented by DARD and PHA *'Maximising access to services grants and benefits in rural areas'* (2009 – 2011) (Phase I) which facilitated a cross departmental coordinated service to maximise access to benefits grants and local services to support rural dweller in, or at, risk of poverty. Phase I proactively targeted vulnerable households in identified rural communities using a community development face-to-face approach.

1.3 MARA Phase I

Phase 1 targeted the top 88 most deprived rural super output areas (SOAs) in Northern Ireland. Nine rural community organisations were procured to lead and deliver the project at a local level. These organisations were based geographically close to or within the SOAs included in Phase I to maximise the benefits of pre-existing networks and links in the community. Lead organisations were tasked with identifying vulnerable households that would benefit from the intervention. Lead organisations were encouraged to target the following vulnerable groups:

- Lone parents
- Older people
- Carers
- Disabled people
- Lone adult households
- Low income families
- Ethnic minorities, and;
- Identified vulnerable farmers and/or fishermen

All identified households were contacted to see whether they wanted to participate which would involve an 'enabler' calling to their homes to help them complete a survey designed to assess eligibility for a range of services, benefits and/or grants.

To meet targets, lead organisations were also tasked with informally recruiting enablers to complete assessment visits to households. In total, 244 enablers were initially trained by PHA and, in the end, a key group of 150 enablers worked across the lead organisations.

To structure and assist the home visit, PHA developed a screening tool designed to assess the services, benefits and/or grants households may have been eligible for. The screening tool included eligibility questions for the range of services, benefits and/or grants included in the project and a number of monitoring and evaluation questions. One survey was completed per household with the main person in the household.

Phase I was evaluated by Health Intelligence, PHA with an external review conducted by Deloitte which incorporated a value for money and social return of investment exercise. Deloitte's evaluation concluded that Phase I was value for money with every £1 invested in the project equating to a social return on investment of £8.62. Notably, this figure under-estimated the value of the project as it focused on benefits to the client and did not include benefits to other stakeholders (e.g., lead organisations, enablers, referral partners etc.). Furthermore, they concluded the

community development approach was effective in reaching those most in need and recommended the project should continue (see Appendix A for recommendations made).

In budget proposals for 2011-2015, DARD renewed its commitment to TRPSI [ii]. Maximising Access project was included as a key programme in this framework and the project was enhanced and extended geographically and was branded as MARA.

1.4 MARA Phase II overview of project delivery model

This section of the report provides an overview of the MARA model. Whilst MARA existed in earlier forms in Phase I, a number of changes have taken place as MARA has evolved. This section of the report outlines the changes made and an outline of the MARA model follows which includes an outline of the MARA structure and the processes involved in delivery.

1.5 Changes to MARA between Phase I and II

Following the successful completion of Phase I, funding was obtained to roll out MARA across all rural areas of Northern Ireland with a target to reach 12,000 households. Learning from Phase I was incorporated into the development of Phase II to improve the service offered and is outlined in Table 1 and summarised below:

Table 1: Changes made to MARA between Phase I and II

Area of change:	Maximising access Phase I	MARA Phase II
Approach	Community development Identifying households in need using local intelligence	No change
Delivery model	Lead community organisation allocated target number of households in local SOAs	No change
Method	In-home assessment conducted by enabler	In-home assessment conducted by enabler, followed by a 6 week follow-up for 80% of households who require a referral
Enabler Workforce	Enablers recruited informally and paid expenses	Staff recruited using 'ideal enabler' profile learned from Phase 1
IT	Paper-based capture requiring inputting onto MS Excel	Bespoke internet based IT solution (MS dynamic) Accessible by lead organisations, enablers, central MARA, referral agencies and evaluators.
Referrals	Manually sent to referral partners	Majority of referrals automatically to referral partners, some manual work required if referral involved form completion

Targeting	Top 88 most deprived rural SOAs' only	All rural SOAs across NI with focus on the next 99 most deprived and the final 99 SOAs with flexibility to return to top 88 most deprived if necessary?
Offering	Warm Homes & Northern Ireland Sustainable Energy Programme (NISEP)/levy	Warm Homes, NISEP/levy, Boiler Replacement grant
	A2B & BECs	BECs (direct to SSA)
	Home safety	No change
	Support services (e.g. home help, day care, meals on wheels, etc.)	Universal services - social services and occupation health
	Local services	No change
	Translink Smartpass and Rural community transport partnership	No change

- Phase I focused on the top 88 most deprived SOAs. The SOAs included in MARA now included all rural SOAs across Northern Ireland. The needs of all adults (18 and over) in the households were to be assessed not just the main householder.

- As part of their proposals, lead organisations were required to provide evidence of partnership links within their local areas in the form of Household Identification Partnership Agreements (HIPAs). These links were intended to help them identify households that would benefit from MARA

- Enablers were formally recruited and employed through lead organisations. As such, enablers were paid a wage up to £14 per hour rather than £50 per visit. This change to an employee status was intended to help secure reliable and competent enablers. The change to a paid hourly wage rather than per visit was in-line with other interviewers (e.g., NISRA surveyors).

- The training provided to enablers was refined and designed to be more relevant to the role. The training sessions were managed by PHA and included the following elements:
    - Customer care and interviewing skills
    - Working with vulnerable adults
    - Safetalk (suicide prevention)
    - Induction at lead organisation (including lone worker policy training, IT training)
    - IT training and a shadow visits by a member of the MARA team

- The visit to the client's house where all clients were assessed was referred to as the 1st visit. In MARA a 2nd follow up visit was introduced for any clients who had a referral (anticipated for 80% of clients). The purpose of the 2nd visit was to help clients to complete forms or obtain further information required for some referrals (e.g., Smartpass). Furthermore, the 2nd visit served to address any issues clients may have had in obtaining access to the services, grants and/or benefits and

delays in processing referrals were flagged for someone at the lead organisation to chase up with referral partners.

- A major change was the introduction of a bespoke IT system which aimed to improve the efficiency of the programme by eliminating delays due to data entry and manual processing of referrals. Enablers entered data collected at visits directly onto a laptop and uploaded the data to HSC servers when they were able to connect to the internet. The IT system was designed for referrals, where possible, to be automatically sent to referral partners who could also update the system with client outcomes when available. Not only did the IT system streamline the project but it increased compliance with information governance. Information was held on password protected and encrypted laptops and users had access only to client information pertinent to their current work. Access was restricted for referral partners also who were only able to access the minimum data required for them to process referrals on the client's behalf.

1.6 The MARA model

This sub-section outlines the MARA model used for Phase II delivery. An overview is provided for management structure that is responsible for overseeing delivery of MARA. The approach outlines the processes involved in MARA delivery (e.g., household visits and referral data).

1.6.1 Management groups

Three main management groups were established to assist with the delivery of MARA: the Interdepartmental Regional Project Management Forum (IRPMF), the MARA Implementation Group (MIG), and the Lead Organisation Forum (LOF).

The IRPMF met biannually and was chaired by the Assistant Director of Health and Social Well-being Improvement department of PHA. The group included senior representatives from PHA, DARD, the Department of Health, Social Services and Public Safety (DHSSPS), Northern Ireland Housing Executive (NIHE), Department for Social Development (DSD), Social Security Agency (SSA), and the Department of Regional Development (DRD). The role of IRPMF included providing strategic direction, agreeing implementation, overseeing monitoring and evaluation, advocating for the project within their organisations, and providing feedback to referral partner organisations.

A strategic management group was established with meetings held on a quarterly basis between senior officials in DARD and PHA to address general governance, budget, risk management and program with delivery of objectives

The MIG met monthly and include representatives from PHA and DARD. The role of the MIG included overseeing implementation of MARA, procurement, providing training to staff within lead organisations, quality assure monitoring and evaluation, identify and manage risk and report the IRPMF.

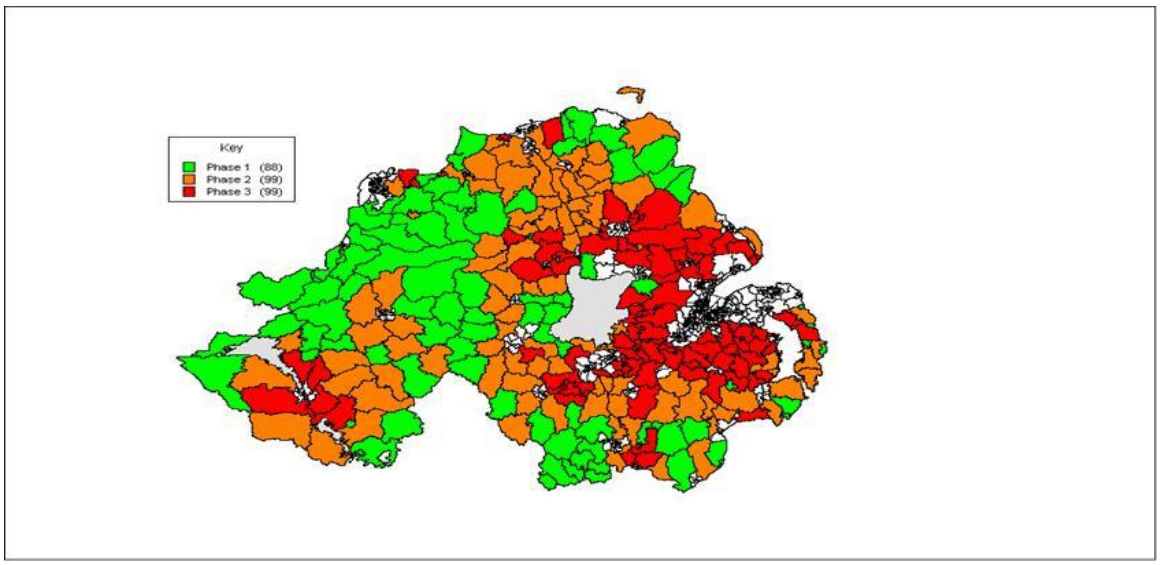
The LOF met bi-monthly and then quarterly at the end of the project and included representatives from PHA, DARD, and appointed project managers within each of the lead organisations. The role of the group was to provide opportunity to share

learning and experiences, monitor progress, and identify and manage risk at a local level.

1.6.2 Approach

All rural SOAs in Northern Ireland (Figure 1) were grouped and allocated to 13 geographical zones (excluding the zone 11) and 12 lead organisations were tendered to deliver MARA across the zones (see Appendix B). Within each lead organisation, there was resource allocation for a project manager, administrative staff and a number of enablers (dependent on the number of households to be targeted).

Figure 1: Map of SOAs targeted in MARA Phase II



The new MARA model was piloted in the Fermanagh area with 100 households primarily to test the changes made to Phase II (detailed in Table 1, pages 12-13). The pilot was evaluated accordingly and findings were incorporated into full implementation (see section 3 for more detail).

Lead organisations used the community development approach deemed successful in Phase I. Initially, lead organisations were to draw on partners from whom they had a Household Identification Partnership Agreement (HIPA) to form steering groups. It was also suggested that steering groups should include key local people within 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, a suitable time was arranged for an enabler to call to the client's home.

1.6.3 The 1st visit – 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 1st visit lasted, on average, 1 ½ hours and collected the following information:

- Demographic information
- Household section: number in household, access to internet, ownership of accommodation)
- Items to assess eligibility for 11 different types of referrals (including whether clients had heard of the referrals, and why they had not previously applied for the services, benefits and/or grants)

1.6.4 The 2nd visit – follow up

Approximately 12 weeks following the 1st visit, 80% of clients who have consented are contacted (where appropriate) to complete a second assessment either face-to-face or via telephone. The 2nd visit was an opportunity to further some referrals (e.g., 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.

1.6.5 Referral data

Following the visits, enablers connected their laptops to the internet to allow for referrals to be automatically forwarded to referral partners. Automatic referrals included referrals for Warm Homes, NISEP/Levy, Home Safety, BECs, Local Services, Rural Community Transport Partnership (RCTP). However, some other referrals could not be sent automatically as they required some other action before the referral could be made (e.g., completion of paper-based forms, visiting a GP, obtaining a passport photograph, etc.) These manual referrals included boiler replacement grants, occupational therapy assessments, social services, and Smartpass) were processed manually by lead organisations.

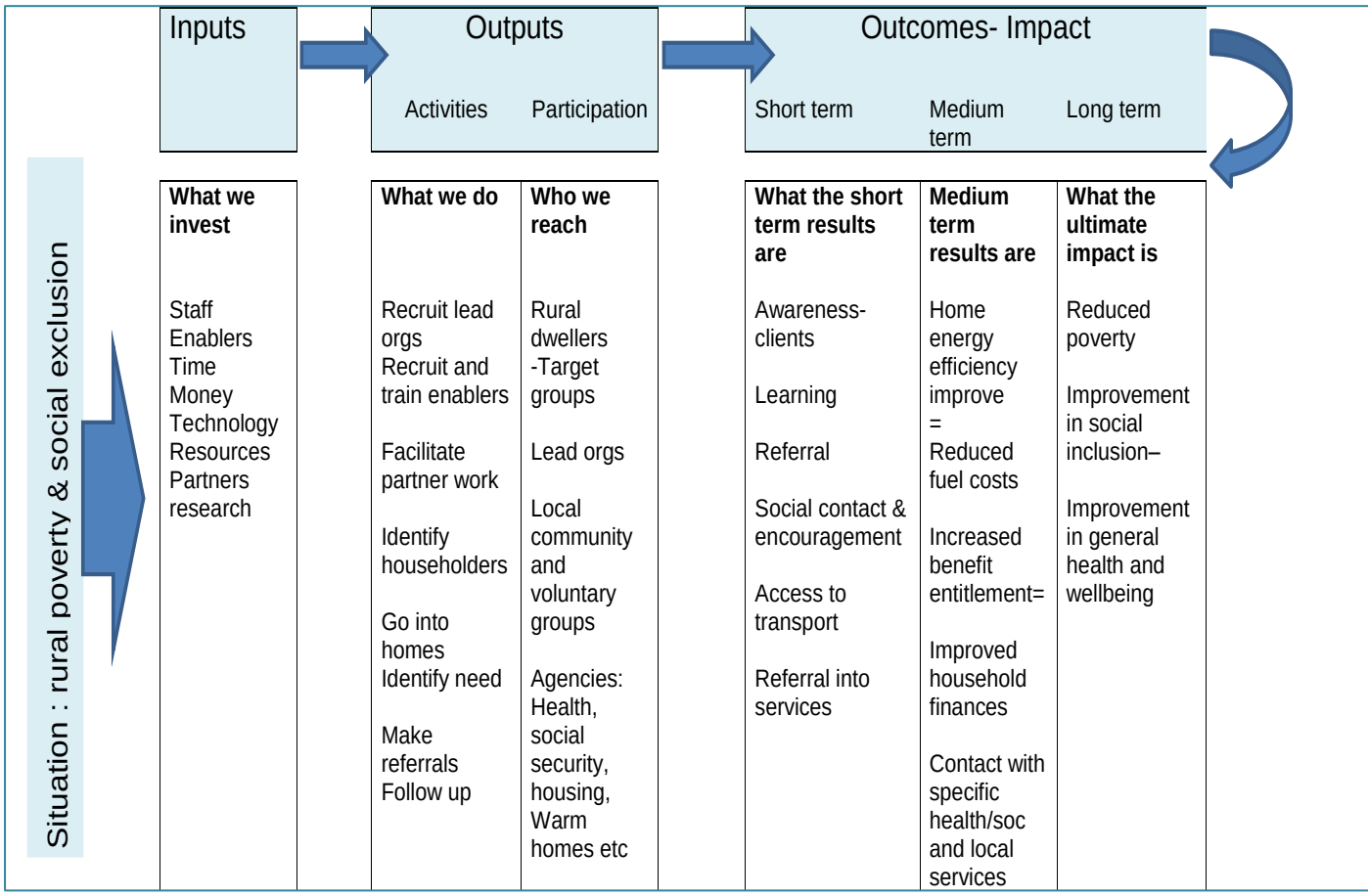
2. Evaluation approach and methodology

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 (e.g.IT) and to examine processes to make recommendations for improvement at an early stage. The evaluation was also designed to assess outcomes.

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 (e.g. 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; and
5. To calculate and evaluate the economic value of MARA and the social return on investment.

Note: Please see interim evaluation reports [v, vi] for evaluation work relating to objective 1.

2.3 Evaluation approach

The approach for the evaluation is outlined in Table 2 which illustrates different approaches relating to the objectives, the approaches used to address each of the objectives, the source of information used, and who carried out the evaluation.

Table 2: MARA Phase II evaluation approach used to address each objective

Evaluation objectives	Approach	Source	Conducted by…
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 to check for data accuracy and assess processes	Internal PHA
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	Internal PHA
The impact on access to services, grants and benefits	Analysis of MARA system data – referral data evaluation follow up survey data	MARA IT system referral data evaluation follow up survey data	Internal PHA
Changes in the determinants of the health and measures of wellbeing of rural dwellers	Analysis of MARA system data – and evaluation follow up survey data	MARA IT system and follow-up survey	Internal PHA

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	Internal PHA External evaluators
Any other impacts	Economic and SROI analysis	Economic and SROI analysis	External evaluators

2.3.1 Methodology

Elements of the evaluation have included the following:

I. Pilot in Fermanagh area to test IT system and all processes: analysis of client data (May, 2012);
II. Interviews with project managers in lead organisations (March, 2013; February, 2014);
III. Lead organisations - Proforma regarding household identification and recruitment of enablers (August 2012; February 2014);
IV. Lead organisations – proforma regarding processing referrals (May 2015);
V. Survey of enablers (March 2014);
VI. Stakeholder consultation and SROI analysis (carried out by Deloitte – January to April, 2015)
VII. Analysis of clients pre- and post-intervention data (including full implementation period, April, 2012 to December, 2014);
VIII. Sample survey of clients 12 month after 1st visit (including full implementation period).

2.3.2 Client follow-up survey

At 12-months from the initial MARA assessment, clients completed a telephone evaluation survey which included the following items:

- Client experience during the initial assessment and 12-week review
- The outcomes of some referrals not captured by the MARA IT system (i.e., Occupational Therapist Assessments, Translink Smartpass, and Local Services)
- Warmth of home
- Health and Wellbeing (including 2 questions measuring general and physical health, 7-item measure of positive mental wellbeing[1]; and 6-item measure of social connectedness[2,iii]).
- Service feedback

[1] The short version of the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBs) is a revised version of a 14-item scale. The scale is designed to measure positive mental wellbeing and has been found to be reliable, robust and valid for use in populations aged 14+ years. Responses to items (on a 5-point Likert scale range from 1 '*None of the time*' to 5 '*All of the time*') are scored to give a score ranging 7-35, with higher scores indicating higher scores of wellbeing. Clinical cut-off points have not been developed and therefore, the scale was not designed to identify individuals with high or low mental wellbeing. Whilst clinical cut-off points are not available, changes over time can be assessed by examining differences in mean scores.

[2] Hawthorne's (2006) 6-item Friendship Scale is designed to measure social connectedness and has been validated for use in adult populations. Responses to items (on a 5-point Likert scale range from 'not at all' to 'almost always' are scored and summed to give a total score ranging 0-24, with higher scores indicating higher levels of social connectedness. Scores can be grouped into five categories ranging from 'Very socially connected' to 'Very socially isolated'.

Technical note on evaluation follow-up survey: Targeting for the evaluation follow-up survey was based on households (rather than clients) to minimise burden on respondents. In total, 1,031 completed the follow-up survey which equated to the 8% target (see Appendix C for additional tables).

The evaluation follow-up sample had a slightly higher proportion of females and tended to be older in comparison to those who completed the 1st visit. In relation to employment status, those in employment (either full/part time) and the unemployed (seeking and not seeking work) were under-represented, with retired individuals being over-represented at follow-up. Finally, those cohabiting, single and separated or divorced were under-represented with those widowed being over-represented at follow-up. These differences in client profile at follow-up indicated the follow-up sample was slightly skewed towards retired older people.

2.3.3 Pre- and post-analysis of project data

The final evaluation involved analyses of pre- and post-intervention data. This involved the analysis of data collected during the 1st visit using the initial assessment in comparison (where appropriate) to the evaluation follow-up survey completed approximately 12 months post-intervention. This also included analysis of referral data, as necessary, to evaluate outcomes.

The data were downloaded from the MARA IT system in January 2015 and all data was thoroughly cleaned, for example to remove duplicate records. The process of data cleaning resulted in the final figures for those taking part in the project differing from figures previously reported which used figures direct from the MARA IT system. However, data cleaning processes were necessary to ensure only valid records were included in the analysis (see Appendix G for further details).

Fermanagh pilot data was excluded (n=100) from final project analysis. However, the referrals from the pilot phase have been included in the economic SROI evaluation undertaken by Deloitte. Pilot data was removed from the main analysis as a pilot is designed to test and then improve or modify processes. Pilot findings resulted in changes in how MARA was implemented and how data was collected, as per normal protocol. The rationale for inclusion in the economic evaluation is that the outcomes are genuine MARA-related outcomes.

2.3.4 Notes on the report and statistical references

Analysis of the MARA database included analysis not directly relevant to the evaluation. As this report focuses on the evaluation, extra analyses are appended at the end of the report and are not referred to in the main body of the report. This includes reasons for not having already accessed services, frequencies for electoral and council areas (Appendices D, E and F).

Throughout this report, reference is made to a number of variables created using data obtained from the MARA IT system. These key variables are noted below:

Home improvement schemes	The variables included in home improvement schemes variable has been amended throughout the duration of the programme. In this report, this variable includes referrals made on behalf of the household which included Warm Homes, Levy, and Boiler Replacement. In the pilot analysis (detailed in section 3, page 23) this also included Home Safety due to the low numbers targeted. In Phase II, Home Safety was excluded as this was an individual based referral and therefore was not appropriate for inclusion in the other household referral types. The proportions included using this variable cannot be compared to Phase I due to the inclusion of Boiler Replacement which was not available at that time.
Universal services	Referrals for an occupational therapy assessment and/or to social services were grouped together under 'universal services'.
Single parent status	There was a 'household type' variable that was intended to be an indicator for those in single parent households. However, comparison of single parents using this variable did not tally with the number of adults living in households and/or the number of children living in households. Consequently, this status was identified based on one person living in a household with at least one child. However, we do not know which of these variables is unreliable (the household type numbers of people living in households). Therefore, this variable may under-represent single parents that participated in the project.
Older people	This refers to individuals aged 65 years and above. This differs in comparison to Phase I which previously used pensionable age. However, legislative changes have since been introduced to increase pension age with various ages applied depending on individual's circumstances. Therefore, analyses relating to this group cannot be directly compared to Phase I.
Lone adult	As with single parents, the 'household type' variable was deemed unreliable. Instead this variable used the number of adults and number of children living in a household. So, this relates to cases whereby a single adult only was living in a household.
Low income status	Gross income where available was adjusted to take into account the different household composition and size, a process known as equivalisation and is a standardised methodology. Once equivalised, households identified as having a household income (before housing costs are deducted) below 60% of the Northern Ireland median household income were categorised as 'low income'. The latest figure available for the median household income in Northern Ireland population was for 2012/13[iv].
Ethnicity	Ethnic minority was a key target group intended to be included in MARA. However, the majority of clients were categorised as 'other ethnic group' and specified as 'white'. The ethnic minority population in Northern Ireland is more reflective of nationality (e.g. Polish and Latvian). This means there is not enough information captured using this variable to be able to distinguish ethnic minority groups. Furthermore, 31 individuals were listed as requiring an interpreter. Of these, 18 specified a language (including Lithuanian, Russian, Latvian and Polish) which suggested ethnic minority status. However, only one of the 31 requiring an interpreter was categorised as an ethnic minority. Consequently, no further analysis was carried out based on this group.

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 Early evaluation findings from initial report and interim report

The data gathered from the 100 households participating in Phase II between January and March 2012 were analysed and presented to the MARA Implementation Group (MIG) in two reports submitted in May 2012[v] and April 2013[vi]. The May 2012 report focused on analysing MARA IT system data to assess data completeness, client profiling, outcomes in comparison to targets, and client health and wellbeing. Not enough time had lapsed at this stage to allow for referrals to be processed or outcomes realised. A fuller analysis of the data was presented in April 2013 which included referral outcome data.

3.1 Interim evaluation: summary of findings and recommendations

Two reports submitted in May 2012[v] and April 2013[vi] addressed process evaluation at the early stage of MARA delivery. A brief summary of the reports is outlined below:

- Initial report: The data collected form the initial 100 households participating in Phase II 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: A fuller analysis of the data included in the initial report was presented in the Interim evaluation report April 2013 which included referral outcome data. At 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;
    - Referrals processes;
    - It system and issues.

- Overall, the initial analysis was valuable in identifying and fine tuning processes and protocols for the MARA IT system, the screening tool used at the 1st visit, and staff training. Client feedback was positive as clients felt that the service was well suited to their needs and were very likely to recommend MARA to their friends.

- One of the most important issues for the success of the MARA project was the successful identification of households for inclusion. The MARA project team noted in the early stages that that household identification has been slower than anticipated. To monitor this, the MARA team encouraged lead organisations to provide weekly progress updates. In addition to monitoring procedures, lead organisations employed several different strategies to identify households. Strategies ranged from engaging with formal and informal referrers and encouraging self-referrals by publicising the project locally. Project managers

reported being flexible and using different methods in different SOAs as they reported that one approach did not work in all areas. In addition lead organisations expressed some frustration with the steering group HIPA (Household Identification Partnerships agreement) that had been suggested by the MARA team in order to identify households in need and felt that allowing lead organisations to forge links with organisations or individuals on a one-to-one basis was a more effective in the identification process.

- Furthermore, project managers highlighted that their difficulty was not in identifying clients but obtaining consent to participate in MARA. They felt that much of the work they were involved in was trying to raise the local profile of MARA, important 'leg work' that would make potential householders feel less suspicious and more willing to participate. Project managers felt that this work had slowed their progress with client consent and they called for more to be done regionally by the MARA project team in this respect. In response to this, promotion of the project continued to be high on the agenda of PHA and DARD.

- The source of IT problems in the early stages had not always been clear and took some time to identify. Project managers felt that this had been a burden in terms of demand on staff time and resources. The MARA project team acknowledged issues with the IT system and all lead organisations later reported that the system was working effectively.

- Some other issues highlighted at that time included the need to emphasise with lead organisations and staff the importance of actively trying to identify and recruit in the vulnerable groups There were some issues at this stage with consistent use of the local directory of services and it was emphasised that these needed to be regularly updated with relevant services and that any enablers not making use of local services aspect of the assessment should be reminded of its importance to the programme.

- Through analysis of the Phase II data for the initial 100 households a number of data quality issues were identified and feedback was given to the Implementation Group in May 2012. Consequently, amendments were made to the IT system to ensure that data quality was of a high standard for reporting on MARA going forward. In addition the importance of encouraging regular and timely updates on client progress from referral was emphasised as this information would be essential to demonstrating effectiveness of MARA.

- Some issues for consideration were presented to the MIG as a result of the evaluation work. These included process and outcome issues and are detailed in Table 3 along with action taken as a result.

Table 3: Issues for consideration and action taken resulting from interim evaluation

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 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. 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.	Generally, the issue of cost-effectiveness is discussed with 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.

4 Final evaluation findings

4.1 Household targeting

In total, 12,085 households took part in MARA which exceeded the target of 11,925 and included 13,784 clients. Overall, targets set for household identification were exceeded in seven zones.

Zone 5 showed the largest discrepancy between the target number of households to be visited and the number achieved. Records for this zone were manually searched with a view to explaining the discrepancy particularly as records held by the lead organisation indicated that targets had been achieved. This manual search highlighted a synchronisation issue that resulted in some records not being included in the analyses. Therefore, the numbers of households achieved in Table 4 are reflective of the numbers used for analyses but may under-estimate the households achieved in some areas.

Table 4: Numbers of households participating in MARA against targets and numbers of assessments completed

Zone	Lead organisation	Household targets	Households achieved[3]	1st assessments	Second assessments[4]
		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)**

[3] Analytic note, based on '*Primary*' variable
[4] Analytic note, based on '@2_Review_Complete' variable

4.2 Objective 3: To evaluate the impact of MARA on clients' access to services, grants and benefits

4.2.1 Overall Performance against targets

All referral targets set for MARA were exceeded except for Transport referrals (see Table 5):

- The number of households accessed exceeded targets by 160;
- Referrals to a Home Improvement scheme were more than double the target (53% referred compared to the target of 20%). In total, 40% of households were referred to one home improvement scheme, and 13% were referred for either Warm Homes or Levy and Boiler Replacement;
- Over half of clients were referred for a benefit entitlement check, (target 35%);
- Over one quarter (29%) were referred to a local service, (target 20%);
- Nearly one in five (19%) were referred to a universal service, exceeding the 15% target. In total, 17% clients were referred for one universal service and 2% were referred for two; and
- One in five (21%) received a transport referral, falling just short of the 25% target. In total, 20% clients were referred to one transport service, 1% were referred to both.

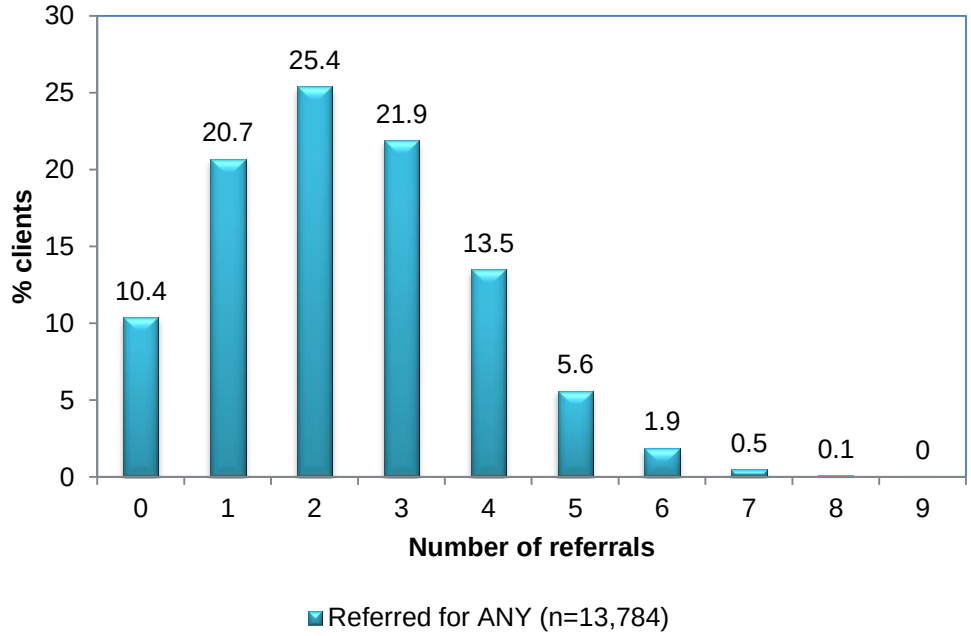
Whilst not a target, 90% of clients were referred for at least one benefit, service and/or grant.

Table 5: MARA Phase II performance against 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[5]	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

[5] Home Safety referrals were associated with clients/individual assessments and not households (like warm homes, levy or boiler replacement referrals). Consequently, home safety was separated from home improvement schemes as limiting analysis to households rather than clients would have excluded 336 referrals.

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



4.2.2 Successful outcomes

As MARA is service about improving and creating access, targets were based on referrals made regardless of outcome. However, changes to the IT system and processes improved the ability to obtain outcome data. The proportion of clients who had successful claims is as follows (Table 6):

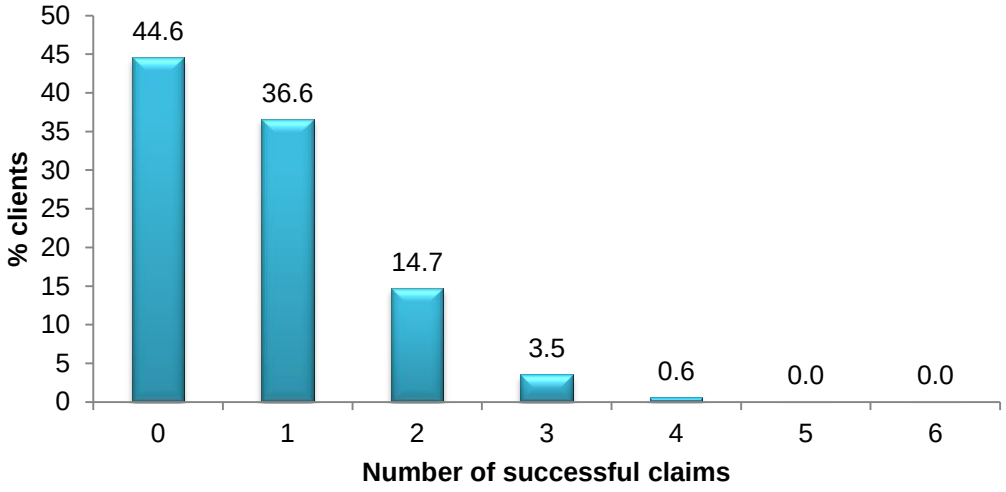
- 30% of those referred to home improvement schemes were successful. This equated to 16% of all households that had measures carried out to improve the energy efficiency of their home. The majority (14%) had a successful Warm Homes or Levy claim and 3% were awarded a Boiler Replacement grant.
- 77% of those referred to Home Safety were provided with equipment and/or advice from the Home Safety advisor which equated to 40% of all clients;
- 7% of those referred for BECs were awarded a benefit which equated to 4% of all clients;
- 39% of those referred to a universal service had a successful outcome which equated to 7% of all clients (6% 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).
- 20% of those referred were sent information about a service they were interested in their local area which equated to 6% of all clients.

Table 6: The proportion of those who had successful claims

Outputs	Performance (referred)	Successful claims	
		(% of those referred)	(% of all)
Home improvement schemes[6]	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[7]	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)

Over half of the clients (55.4%) had a successful outcome for the referrals made on their behalf (Figure 4). Note: a small number of clients were successful for five or six claims but this was too small to note in percentages.

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



[6] Due to differences in categorisation, the total proportion of those referred for any of the home improvement schemes cannot be compared to Phase I (Phase II includes additional services Boiler Replacement and Home Safety).

[7] Home Safety referrals were associated with clients/individual assessments and not households (like warm homes, levy or boiler replacement referrals). Consequently, home safety was separated from home improvement schemes as limiting analysis to households rather than clients would have excluded 336 referrals.

4.2.3 Key messages

Key findings for this section are depicted in the box below which highlights the success of MARA:

With the exception of transport referrals, all MARA targets and objectives were achieved which shows MARA was successful.
Nine out of ten 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 following a referral (55.4%)

4.3 Objective 2: To assess identification and uptake by area and vulnerable groups

This section describes the characteristics of clients included in MARA with a view to illustrating the client profile. This section also describes targeting and uptake by geographical area and finishes with focusing on vulnerable groups intended to be included in MARA.

4.3.1 Participation

In total, 12,085 households participated in MARA with 13,784 clients completing assessments during the 1st visit. Second assessments were completed by 83% of clients. The number of households participating in MARA was exceeded in the majority of Zones (with the exception of Zones 5, 7 and 9). Whilst some Zones did not exceed the targets set, the project was designed to allow for redistribution across SOAs to ensure those most in need benefitted from the intervention.

4.3.2 Client characteristics

The overall profile for clients included in MARA was as follows:

- 40% clients were male and 60% female. The gender breakdown by zone indicated that gender was roughly equivalent across the zones.
- Clients were aged 64 years on average (ranging from 18 to 102 years). Over half (55%) of all clients were 65+.
- Again over half (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;
- Most (96%) households had a phone, less than half (47%) households had internet access, with 99% of these having broadband access. Around 80% of household in NI has access to the Internet with little variation between urban and rural areas [vii]. This highlights that the level of internet access for MARA clients is below average which may be reflective of the technological age gap.
- Most clients (97%) were registered with a GP.

Table 7: Client characteristics

		1st visit
		%
Sex	Male	40
	Female	60
Age	18-39	9.4
	40-59	23.9
	60-64	10.2
	65+	55.4
	Missing	1.0
	Average age	64 years
Relationship status (n=13,784)	Married	51.3
	Widowed	23.1
	Single	15.1
	Separated/divorced	8.0
	Cohabiting	1.5
	Civil partnership	0.3
	Missing	0.7
Economic activity (n=13,784)	Retired	57.9
	Working (employed/self-employed full/ part time)	19.0
	Not working (not seeking work sick or disabled)	17.7
	Unemployed (seeking)	3.7
	Student	0.3
	N/a and missing	1.5
Income status (n=12,085)	Low income	29.9
	Not low income	40.5
	Missing[8]	29.7
Dependents (n=12,085)	Households with children <18 years	18.3
	Households no children	81.7
Household composition (n=12,085)	Average household size	2.1
	Range	1 to 8
	1 person households	37.0
	2 person households	36.6
	More than 2 person households	25.2

[8] Income was only asked of the primary household client and this was to be reflective of the total household income. The high proportion of missing cases was mainly due to the client saying they were that there was other household income but they did not know how much.

4.3.3 Targeting by geography and deprivation levels

The numbers of households targeted for inclusion in MARA were initially based on NISRA's multiple deprivation indices for rural Super Output Areas (SOAs). Secondary to this, the SOAs were grouped in relation to the Northern Ireland geography. Although the groupings were largely by deprivation, this second layer of distribution resulted in some more deprived SOAs being grouped with more affluent SOAs. The SOAs were grouped into the following:

- the first 88 rural SOAs
- the next 99 rural SOAs; and
- the final 99 rural SOAs.

The top 88 SOAs included the most deprived SOAs that were previously targeted in Maximising Access to services grants and benefits project (PHASE I). Therefore, MARA Phase II focused on the next 198 SOAs but allowed for some targeting in the top 88 most deprived SOAs.

In total, 286 SOAs were targeted in MARA but households from 343 SOAs were included. Zones 4, 9 and 13 had the highest proportion of participating households beyond the targeted SOAs. Table 8 shows the number targeted and achieved in each of the deprivation/geographical bands and Table 9 shows the expected and actual distribution.

Table 8: Household targeting in relation to deprivation and SOAs

Targeted households within SOAs					
The first 88 rural SOAs		**Next 99 rural SOAs**		**Final 99 rural SOAs**	
Target	**Perform**	**Target**	**Perform**	**Target**	**Perform**
2125	**+1009**	**4950**	**-312**	**4950**	**-954**

Table 9: Target and actual households included in MARA by deprivation/ geographical bandings

SOA	Expected no of households	Expected % distribution	Actual no of households	Actual % distribution
First 88 SOAs	2125	17.7	3134	26.6
Next 99 SOAs	4950	41.2	4638	39.4
Final 99 SOAs	4950	41.2	3996	34.0
Total	12,025	100.0	11768	100.0

Analysis based on these groupings for SOAs indicated the following:

- The total number of households from the top 88 most deprived SOAs intended to be included in Phase II was to equate to 17% of the overall target number of

households. However, households within these SOAs equated to 26% of the overall sample. All zones that were to target households in the top 88 most deprived SOAs made gains in the number of households accessed in comparison to targets;

- The next 99 deprived rural SOAs were intended to make up 41% of the overall household target but the actual proportion was 38%. Zones with these areas showed some variation with some making gains and some making losses in comparison to targets. Overall, the households accessed in the next 99 most deprived SOAs were slightly below target.
- The least 99 deprived SOAs were also intended to make up 41% of the final sample but actually made up 33% of households accessed. All zones accessed less than the targeted amount of households for the 99 least deprived SOAs.

4.3.4 Reaching vulnerable groups

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

Table 10 outlines the proportion of those in reached each target group. 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 for discussion on ethnic minority data quality issues).

Table 10: Proportion of clients reached within vulnerable groups (n=13,784).

	1st visit		Phase I[9]
Vulnerable groups	**n**	**%**	**%**
Single parent	545	4	10
Older people	7697	56	52
Lone adult	4295	31	42
Low household income	4152	43	47
Carers	2461	18	21
Disabled[10]	3729	32	60
Identified vulnerable farmers and/or fishermen	1565	11	10
Ethnic minority	43	<1	2

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

[9] Figures rounded to nearest whole number from Phase I report.
[10] 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 first assessments (n=11,739), for second assessments (n=9,609) and the evaluation follow-up (n=973).

4.3.5 Vulnerable groups reached: zone variation

There was some zone variation in terms of reach for vulnerable groups (Table 11). While the oldest age group made up the main proportion of clients across most zones for 2 zones the highest proportion of clients came in the low income group (Zone 7 and 9).

Table 11: Proportion of vulnerable groups reached in each zone

		Older people	Lone adults	Low income	Single parents	Identified vulnerable farmers/ fishermen	Disabled	Carers
Zone	**Regional MEAN**	56%	31%	43%	4%	11%	32%	18%
1	TADA	55	30	42	4	22	29	17
2	CWSAN	62	33	39	3	12	40	16
3	CDRCN	46	32	40	6	9	29	17
4	RNWCS	50	33	43	5	7	27	15
5	NACN	59	32	37	4	14	33	18
6	OFRA	60	44	48	4	10	40	12
7	CRUN	50	28	55	5	8	23	17
8	COSTA	63	33	40	2	13	37	22
9	SPACE	50	25	54	5	15	29	24
10	CDRCN	51	31	35	5	6	39	16
12	TADA	51	24	34	5	12	21	18
13	SACN	67	43	45	2	4	33	13
14	FRCN	76	36	54	1	6	37	10

NOTE: Grey denotes instances where the proportion is well above the MARA regional average

All zones accessed a greater proportion of older people with Zone 14 enlisting the highest proportion of **older** people.

The average proportion of **low income** groups was 43%. However, more than half of the clients were in low income groups in three zones: zone 7 (55%), zone 9 (54%), and zone 14 (54%). The lowest level of low income groups was in zone 12 (34%).

There was consistency among all zones for access to **single parents** with zone 3 enlisting slightly more than others.

The proportion of **identified vulnerable farmers and/or fisherman** was consistently around 11% for the majority of zones. However, zone 1 enlisted double this proportion (22%) and zone 9 (15%) enlisted more identified vulnerable farmers/fishermen. The lowest proportion of identified vulnerable farmers/fishermen were enlisted in zones 13 (4%), 14 (6%) and 10 (6%).

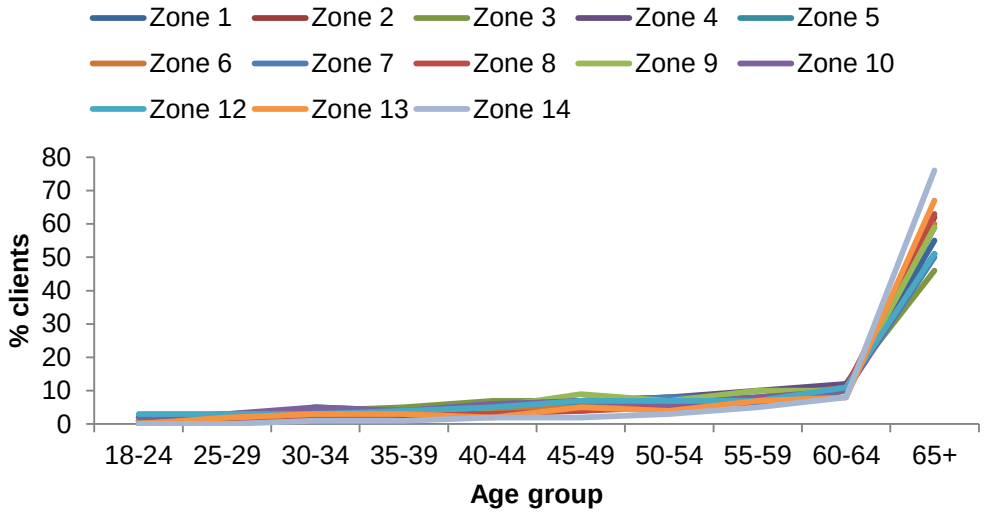
The average for **disabled** people was 32% but this was not consistent across all zones. For instance, 40% of clients in zones 2 and 6 were disabled, whereas zones 7 and 12 were below the average (23% and 21%, respectively).

The average proportion for **carers** was 15% and was fairly consistent across zones with zones 9 and 8 reaching a greater proportion in their areas (24 and 22%, respectively).

The average proportion of **lone adults** (31%) was fairly consistent but with zones 6 and 13 above this average at 44% and 43%, respectively. The lowest proportion of lone adults was in zone 12 (24%).

A note on age:
By zone, the average client age was equivalent to the overall profile (64 years). However, the age profile in Zones 13 and 14 were more skewed towards older clients (M=67 and M=71, respectively). Overall, recruitment tended to favour those over 65 years with 56% of clients falling in this category. This was most pronounced in Zone 14 were more than three quarters of clients (76%) were 65 years or above (Figure 5).

Figure 5: Proportion of clients within age groups by Zone (n=13,784)



4.3.6 Referrals and outcomes for vulnerable groups

Home improvement scheme referral
The proportion of households referred to a home improvement scheme (Warm Homes, NISEP/Levy and/or Boiler Replacement Grant) ranged from 50% to 56% for vulnerable groups. Being in a target group was not significantly related to a referral for a home improvement scheme single parents, older people, carers, disabled or those on a low income. However, there were significant relationships for lone adults and farmer/fishermen:

- Lone adults were less likely to be referred to a home improvement scheme than households with more than one person living in them (50% vs. 55%; p<.001);
- Identified vulnerable farmers/fishermen were more likely to be referred to a home improvement scheme than those who were not identified vulnerable farmers/fishermen (56% vs. 52%; p<.01).

Home improvement scheme success

The proportion of households successful following a referral to a home improvement scheme ranged from 14% to 17% when analysed by vulnerable groups. The only significant relationship was for older people:

- Older people were more likely to have a successful claim to a home improvement scheme compared with younger people (16% vs. 15%; p<.05).

Home Safety check referral

The proportion of clients referred for a Home Safety check ranged from 43% to 61% when analysed by vulnerable groups. There were no significant relationships between vulnerable groups and a home safety check referral for single parents and identified vulnerable farmers/fishermen. However, there were significant relationships for other vulnerable groups:

- Older people (57% vs. 43%; p<.001), lone adults (60% vs. 47%; p<.001), and those who were disabled (61% vs. 48%; p<.001) were more likely to be referred for a check compared to those not in the vulnerable groups;
- Carers (46% vs. 52%, p<.001) and those on a low income (56% vs. 58%; p<.05) were less likely to be referred compared to those not in the vulnerable groups.

Home Safety check success

When analysed by vulnerable groups, the proportion of clients who had a successful outcome following a home safety referral ranged from 29% to 50%. With the exception of identified vulnerable farmers/fishermen, all vulnerable groups were significantly related to a successful outcome:

- Single parents (31% vs. 40%, p<.001), carers (35% vs. 40%, p<.001) and those on a low income (42% vs. 46%, p<.001) were less likely to have a successful outcome compared to those who were not in the vulnerable groups;
- Older people (48% vs. 29%, p<.001), lone adults (48% vs. 35%, p<.001) and disabled people (42% vs. 46%, p<.001) were more likely to have a successful outcome compared to those not in the vulnerable groups.

BECs referral

The proportion of clients referred for BECs ranged from 48% to 61% when analysed by vulnerable groups. Being in a target group was not significantly related to older people, lone adults, or carers. However, there were some significant relationships:

- Single parents (59% vs. 53%, p<.05) and disabled people (59% vs. 48%, p<.001) were more likely to be referred for a BECs compared to those not in the vulnerable groups;
- Identified vulnerable farmers/fishermen (50% vs. 54%, p<.01) and low income (61% vs. 54%; p<.001) were less likely to be referred for BECs compared to those not in the vulnerable groups.

BECs success

Between 3% and 6% of clients were successful for a benefit when data were analysed by vulnerable group status. There were no significant associations for single parents, lone adults but there were significant findings for other vulnerable groups:

- Older people (4% vs. 3%, p<.001), carers (5% vs. 4%, p<.05), disabled (5% vs. 3%, p<.05) and low income (6% vs. 3%, p<.001) were more likely to have additional benefits as a result of MARA;
- Identified vulnerable farmers/fishermen were less likely than those not in the vulnerable group to have additional benefits as a result of MARA (3% vs. 4%, p<.05).

Universal service referral

When analysed by vulnerable groups, the proportion of clients referred to a universal service ranged from 6% to 46%. Significant relationships were:

- Single parents (6% vs. 20%, p<.001), carers (14% vs. 20%, p<.001), identified vulnerable farmers/fishermen (15% vs. 20%, p<.001) and those on a low income (18% vs. 21%, p<.01) were less likely to be referred to a universal service compared to those not in the vulnerable groups;
- Older people (25% vs. 12%, p<.001), lone adults (25% vs. 17%, p<.001) and disabled people (46% vs. 6%) were more likely to be referred to a universal service than those not in the vulnerable groups.

Universal service success

There were a number of significant relationships between success following a universal service referral and vulnerable groups:

- Older people (10% vs. 5%, p<.001), lone adults (10% vs.6%, p<.001) and disabled (18% vs. 2%,p<0.001) were more likely to have a successful outcome compared to those who were not in the vulnerable groups;
- Single parents (2% vs. 8%; p<.001), carers (5% vs. 8%, p<.001), identified vulnerable farmers/fishermen (6% vs. 8%, p<.05) and low income (7% vs. 9%, p<.001) were less likely to have a successful outcome compared to those not in the vulnerable groups.

Transport referral

The proportion of clients with a transport referral ranged from 17% to 27% when analysed by vulnerable groups. Being referred was not related to single parents, carers or disabled. Significant relationships were:

- Older people (23% vs. 18%, p<.001), lone adults (25% vs. 19%, p<.001) and those on a low income (23% vs. 20%, p<.001) were more likely to have a transport referral;
- Identified vulnerable farmers/fishermen were less likely to have a transport referral (18% vs. 21%, p<.001);

Local service referral

The proportion of clients referred to a local service ranged from 24% to 32% when analysed by vulnerable groups. Referral to a local service was not significantly associated with single parents, older people, carers, or identified vulnerable farmers/fishermen. However, there were the following significant associations:

- Lone adults (32% vs. 36%, p<.001), disabled people (30% vs. 24%, p<.001) and those on a low income (32% vs. 26%, p<.001) were more likely to be referred to a local service compared to those not in the vulnerable groups.

Transport success

There were a number of significant relationships between success for a transport referral and vulnerable groups:

- Older people (10% yes vs.7% no, p<.001), lone person 11% vs.8%, p<.001) and disabled (12% vs. 7%,p<0.001) were more likely to have a successful outcome compared to those not in the vulnerable groups;
- Single parents were significantly less likely (4% vs. 9%, p<0.001).
- There were no significant relationships for a successful transport referral and all other vulnerable groups (i.e., carers, identified vulnerable farmers/fishermen and low income).

Local service success

A successful outcome (i.e., those given information about a service) following a local services referral ranged from 4% to 7% when analysed by vulnerable groups. There were no significant findings relating to single parents, older people, or carers. However, the following findings were significant:

- Lone adults (7% vs. 5%, p<.001), disabled (7% vs. 5%, p<.001) and those on a low income (7% vs. 5%, p<.01) were more likely to have a successful outcome compared to those not in the vulnerable groups;
- Identified vulnerable farmers/fishermen were less likely than those not in the target group to have a successful outcome (4% vs. 6%, p<.001).

Table 12 summarises significant associations between target group status and the types of referrals offered by MARA:

- Being a single parent was not associated with being referred to home improvement schemes, for a home safety check, BECs or transport. However, single parents were more likely to be referred for any referral compared to those who were not single parents.
- Older people were more likely to be referred for a home safety check, to a local service, for universal services and transport or for any referral type compared to younger clients. However, being older was not associated with referrals to home improvement schemes, BECs or local services.
- Lone adults were more likely to have any referral, including being referred for home safety checks, local services, universal services, and for transport compared to those living with other people. However, lone adults were less likely to be referred to home improvement schemes and referral to BECs was not associated with vulnerable group status.
- Those on a low income were more likely have any referral. When analysed by individual referral types, this included being referred to BECs, for a local service and to transport than those on a higher income. Those on a low income were less likely to be referred for a home safety check and to a universal service. There was no relationship between being on a low income and being referred to a home improvement scheme.
- Carers were less likely to have any referrals including being referred for a home safety check, or to a universal service. Vulnerable group status was not associated with referrals to a home improvement scheme, BECs, local services, or transport.
- Disabled persons were more likely to have any referral including being more likely to be referred for a home safety check, BECs, to a local service, for

universal services. Being disabled was not associated with being referred to a home improvement scheme or for transport.

- Identified vulnerable farmers/fishermen were more likely to be referred to a home improvement scheme but less likely to be referred for BECs, universal or transport services.

Table 12: Significant associations between vulnerable groups and referrals

Referral type	Vulnerable groups						
	Single parents	Older person	Lone adult	Low income	Carers	Disabled	Farmer/ fishermen
Home improvement schemes							
Home safety							
BECs							
Local services							
Universal services							
Transport							
ANY							

NOTE: *Green shading indicates referrals were significantly higher in the vulnerable group compared to those not. Red shading indicates referrals were significantly lower for those in the vulnerable group compared to those not. White indicates that there were no significant differences between those in the vulnerable groups and those who were not.*

Table 13: Significant associations between vulnerable groups and successful outcomes

Referral type	Vulnerable groups						
	Single parents	Older person	Lone adult	Low income	Carers	Disabled	Farmer/ fishermen
Home improvement schemes							
Home safety							
BECs							
Local services							
Universal services							
Transport							
ANY							

NOTE: *Green shading indicates successful referrals were significantly higher in the vulnerable group compared to those not. Red shading indicates successful referrals were significantly lower for those in the vulnerable group compared to those not. White indicates that there were no significant differences between those in the vulnerable groups and those who were not.*

Table 13 above summarises the significant associations between vulnerable groups and successful outcomes following referrals:

- 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.
- Identified vulnerable farmers/fishermen were less likely to receive additional benefit entitlement, local services or universal services.

When analysed by gender and age, the following significant associations were found (Table 14):

- Being referred for home improvement schemes was significantly associated with males and being aged 25+, whereas older people were significantly more likely to be successful for these claims and people aged 30-39 years were least likely;
- Being referred for a home safety check was significantly associated with being female but there were no significant associations for successful claims;
- Being referred and successful for a local services referral was significantly associated with being female;
- Being referred and successful for a transport referral was significantly associated with being aged 60-64 with clients aged 30-34 least likely to be referred or successful.

Table 14: Significant associations with demography and referrals

Referral type	Referrals associated with…	Successful claims associated with…
Home improvements	Males Aged 25+	Older people Aged 30-39 years least likely
Home Safety check	Females	
BECs	Males	Aged 18-24 years
Local services	Females	Females
Universal services	None	None
Transport	Aged 60-64 years Aged 30-34 years least likely	Aged 60-64 years Aged 30-34 years least likely

4.3.7 Referral outcomes by zone

There were significant differences between zones and the proportion of clients who were referred and successful for each of the referral types with the exception of

successful claims following BECs. The differences are unlikely to be associated with zones per se but may be more reflective of the populations within each zone. See Table 15 for a brief summary of the differences between zones.

Table 15: Key findings for significant associations between referrals and zones

Referral type	Referred		Successful outcome	
	Highest Zone (%)	**Lowest Zone (%)**	**Highest Zone (%)**	**Lowest Zone (%)**
Home improvements	9 (63%) and 10 (63%)	7 (40%)	1 (23%)	13 (8%)
	p<.001		p<.001	
Home Safety	14 (65%)	7 (33%)	6 (53%), 8 (53%), and 14 (53%)	7 (23%)
	p<.001		p<.001	
BECs	10 (72%)	12 (26%)	No significant variation	
	p<.001			
	p<.001		p<.001	
Transport	14 (33%) and 1 (32%)	6 (15%) and 13 (15%)	14 (18%)	13 (2%)
	p<.001		p<.001	

4.3.8 Key messages

This section outlined the identification and uptake of MARA by area and vulnerable groups. Key messages are as follows:

4.4 Objective 4: Changes in the health and wellbeing of rural dwellers

MARA clients' health and wellbeing were measured at 1st visit and at the evaluation follow-up using items to measure general health, physical health, positive mental wellbeing and social connectedness. Whilst 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). Social connectedness was measured using a 6-item Friendship Scale. 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 were encouraged, where possible, to let clients self-complete the health and wellbeing section of the assessment. However, the evaluation follow-up was completed via telephone and clients were, therefore, unable to self-complete.

There are some limitations with the scale used to measure positive mental wellbeing. Cut offs for with scores for WEMWBs have not been developed. This means we do not know whether scores illustrated good or poor mental wellbeing. However, WEMWBs has also been used in a representative sample of the general population in Northern Ireland. Therefore, we are able to make comparisons in overall scores lending some interpretation to the scale.

Psychometrically, WEMWBs is considered unreliable if a high proportion of respondents score the highest score for the scale. This is known as a ceiling effect and may highlight methodological errors and raises concerns about the validity of the findings. For WEMWBs, the recommended maximum proportion scoring the highest score in the general population is 15%. For MARA, 39% scored the highest score highlighting that findings based on analysis using WEMWBs is unlikely to be reliable.

Analysis against each of the measures of health and wellbeing (i.e., general health, mental wellbeing and social connectedness) were analysed to provide an overall view of client health and wellbeing and any changes in average ratings for improvement. Health and wellbeing was analysed by demography, zone, vulnerable groups, referrals and successful claims, and deprivation. General health was not included as analysis showed little difference between ratings of both.

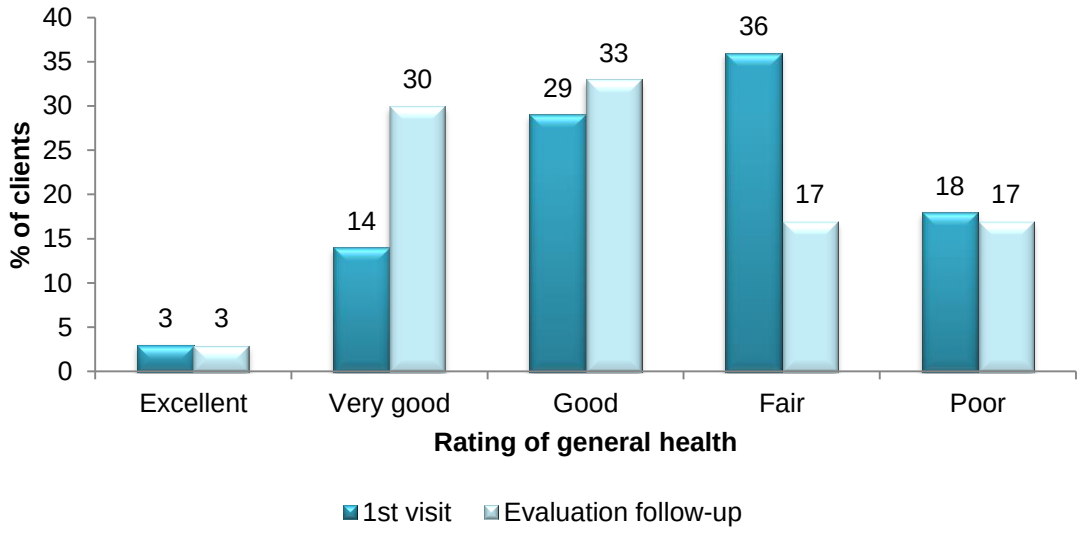
4.4.1 Self-ratings of general health

Half (50%) of <u>all</u> clients at the 1st visit rated their general health as good to excellent and 50% rated their general health as 'fair' or 'poor' (with just under a fifth, 18%, saying their general health was poor).

The mean score for general health at the 1st visit was **2.5** this increased to **2.9** at the evaluation follow up survey and this change was statistically significant ($p<0.001$; matched clients, n=935).

Figure 6 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 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 6: Self-rated general health status at 1st visit and evaluation follow-up, matched sample (n=935)



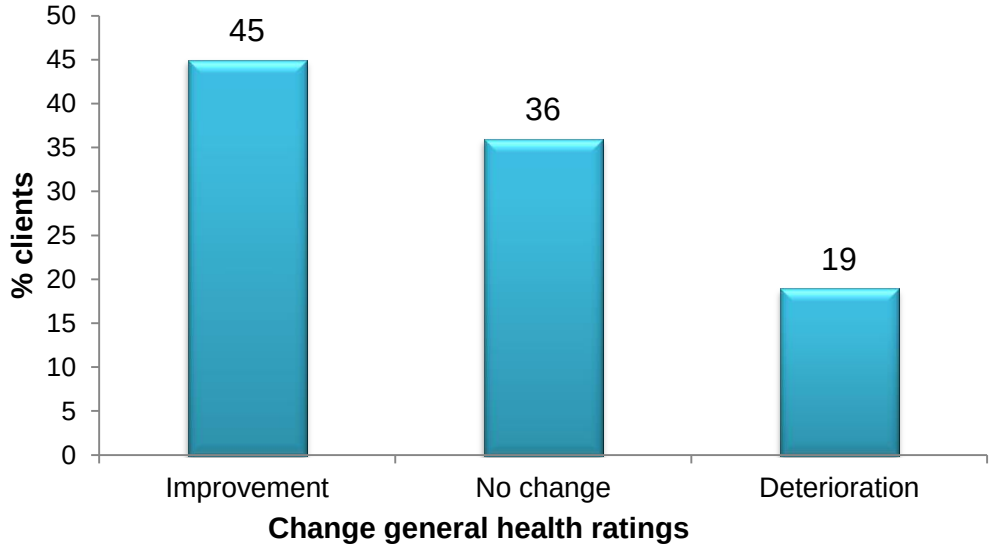
Categorical change between the 1st visit and evaluation follow-up were analysed to assess improvements in general health. For instance, if clients rated their general health as 'poor' at the 1st visit and 'fair', 'good', 'very good' or excellent' at the evaluation follow-up, this was analysed as improvement. Deterioration was noted if clients rated their general health as 'good' at the 1st visit but 'fair' or 'poor' at the evaluation follow-up. No change was noted in instances whereby clients' categorical rating of general health did not change between the 1st visit and evaluation follow-up.

Using this method to measure improvements, Figure 7 shows the change in general health. Overall, 45% of clients reported an improvement in general health with 36% reporting no change and 19% showing deterioration. Improvement in general health was significantly related to the following:

- Improvements were highest in Zones 3 (55%) but deterioration was highest in Zone 13 (40%, p<.05);
- Those referred for a home safety check were more likely to improve compared to those not referred (49% vs. 40%; p<.05);
- Those successful following a home safety check were more likely to improve than those who were not successful (50% vs. 41%; p<.05);
- Those successful following a transport referral were more likely to improve compared to those who were not successful (48% vs. 45%; p<.05);
- Those successful for anything were more likely to improve compared to those who were not successful (49% vs. 37%, p<.01);

- Improvement in general health was not related to gender, any vulnerable groups, deprivation quintile, or any other referral types (referred or successful).

Figure 7: Change in self-report general health between 1st visit and evaluation follow-up, matched sample (n=935)



4.4.2 Positive mental wellbeing

Seven items were used to measure positive mental wellbeing with items being scored (from 7 to 35) and multiplied by 2 (for comparisons to the full item scale) to give an overall score of wellbeing. The mean score for the full sample at the 1st visit was 54.3 and this was above the mean score for the general population in Northern Ireland (M=51.0[viii]). It is not possible to tell from the scale whether this score indicates good/poor mental wellbeing as cut offs have not been developed.

The mean score for matched clients was **55.7** for the 1st visit and this significantly increased to **63.2** at the evaluation follow-up (p<.001, n=835). This increase should be treated with caution as the impact of ceiling effects may have rendered this analysis unreliable (see page 43 for a more detailed discussion). No further analysis was undertaken based on positive mental wellbeing.

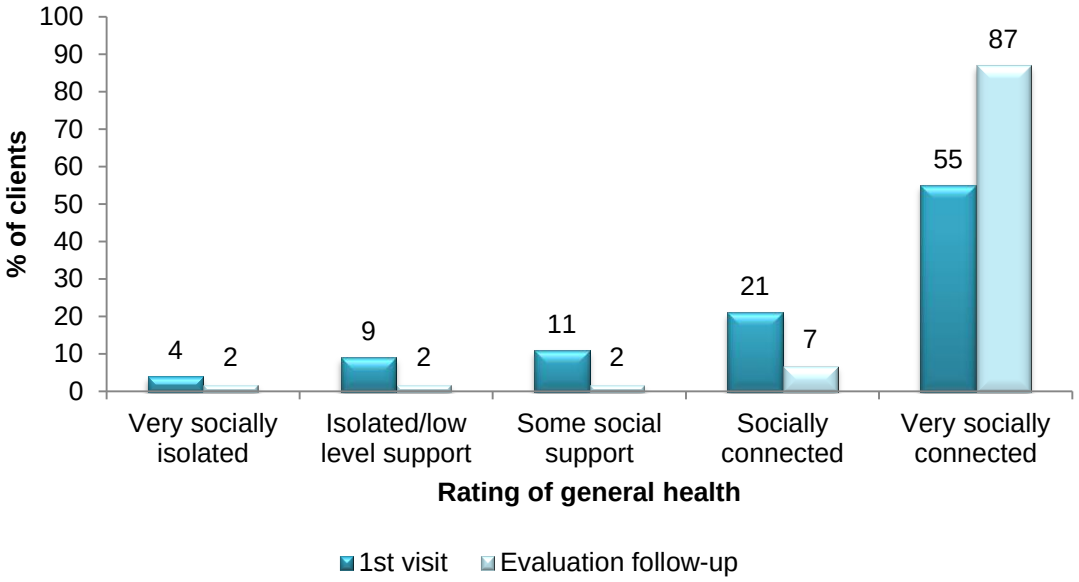
4.4.3 Social connectedness (Friendship scale)

The majority of <u>all</u> clients (85%) at the 1st visit had at least some level of social support, 9% were isolated or had low level social support and 5% were very socially isolated.

The mean score for social connectedness at the 1st visit was **20.6** and this significantly increased to **23.0** at the evaluation follow-up (p<0.001, matched clients n=798).

Figure 8 shows categories of social connectedness at the 1st visit and evaluation follow-up for the matched sample. Whilst the majority of clients were socially connected at the 1st visit, the proportion of clients who were categorised as being 'very socially connected' increased.

Figure 8: Social connectedness at 1st visit and evaluation follow-up, matched sample (n=798)

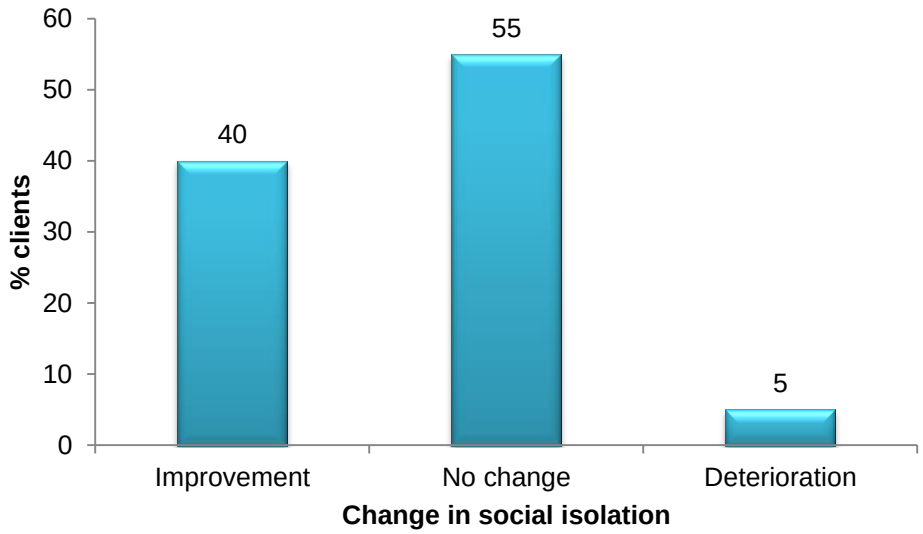


As with ratings of general health, change in categories of social connectedness were used to indicate whether clients improved, deteriorated or whether there was no change in social connectedness.

Using this method, Figure 9 shows that two fifths (40%) became more socially connected, 55% showed no change and 5% became more socially isolated. Improvement in social connectedness was significantly related to the following:

- Improvements in social connectedness were highest in zone 14 (61%) and lowest in zone 1 were deterioration was highest (14%) p<.001);
- Lone adults (46% vs. 37%, p<.01) and disabled people (47% vs. 37%, p<.01) were more likely to improve in terms of social connectedness compared to those not in these vulnerable groups;
- Identified vulnerable farmers/fishermen were less likely to improve in terms of social connectedness compared to those who were not in this vulnerable group (31% vs. 41%, p<.05).
- Clients referred for BECs (45% vs. 34%, p<.05) and universal services (48% vs. 38%, p<.05) were significantly more likely to improve compared to those not referred;
- Clients successful outcome following a referral for BECs (43% vs. 40%, p<.05) and universal services (57% vs. 38%, p<.01) were more likely to improve;
- Improvement in social connectedness was not significantly related to gender, deprivation or any other referral type (referred and successful) or target group.

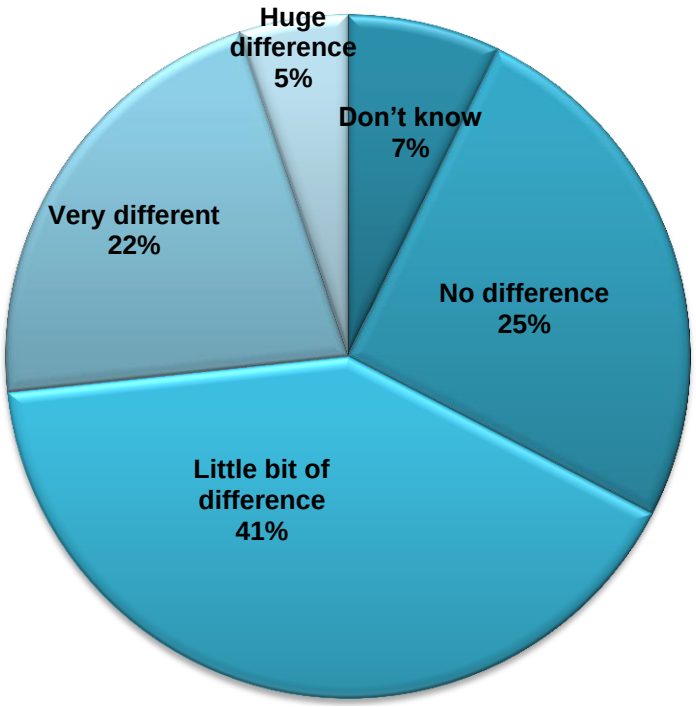
Figure 9: Change in social connectedness between 1st visit and evaluation follow-up, matched sample (n=798)



4.4.4 Difference MARA made

At the evaluation follow-up, clients were asked to report on the difference they felt MARA made to their lives (Figure 10). 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*'.

Figure 10: Client ratings of the difference MARA made to their lives (n=1,102)



4.4.5 Key messages

The key findings associated with health and wellbeing is presented in Table 16. Overall, clients' ratings of general health and social connectedness significantly increased between the 1st visit and the evaluation follow-up.

Table 16: Key findings for health and wellbeing

Health measure	Change	Associated with
General health	Significantly increased	Universal services referral Successful transport membership Disabled
Social connectedness	Significantly increased	Lone adults Disabled Not identified vulnerable farmers/fishermen Referral to and successful outcome for BECs and universal services

Overall, given the findings presented in this section, it is concluded that participation in MARA improved client general health and social connectedness.

General health particularly improved for those who received a home safety referral and those who had a successful outcome following a referral to a transport agency or a home safety check. This is an important finding given that improvements to general health may not be expected given the client profile.

Given that a key tenet of MARA is to improve social connectedness, it is encouraging that significant increases in social connectedness were noted. This is even more encouraging given that levels of social connectedness were already high with more than half at the 1st visit being 'very socially connected'.

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

Deloitte were commissioned to undertake an independent evaluation of MARA Phase II to calculate and evaluate the economic value of the project and conduct a social return on investment for the benefits to clients [ix]. Deloitte also engaged with representatives from lead organisations and strategic stakeholders representing key referral partners (please see their report for fuller discussion relating to the external evaluation).

Deloitte highlighted that MARA serves to reach individuals who are unable or unwilling to access services, grants and benefits through mainstream routes. Their report notes that MARA takes a unique community development approach that benefits a wide range of stakeholders. Given MARA's wide-reaching nature, the scope of the external evaluation was to focus primarily on the impact for clients. Deloitte found a social return on investment of £6.00 per every £1 invested. They projected the social return over a five-year period would equate to £15.52 for every £1 invested. Furthermore, Deloitte concluded that MARA provided value for money and that MARA was effective in maximising access for clients.

4.6 Key questions arising for future development

A number of key issues arose from the data presented which required further exploration. These key questions were not in the evaluation objectives but required to be addressed to provide some insight in the future development of MARA. This was especially necessary given the increasing financial pressures placed on all statutory agencies as a result of budget cuts.

4.6.1 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?*' Table 17 compares the referrals and successful outcomes for older and younger people.

Older people were 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. Therefore, these associations were to be expected. However, older people were significantly more likely 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 using these targets it would not be appropriate to focus on older people. However, if we focus on successful outcomes, older people are more likely to benefit. Therefore, for cost effectiveness, it would be more appropriate to limit inclusion to older people in this instance.

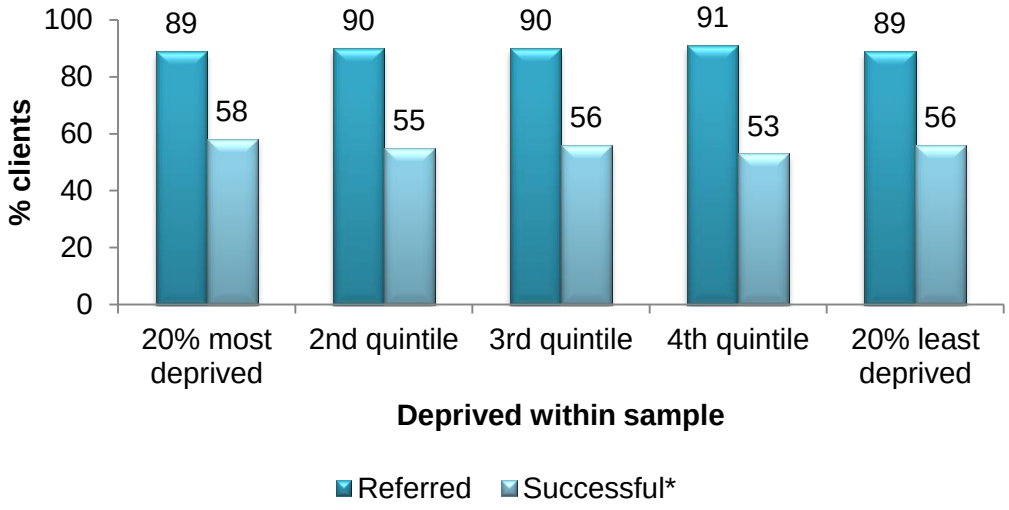
Table 17: Comparisons between older and younger people for referrals and outcomes

	Under 65s	Over 65s
Max number of referrals	7	9
Max number of successful outcomes	6	5
Referrals…	%	%
Home improvement scheme	53	53
Home safety check* **	**43**	**57**
BECs	53	54
Local services	28	28
Universal services* **	**12**	**25**
Transport* **	**18**	**23**
Successful outcomes		
Home improvement scheme*	**15**	**16**
Home safety check* **	**29**	**48**
BECs* **	**3**	**4**
Local services	6	6
Universal services* **	**5**	**10**
Transport* **	**7**	**10**

4.6.2 Should MARA only focus on areas of high deprivation?

Analysis looked at the level of referral and success by deprivation quintile to assess of there was any association between deprivation levels and likelihood to be referred or to have a successful outcome from referral. Whilst being referred for any service, benefit or grant was not associated with deprivation, successful claims for any service, benefit or grant by deprivation quintile was significant ($p<0.03$; Figure 11). However, the pattern was not clear. The highest proportion of clients successful following a referral was in the 20% most deprived SOAs. However, the lowest was in the fourth quintile, not the fifth, as would be expected if there was a clear association with deprivation.

Figure 11: Deprivation quintiles by those referred and successful for services, grants and benefits



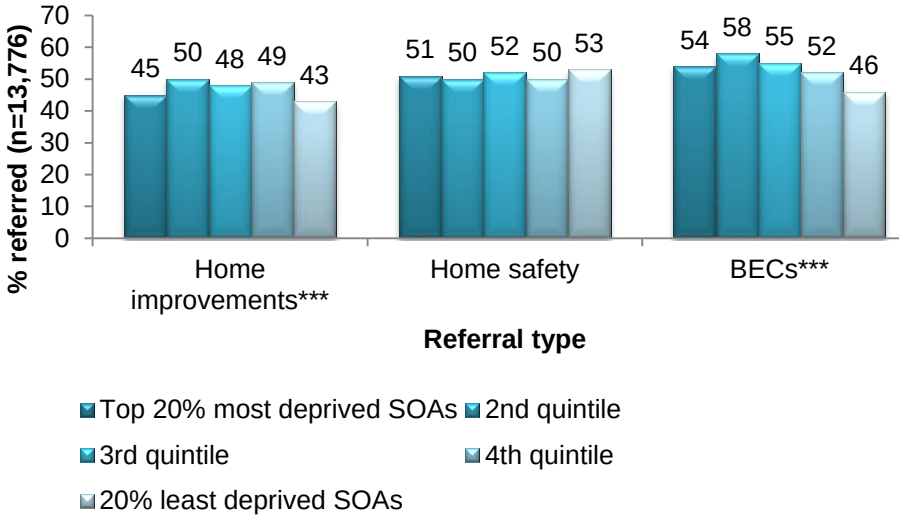
When analysed by the different referral types, again a clear pattern did not emerge. For referrals, the following was found (see Figure 12):

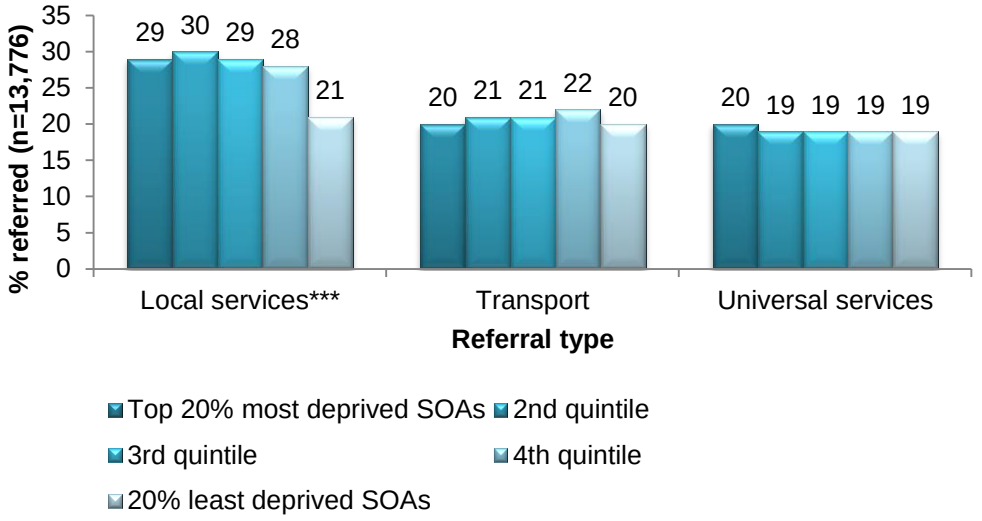
- Those living in the least deprived areas were significantly less likely to be referred to home improvement schemes, BECs and local services compared to more deprived areas.
- No significant associations between deprivation and referral for home safety, transport or universal services.
- Overall, there was no association between being referred for any service, benefit and/or grant and deprivation.

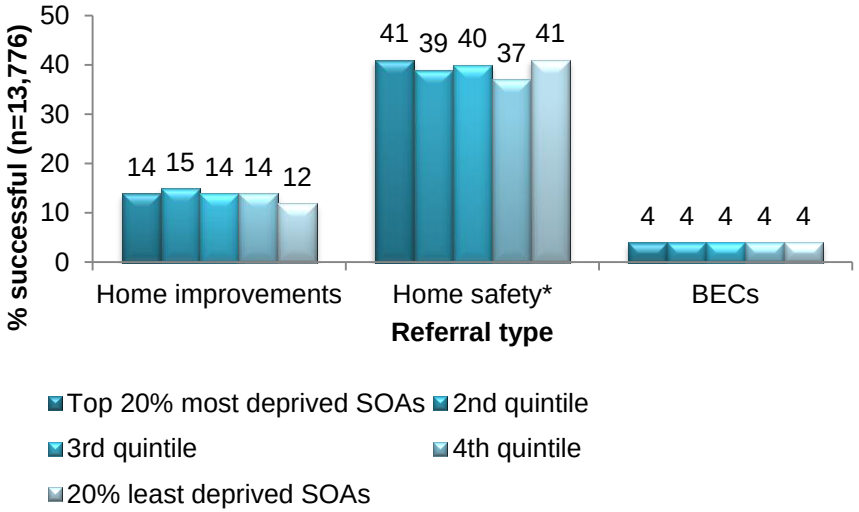
Findings for deprivation area and referral success were mixed:

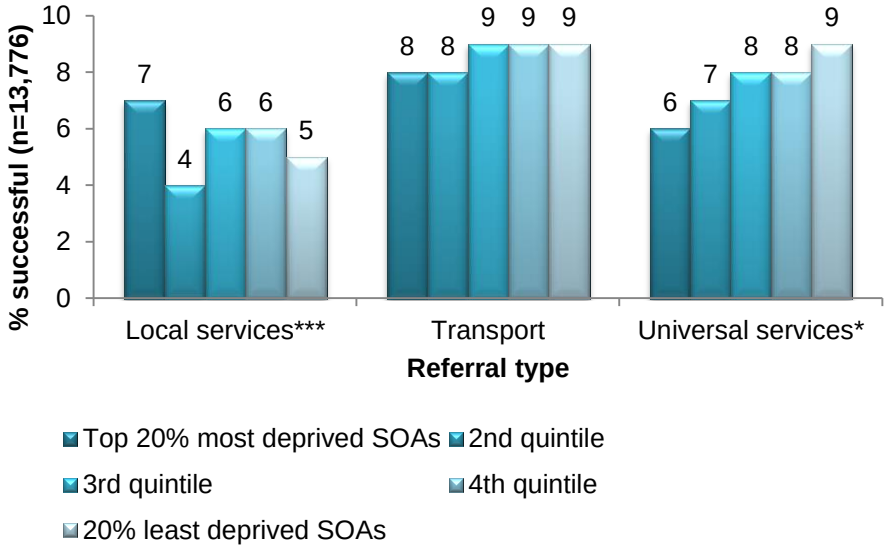
- Those living in the 4th quintile (the 2nd least deprived areas) area were least likely to be successful following a Home Safety referral. Furthermore, success rates for those living in the most (1st quintile) and least deprived areas (5th quintile) were equivalent. Those living in the 2nd quintile were least likely to have a successful outcome for local services, followed by those in the least deprived areas (5th quintile).

Figure 12: Deprivation quintile by referred and successful for each of the individual referral types









- For universal services, those living in the least deprived area (5th quintile) were most likely to have a successful outcome. There was no relationship between level of deprivation and successful outcomes following referrals for BECs, home improvements and transport.
- Overall, those living in the 4th deprived quintile were least likely to have a successful outcome for any referral.

There were a number of findings that indicated that targeting based solely on geographical deprivation would not be appropriate going forward. There was success for universal services in the least deprived quintile and 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. Provided 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.

4.6.3 Does the holistic approach have a cumulative effect?

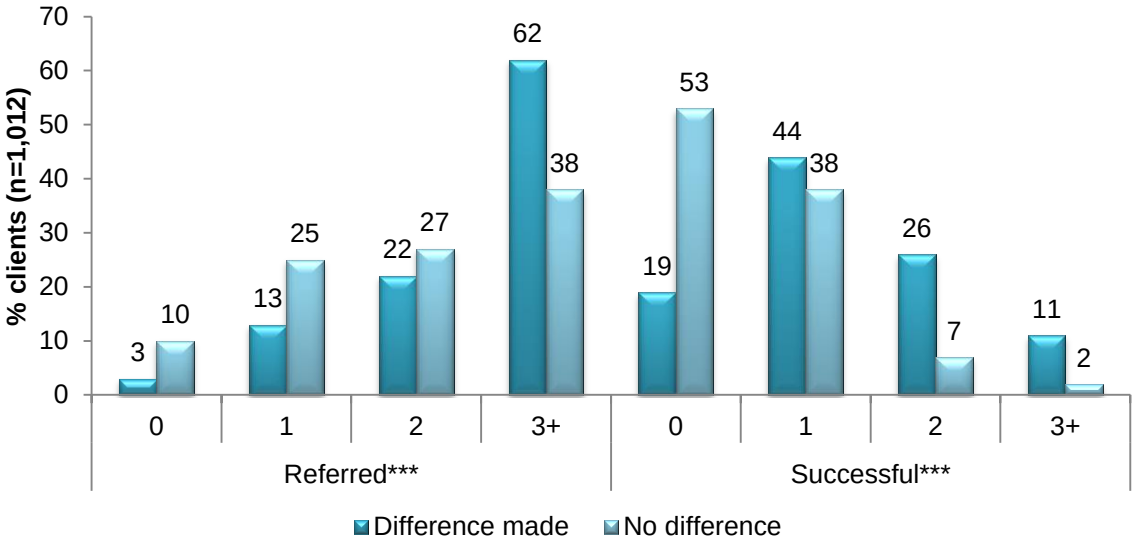
MARA takes a holistic approach by offering clients a wide range of services, benefits and/or grants by assessing client need at one time. It is difficult to investigate whether this holistic approach has a cumulative effect as the effects of one outcome cannot be separated from another. However, analysis 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 (Figure 13).

Clients who had no, 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 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. The highest proportion of clients who said MARA made a difference to their lives was for those who had one successful claim. This is likely reflective of the finding that the majority of clients were successful for one service, benefit or grant only rather than those being successful for two or more claims being less likely to say MARA had made a difference to their quality of life.

Figure 13: Difference MARA made to clients' lives by the number of claims referred and successful for



There is a clear pattern between ratings of difference made and the number of referrals for clients. Any successful outcome for clients results in perceptions that MARA made a difference to their lives. Whilst this finding is positive, it does not appear to be related to the number of successful outcomes for clients. However, improvements in general health were associated with being successful for any service, benefit or grant (see section 4.4.1 for more detail). This was not reflected when analysed by the individual referral types (with the exception of transport) which suggested a cumulative effect. However, it is unclear from this analysis to make firm conclusions about the cumulative effect of MARA on clients.

5 Conclusions

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.

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.

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 benefitted 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.

The level of referrals and successful outcomes even in areas that are being revisited since the earlier Maximising Access project (2009-2011) 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.

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.

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.

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.

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.

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.

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.

5.2 The way forward: options for consideration

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 1, 2 and 3 are subject to budget availability and departmental priorities.

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Appendix A: Recommendations and action following evaluation of Phase I

Phase I evaluation recommendations	Phase II actions
DARD to provide a specific intervention is provided to meet the need highlighted in Phase I.	Funding was secured for Phase II to allow for the project to be rolled out to all rural areas of NI.
The community development approach should continue to be applied...This should include how potential lead organisations can demonstrate existing links/networks across the zones they intend to work across.	The approach adopted in Phase I was used in Phase II. As part of the tendering process, lead organisations were required to include evidence of existing links in the form of HIPAs.
Lead organisations to identify a plan to establish local steering groups to identify and target households.	Lead organisations contractually obliged to form steering groups and discuss issues relating to these groups at the LOFG.
The Regional steering group should include bodies representing the identified vulnerable groups (e.g., ethnic minorities, disabled, lone parents etc.)	The Regional Steering group is a cross departmental forum and by virtue all departments should be proofing policies and programmes in relation to Section 75
All key stakeholders should be fully aware of their roles and responsibilities and buy-in is ensured. This should include consideration of partnerships between lead organisations and referral agencies at a local level to ensure consistency in referrals, and monitoring referrals.	This will be encouraged and reinforced at Lead Organisation Forum and in meetings with referral partner organisations.
Consideration to be given to taking opportunities to share best practice with agencies when opportunities are available. 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 long term.	Accepted and the MARA team continue to advocate sharing best practice at meetings with all referral partners and at the Regional Interdepartmental Forum.
Development of more robust selection criteria for enablers including more interactive training, and monitoring of quality of enablers, and a forum for enablers to gain support.	Enablers recruited using a formal recruitment process and were paid as employees of the lead organisation. Training was revised to be more relevant to the role and project managers monitored quality via shadowing on visits and data quality assessment.
The development of a full marketing plan for promotion at a strategic and operational level including sharing lessons/best practice with stakeholders, MARA branding and a proactive marketing plan to promote and raise awareness of the programme and impacts when available.	Consideration given as to how best to develop a marketing plan for the project. At operational level, the lead organisations continue to play a key role in marketing the project based on the community development ethos of MARA. Strategically, the MARA brand was established and widely promoted particularly within the health care sector by the Chief Executive of PHA.
Development of a formal mechanism for sharing learning across the project (e.g., an intranet site)	Regular meetings with all lead organisations and representatives from PHA and DARD have served as a formal mechanism to share learning across the

	project. The face-to-face approach was deemed the most suitable vessel for this.
Directly engage with a regional representative across the key vulnerable groups to help reach hard to reach groups.	This was the remit of lead organisations who were to proactively engage with key representative groups in their local areas to achieve this goal.
All stakeholders to ensure referral tracking is consistent.	The IT system enables electronic referral and the appointment of an IT systems manager to work with and support referral partners will ensure consistency.
A systematic approach should be used to collect householder feedback with feedback being addressed on an on-going basis.	Implementation of a second visit will be key to collecting feedback from householders. In addition, the evaluation will ensure that 8% of households participating are contacted for feedback.
Consideration to be given to best practice for quality controls in working directly with vulnerable groups – e.g. enhanced training.	Enabler and project manager training given included 'Working with vulnerable adults' and 'Safetalk' to help them become more aware of working with the most vulnerable clients.
To take time to identify key people who have extensive local knowledge and to ensure a representative spread of people across the geographical area…It is important that relationships are developed in advance of going into the community to ensure appropriate targeting.	The establishment of HIPAs in each zone are a mandatory part of the procurement process.

Appendix B: Zones with corresponding lead organisations and geographical reach

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	Coundty 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

Appendix C: Validating the evaluation follow up sample

Table 18: Comparison of households included in MARA Phase II for the 1st visit and evaluation follow-up by zone

Zone	Lead organisation	Households achieved n (%)	Evaluation follow up n (% households)
1	TADA	459 (108)	42
2	CWSAN	1191 (101)	119
3	CDRCN	1071 (104)	91
4	RNWCS	956 (106)	91
5	NACN	1617 (98)	134
6	OFRA	471 (101)	38
7	CRUN	919 (100)	73
8	COSTA	1316 (100)	109
9	SPACE	1357 (100)	109
10	CDRCN	834 (102)	68
12	TADA	873 (103)	65
13	SACN	351 (100)	28
14	FRCN	670 (100)	64
	Total	**12085**	**1031 (8%)**

Table 19: Comparison of target group status between 1st assessment and evaluation follow-up

Vulnerable groups	First assessments n	First assessments %	Evaluation follow-up n	Evaluation follow-up %
Single parent	545	4	15	2
Ethnic minority	43	<1	2	<1
Older people	7697	56	691	67
Lone adult	4295	31	352	34
Low household income[11]	4152	43	317	38
Carers	2461	18	179	17
Disabled[12]	3729	32	379	39
Identified vulnerable farmers/fishermen	1565	11	124	12

[11] Low income: income not provided for some so base number is lower for those completing the 1st assessment (n=9,778) and for 2nd assessment (n=8,374) and for the evaluation follow-up (n=842).
[12] 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 first assessments (n=11,739), for second assessments (n=9,609) and the evaluation follow-up (n=973).

Appendix D: Charts relating to geography

Figure 14: Proportion of clients in Phase II by Council area

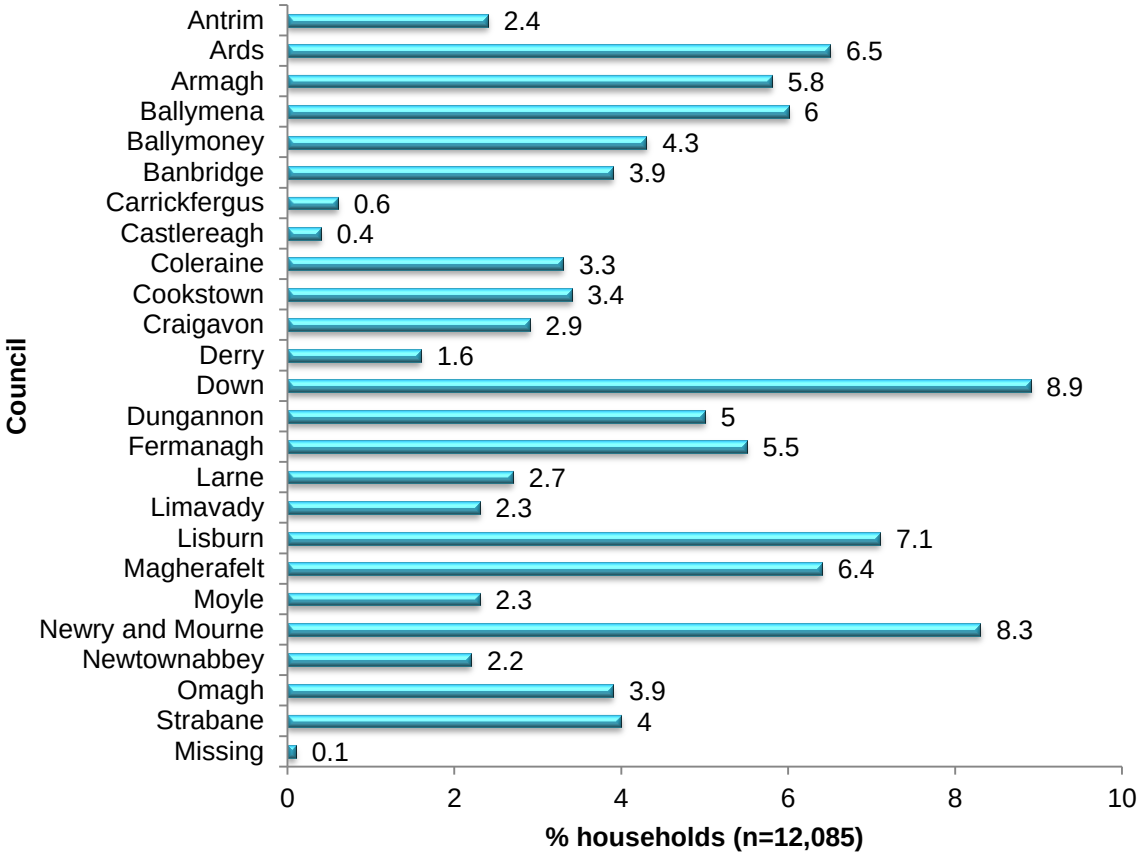


Figure 15: Referral source for households (n=12,085)

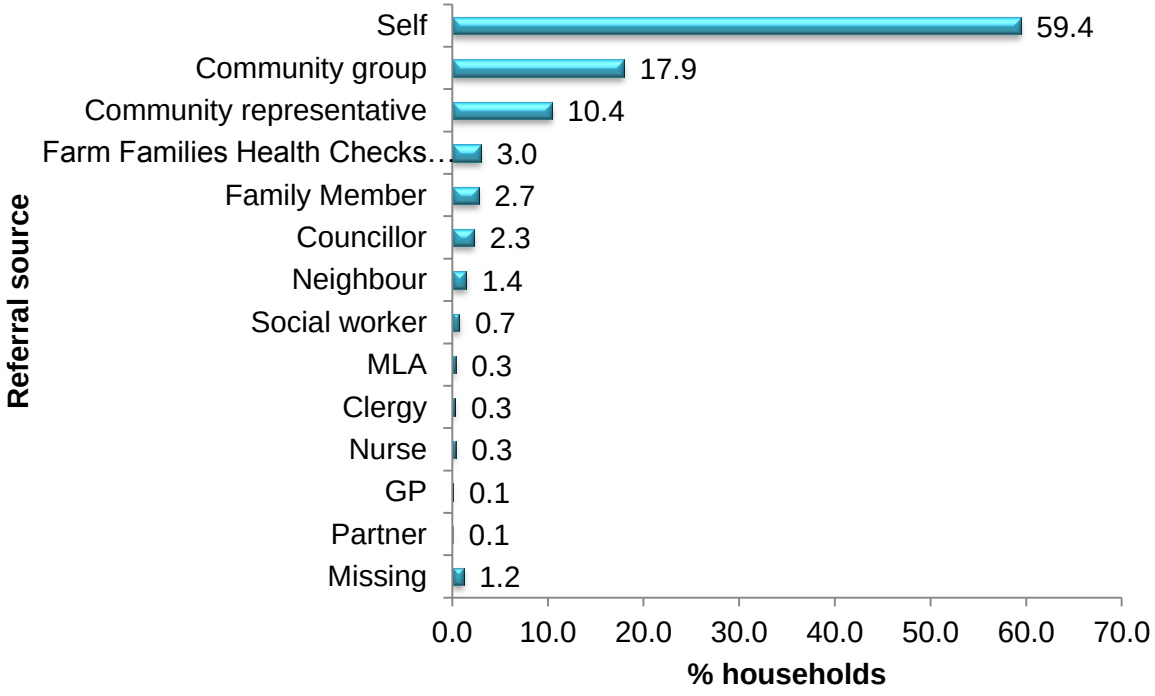
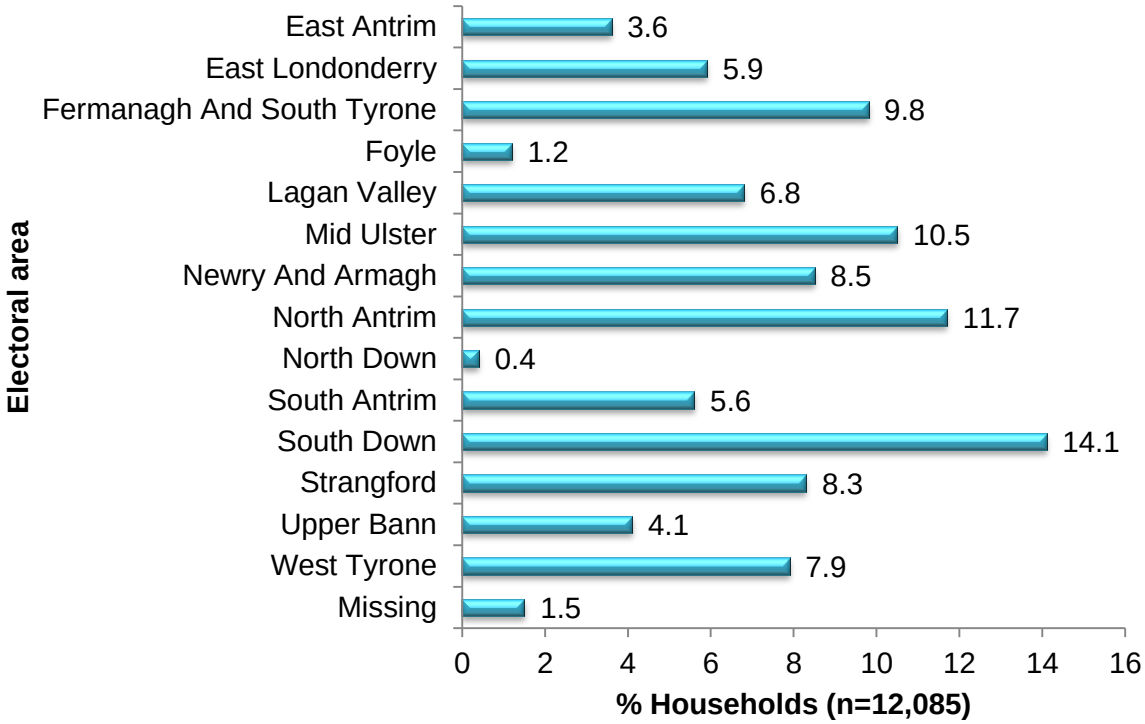


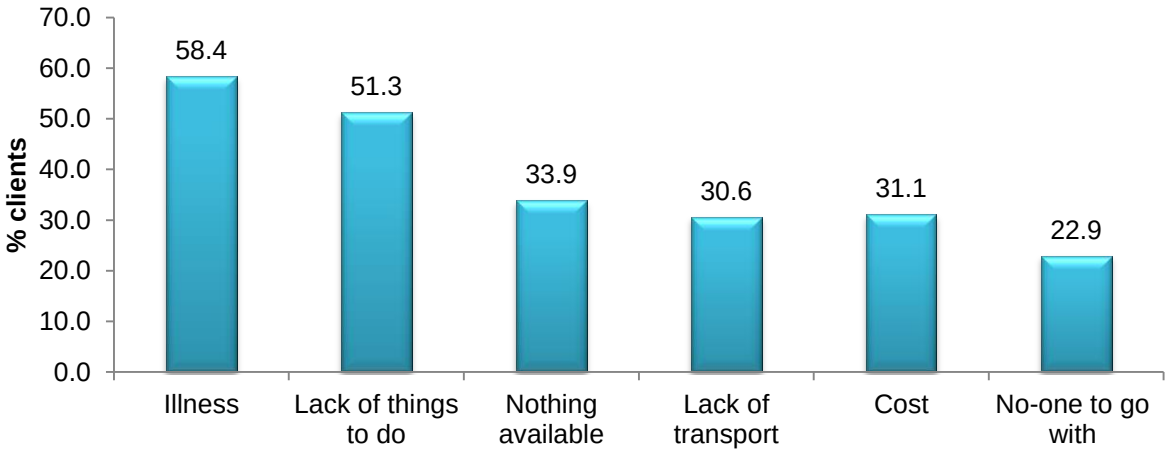
Figure 16: Proportion of households by electoral area (n=12,085)



Appendix E: Additional information relating to local services

Despite clients being socially connected (see section 4.4.3), there was demand for local services among this population. In total, 15% (equating to 2,107 clients) said they would like to get out more often at the 1st visit. However, there were a number of barriers preventing clients from doing so (Figure 17). Over half said that poor health was preventing them doing things they enjoy which was likely to be reflective of the age profile of the clients. Over half said there was lack of things to do in their area. A third said there nothing suitable in their area. Three in ten said that cost was a barrier, and just over a fifth said it was because they have no-one to go with.

Figure 17: Barriers to getting out more for those who would like to do so (n=2,107)



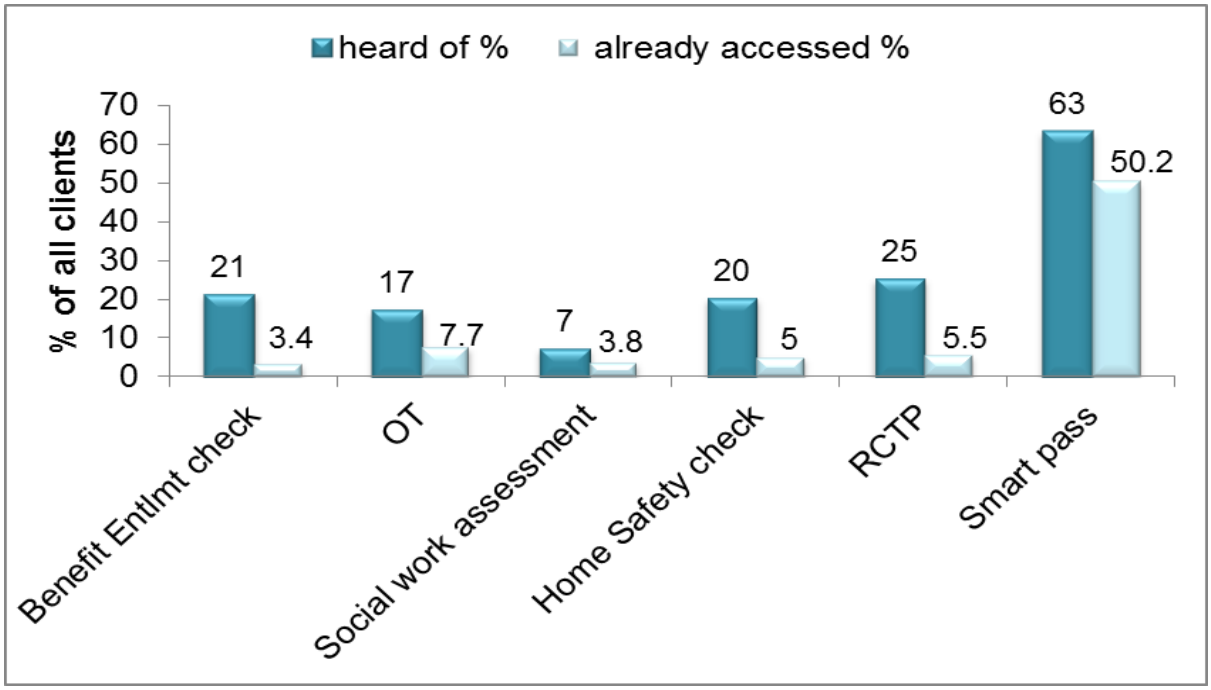
To help provide clients with an idea of the services available, lead organisations drafted 'local directories' for enablers to go through and leave with clients at the 1st visit. The local directories included a list of services available in the local areas with contact details for each. The majority of lead organisations created two or three local directories (with some creating up to 18) to ensure they were local. To ensure they were up-to-date, lead organisations updated the directories bi-annually with many creating another list of services within the lead organisation and updating these weekly. The local directories appear to have made an impact with clients as 82% at the evaluation follow-up (approximately 12 months post programme) remembered being given a directory and 34% said they had used the local directory to access services in their areas. However, identification of those who actually attended local services proved difficult.

Appendix F: Reasons for not accessing services

All clients were asked about their awareness of services and if they already had access to them. Figure 18 shows that the majority had heard of and had accessed the Translink Smartpass. One quarter of clients was aware of RCTP in their area and one fifth had heard of BECs and Home Safety checks.

Access to services, grants and benefits was low for all services, grants and benefits with the exception of Smartpass.

Figure 18: Proportion of clients who had heard or already accessed services, grants and benefits (n=13,784)



- Reasons for not having accessed BECs include 20% of clients not thinking they were eligible, and 17% not knowing how to apply. Table 21 lists the reasons.

Table 20: Reasons for not having accessed a BECs prior to taking part in MARA (n=2,880)

Reason for not accessing:	BECs	
	n (heard of) = 2880	%
Didn't think was eligible	583	20
Didn't know how to apply	508	17
Lack of awareness	175	6
Have sufficient	161	6
Turned down	127	4
Worried about impact	92	3
Not worth it	91	3
Previous bad experience	49	2

Confidentiality	41	1
Stigma	13	1
Didn't have the time	12	<1
Don't want to apply for this	-	-
None of the above	743	26

- There was a variety of reasons for not having accessed other services (Table 22). For instance, 18% thought they would not be eligible for a home safety check, 13% of people did not know how to apply for an OT assessment. In many other cases, clients were already satisfied with their services or felt they did not need of them at the time of asking.

Table 21: Reasons for not having accessed other services

	OT (n=2291)	Social work assessment (n=1014)	Home safety check (n=2755)	RCTP (n=3464)	Smart pass (n=8666)
	%	%	%	%	%
Didn't think was eligible	9	4	18	2	4
Didn't know how to apply	13	5		9	3
Turned down/not eligible	1	1	<1	<1	<1
Didn't want to apply for this	2	2	3	4	1
Previous application or access has expired	7	2	-	1	1
Satisfied with existing arrangements	14	26	-	23	3
I didn't have all the information needed to apply	3	1		2	1
I don't think I need this at present	6	15	9	16	2
I have applied and am waiting on a response	4	1	1	<1	<1
Not a priority group	-	-	6	-	-
Didn't realise this available in my area	-	-	13	-	9
NIHE carry out checks	-	-	1	-	-
None of the above	23	23	17	16	-

Table 22: Proportion of clients who had heard of services, had recent access/checks and who benefited from MARA

Referral type	Heard of (n=13784)		Recent	
	N	%	Number who had recent checks or access	Number of those who already had recent access/check but now receiving additional services as result of MARA (%)
BECs	2880	21	471 check	4 (1%)
OT assessment	2291	17	1063 have OT	49 (incl. advice) (5%)
Social work assessment	1014	7	534 assessment	7 (1%)
Home Safety check	2755	20	679 check	3 (<1%)
RCTP	3464	25	763 registered members	3 (<1%)
Smartpass	8666	63	6921	0

Appendix G: Data cleaning procedures

When downloaded, the MARA data was thoroughly cleaned to ensure the remaining sample was robust and included only genuine cases. Data cleaning procedures ensured the findings presented in this report were valid and reliable. Figure 19 shows the process undertaken to clean the dataset:

Figure 19: Data cleaning procedures