Controlling Migration Fund evaluation

Project-level evaluation report

Lead local authority: Cambridgeshire

Project name: Tackling Alcohol Misuse

August 2022

Department for Levelling Up, Housing and Communities

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Executive summary

This project-level evaluation report presents the key findings relating to the delivery of and outcomes achieved by the Tackling Alcohol Misuse project, led by Cambridgeshire County Council.

Project overview and objectives

Cambridgeshire County Council received a Controlling Migration Fund (CMF) grant of £283,347 for the Tackling Alcohol Misuse project. The project aimed to address alcohol misuse and wider health behaviours among the Eastern European community[1] in Wisbech and Peterborough. Activities included: training outreach and community workers from the Eastern European community and the provision of information and advice on alcohol misuse and alcohol-related treatments to Eastern European communities. These activities aimed to contribute towards the CMF outcomes listed in table 1.1.

Ipsos MORI undertook an evaluation of the Tackling Alcohol Misuse project between November 2018 and December 2019. A theory-based approach was taken to the evaluation, with the aim of reviewing and testing the outputs and outcomes intended through the project activities[2]. Evaluation activities included: a scoping phase with project staff, including the development of a project logic model; interviews with project staff, delivery partners and wider stakeholders; a focus group and interviews with beneficiaries; a short pre- and post- beneficiary questionnaire drafted by Ipsos MORI and administered by project staff; and a review of monitoring information and secondary data collected and provided by the project.

Progress towards intended outcomes

Progress towards intended CMF-level intermediate (and longer-term outcomes where expected during the evaluation timeframe) is summarised in table 1.1 below. Evidence indicates that the project contributed to four outcomes, while there is limited evidence that the project contributed towards the two remaining outcomes.

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[1] While the project did not define project participants by nationality, recent migration was considered particularly high from ‘A8’ accession countries (Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia).

[2] Theory-based approaches to evaluation use an explicit theory of change to draw conclusions about whether and how an intervention contributed to observed results. For more information, see:

https://www.canada.ca/en/treasury-board-secretariat/services/audit-evaluation/centre-excellence-evaluation/theory-based-approaches-evaluation-concepts-practices.html

Table 1.1: Summary of progress towards intended outcomes

Intended Outcome	**Assessment of progress made by December 2019**
Intermediate outcome 1: Expanded and strengthened networks and partnerships	The evaluation found evidence that the project contributed to strengthening existing networks and partnerships with civil society organisations and GPs and creating new partnerships with local employers. Identifying shared objectives with local support organisations and workplaces was key to successful partnerships.
Intermediate outcome 2: Increased coordination and cooperation between agencies	The evaluation found evidence that staff signposted and referred beneficiaries to wider services as part of the support provided, indicating increased collaboration and coordination between agencies.
Intermediate outcome 3: Acquired expertise to deal with local issues	The available evidence indicates that the project contributed towards increasing the expertise of staff and delivery partners to address the local issue of alcohol abuse and other support needs of the Eastern European community in both areas. This knowledge contributed to the decision to create a dedicated housing team to support the Eastern European community in Wisbech.
Intermediate outcome 4: Increased understanding and access to public services	The evidence indicates that the project has increased access to public services and contributed to greater awareness and understanding of the harms of alcohol misuse among target beneficiaries. However, cultural barriers to behaviour change remained prevalent, suggesting that further sustained work in this area may be required.
Intermediate outcome 5: Improved quality of public space	The evaluation found little direct evidence of improved quality of public space, in part due to the limited evidence gathered on wider residents' perspectives. The available data suggests that street drinking incidents and associated littering were reduced, which could in part be due to the

	outreach work conducted through the project. However, Fenland District Council residents' surveys suggest that street drinking remains a concern among residents.
Longer-term outcome 1: Increased well-being (migrants)	There is mixed evidence on the extent to which the project contributed to improving the wellbeing of project beneficiaries. Secondary data shows that there was a reduction in the number of hospital admissions due to alcohol specific conditions during the project period in Peterborough, dropping below the England average for the first time in a decade. However, in Fenland, hospital admissions due to alcohol specific conditions remained quite high.

Additionally, there was evidence to suggest that the project contributed to two unintended outcomes: **improved housing advice** and **housing issues identified and resolved** in both areas.

The reduction in littering and street incidents suggests that the project is likely to contribute towards two longer-term CMF outcomes in future: **reduced crime and antisocial behaviour** and **improved cleanliness and quality of public space**.

What works?

- The project built a strong network of partners that enabled project staff to deliver services more effectively and efficiently by, for example, carrying out joint outreach work.
- By hiring project staff with relevant language skills and community outreach experience, the project increased trust among the Easter European community and raised awareness around alcohol harms and services available.
- The street outreach work and social media promotion activities helped project staff to recruit Eastern European community members who could benefit from the project.
- The project encountered some cultural barriers to engaging intended beneficiaries in project activities. This included difficulties engaging Eastern European beneficiaries in volunteering activities (which staff felt reflected a cultural reluctance to take part in unpaid work) and in engaging family members and friends of service users in group sessions (due to a perceived cultural stigma surrounding alcoholism).

- A cost benefit analysis of monetizable project outcomes related to reduced alcohol dependency estimates that every £1 of CMF funding returned on average £1.48 of monetizable economic benefit to society.

For whom?

- Eastern European community members with alcohol misuse issues were the main beneficiaries of the project activities. The outreach work carried out was particularly beneficial in building trust among Eastern European community members drinking on the streets, many of whom were also rough sleepers.

- Indirectly, there was some evidence that the project may have contributed to reducing tensions between Eastern European community members and the wider local resident population in Wisbech, by addressing issues caused by street drinking. However, the project did not include activities targeted directly at the wider local resident population and therefore the evaluation did not explore resident perspectives directly.

- The local authority benefited from the project through increasing its knowledge on the existing socio-economic and health needs of the Eastern European community, an expanded network of partners and organisations that the local authority collaborates with and improved signposting to available health services.

In what circumstances?

- The project arose out of an identified need for improved access to alcohol recovery services and wider health services among Eastern European community members living in Wisbech and Peterborough.

- The project hired outreach and recovery workers that spoke Eastern European languages and with experience in community engagement. This was important in order to build trust, as Eastern European community members were considered reluctant to engage with services due to language and cultural barriers.

- While both areas had similar delivery models, reaching out to Eastern European community members at outreach walks worked more effectively in Wisbech than in Peterborough. Wisbech had a smaller population and street drinkers tended to be based in tightly defined public spaces.

1 Introduction

The Department for Levelling Up, Housing and Communities (DLUHC), then known as the Ministry for Housing, Communities and Local Government, commissioned Ipsos MORI and the Migration Observatory at the University of Oxford to conduct an independent evaluation of the Controlling Migration Fund (CMF) in May 2018. Launched in November 2016, the CMF aims to help local authorities across England develop and deliver activities to mitigate the perceived negative impacts of recent and unexpected migration on communities in their area. DLUHC provided funding to local authorities to deliver projects that aim to address local service pressures, tailored to their context and needs. While the primary emphasis is on relieving pressure on public services in a way that delivers benefits to the established population, the fund also seeks to support wider community cohesion and the integration of recent migrants and, in gaining a greater understanding of the local migration data landscape where there is currently a lack of accurate local data.

Project-level evaluations of 14 CMF-funded projects were conducted as part of the CMF evaluation. The project-level evaluations aim to assess the effectiveness of various project approaches in delivering against their local-level objectives and those of the wider fund[3]. They seek to build an understanding of what works, for whom and in what context to relieve pressure on local services due to recent or unexpected migration. This project-level evaluation report presents the key findings relating to the delivery and outcomes for the Tackling Alcohol Misuse project led by Cambridgeshire County Council.

The area context

Cambridgeshire County Council applied for CMF funding after identifying issues surrounding alcohol misuse among the Eastern European migrant population[4] in Peterborough and Wisbech. A Migrant and Refugee Needs Assessment for Cambridgeshire, carried out by the County Council and Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) in 2016, identified the East of England as an area with high levels of migration in comparison to other areas of the United Kingdom[5] (particularly from European Union ‘A8’ accession countries[6]). The rise in international migration was particularly high in Fenland (where Wisbech is located) and Peterborough[7]. Between 2006 and 2011, the number of non-UK born citizens arriving in Fenland and Peterborough increased four-fold and in 2016 Wisbech contained five of the 10 wards with the highest proportion of Eastern Europeans in Cambridgeshire[8].

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[3] An overall Theory of Change, created during the scoping stage, outlines the intermediate and longer-term outcomes (see Appendix 1).

[4] The project did not define project beneficiaries by nationality,but targeting the project at the “Eastern European” community generally.

[5] https://cambridgeshireinsight.org.uk/wp-content/uploads/2018/09/Cambs-Migrant-JSNA-full-v12_0-FINAL.pdf

[6] Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia

[7] With rises in non-UK population from 2,641 to 8,209 (210.8%) in Fenland and 15,268 to 37,892 in Peterborough (148.2%) between 2001 and 2011 (see footnote 4 above).

[8] Ibid.

In January 2017, the Home Office recognised both areas as Local Alcohol Action Areas (LAAA)[9]. Data on service users provided by two local support organisations operating in Cambridgeshire (Change Grow Live (CGL) and Aspire Recovery Service (Aspire)[10] showed that, in 2016, approximately half of the identified street drinkers in Peterborough and most of the identified street drinkers in Wisbech were from Eastern European countries[11]. Moreover, service users and local authorities reported that lifestyle and alcohol recovery services in Peterborough and Wisbech relied heavily on interpreters, that impeded the relationship between recovery workers and clients and reduced engagement among Eastern European communities with recovery services[12]. Specific challenges identified by Cambridgeshire County Council as a result of street drinking among the Eastern European community are outlined below.

Pressure on health services

The Needs Assessment identified pressure on public services, particularly Accident and Emergency (A&E) services, due to health issues among Eastern European residents caused by high levels of alcohol consumption. The local authority reported that staff at Peterborough City Hospital (PCH) had seen high numbers of presentations of Eastern European patients with severe health problems in 2016[13]. The Hospital Alcohol Liaison service at PCH also reported an increase in referrals of Eastern European patients to alcohol recovery treatments (from 6% in 2012/13 to 10% in 2015/16)[14] [15]. The table below includes the number of referrals of Eastern European patients to alcohol recovery treatments over the last four years[16].

Table 1.2: Number of referrals

Year	Number of referrals	Change from previous year
2016/2017	50	38% decrease
2017/2018	59	18% increase
2018/2019	70	19% increase
2019/2020	75	7% increase

[9] https://www.john-gaunt.co.uk/news/local-alcohol-action-areas-laaa-phase-2-announced

[10] Aspire is the same organisation as CGL, but in Peterborough CGL is called Aspire.

[11] Data included in the CMF project bid

[12] Ibid.

[13] Ibid.

[14] Ibid.

[15] Updated figures were not available to the evaluation.

[16] Data provided by Local Authority

Alcohol-related crime

Cambridgeshire Constabulary identified foreign nationals as disproportionately responsible for alcohol-related crimes in Peterborough, including being drunk and disorderly, assault and driving under the influence of alcohol[17]. Based on a 2018 report on the impact of drugs and alcohol in Fenland, alcohol related crime increased by 54% between 2014 and 2016 in Wisbech[18]. To tackle the long-term public concern around street drinking and alcohol-related crime, a Public Spaces Protection Order (PSPO) was introduced in Wisbech in October 2017 to address alcohol-fuelled incidents and anti-social behaviour in the town.

Homelessness

The local authority emphasised that many of the Eastern Europeans reported drinking on the streets in Wisbech and Peterborough were also rough sleepers[19]. Peterborough had one of the highest rates of homelessness in the East of England, with more than 1,100 people living on the street in 2018[20]. A Fenland District Council representative linked homelessness among Eastern European community to mental health issues, drug and alcohol dependency, welfare cuts and poor private rental conditions[21].

Reduced quality of public space

As part of the needs assessment, the local authority identified concerns about the impact of street drinking on public spaces in Wisbech and Peterborough. The Wisbech Alcohol Partnership carried out preliminary outreach and engagement work to assess issues relating to street drinking and identified 41 people drinking on the streets in Wisbech[22]. In Wisbech, the local authority recorded 1,023 containers picked up from local streets, parks and around benches and playgrounds, representing a 52% increase compared to a similar survey in 2014[23]. A local newspaper report in 2016 identified street drinking by Eastern European people in Wisbech as an issue affecting community cohesion[24]. Street drinking and its impact on the quality of public spaces was also considered an issue in Peterborough, however no data was made available to the evaluation about the impact of street drinking on public spaces in this area.

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[17] Ibid.

[18] https://cambridgeshireinsight.org.uk/wp-content/uploads/2019/02/fenlandQ3___1.0.pdf

[19] Data included in the CMF project bid

[20] https://england.shelter.org.uk/media/press_releases/articles/320,000_people_in_britain_are_now_homeless,_as_numbers_keep_rising

[21] https://www.wisbechstandard.co.uk/news/plans-to-tackle-homelessness-in-fenland-1-5877013

[22] Data included in the CMF project bid

[23] Fenland District Council undertook a litter survey in Wisbech in August 2016

[24] Wisbech Standard, "New report shows how Wisbech is bearing the brunt of mass immigration and the strain it places on health, housing and education", available online: http://www.wisbechstandard.co.uk/news/new_report_shows_how_wisbech_is_bearing_the_brunt_of_mass_immigration_and_the_strain_it_places_on_health_housing_and_education_1_4653684

Resident concerns

Linked to the issue of street drinking outlined above, the needs assessment identified residents feeling uncomfortable using local parks and open spaces due to the high number of street drinkers and the number of alcohol containers found on the streets. According to the local authority, residents saw street drinking as giving neighbourhoods a negative image. This was reflected in local press and social media, for example the Wisbech Standard, which stated that these issues affected people's feelings around public safety and increased tension with the local resident population[25]. Moreover, in the Fenland District Council residents' surveys carried out quarterly in 2018 and 2019[26], street drinking was identified as one of the top four concerns (often the first or second concern) for residents[27]. Other key concerns included speeding/anti-social driving, burglary or theft and antisocial behaviour.

The CMF-funded project

Cambridgeshire District Council received £283,347 CMF funding in September 2017 for the Tackling Alcohol Misuse project. The two-year project (running from September 2017 to December 2019) focused on addressing alcohol misuse and wider health behaviours among the Eastern European community in Wisbech and Peterborough. The project aimed to deliver three activity strands, with small differences between the two project areas, outlined below.

Pre-treatment activities included promotional and outreach activities to raise awareness among Eastern European community members and increase engagement, as well as activities to engage partners in service delivery. These include:

- **Outreach and engagement work in the street** through walkabouts taking two to three hours and through visits to local day and night centres and other relevant agencies. The aim of the outreach and engagement work was to increase awareness among the Eastern European community of the behavioural change programmes and alcohol recovery treatments available to them through the project, and, if possible, engage potential beneficiaries with alcohol misuse problems to access treatment. These interactions were referred to as "advice and information contacts". The outreach activities also included attending night shelters and day centres and delivering brief advice sessions on alcohol misuse and available services.

- **Campaign activities to deliver alcohol harm reduction messages** (only in Peterborough). The aim of the campaign activities was similar to the outreach and engagement work, namely, to increase awareness among Eastern European

[25] Ibid.

[26] Unpublished survey data held by the local authority and shared by the project.

[27] Survey does not cover Peterborough.

community members about project activities available to them, including behavioural change programmes and alcohol recovery treatments. These activities were carried out by one service provider in Peterborough in several Eastern European languages using mainly social media channels (such as Facebook), but also by distributing education and referral resources (leaflets on alcohol harms and services available) delivered to partners and wider stakeholders to be made available to Eastern European community members.

- **Development of information, education and referral resources**. The project leads aimed to develop the following resources for beneficiaries: information leaflets on alcohol harms and available services in several Eastern European languages; education resources with detailed information about how alcohol harms people's health as well as services available for Eastern European community members involved in treatment, delivery partners and wider stakeholders; and referral resources with information about relevant services for Eastern European community members. Resources would be handed out by outreach workers during their activities, as well as made available in local day centres, night shelters and other relevant agencies and public services.

The project also intended to deliver **training activities**, including:

- Upskilling Eastern European community members and leaders to support the wider Eastern European community to address substance misuse. The project aimed to upskill Eastern European community members to become community leaders and raise awareness among the Eastern European community of the harms of alcohol consumption and available services to address substance misuse issues. In this way, the project aimed to build trust between Eastern European community members and service providers and increase engagement with services. This activity did not take place due to challenges explored in Chapter 3.

- Training for project staff and other professionals working with the Eastern European community to deliver advice services, delivered by service providers to their own staff and to other agencies in Peterborough. The project aimed to train professionals working with Eastern European communities to understand how Identification and Brief Advice (IBA)[28] works to be able to refer beneficiaries to the project. This included training for professionals working in housing, criminal justice, social work and local day centre staff and advice agencies. In this way, the project aimed to increase the number of Eastern European community members accessing the treatment service for Brief Advice and support community networks to address alcohol misuse among Eastern European community members.

- Group sessions with Eastern European community members and friends and families of treatment beneficiaries. The project aimed to build awareness around the harms of alcohol misuse and the services available through group sessions.

[28] Identification and Brief Advice (IBA) has potential to prevent and reduce alcohol-related harms. It involves attempting to identify risky drinking and provides advice to those who need it, with the goal of encouraging heavy drinkers to reduce their consumption.

In-treatment activities[29] included the development and delivery of tailored support packages, including:

- Identification and Brief Advice (IBAs, also referred to as 'Tier 2'). IBAs are one-to-one sessions that normally last a maximum of two hours. The project staff aimed to target all Eastern European community members misusing alcohol to attend IBA sessions.

- Structured alcohol reduction treatments (also referred to as 'Tier 3') were targeted to Eastern European community members misusing alcohol, these were carried out flexibility depending on the needs of the beneficiaries, but it was recommended to have one to two one-to-one sessions during a period of 12-weeks.

The aim of these support packages was to help Eastern European community members to reduce their alcohol consumption and improve their physical and mental health in the longer-term. These treatments can only be accessed if beneficiaries are registered at a GP. Project staff helped potential beneficiaries to register if not already.

- In Peterborough only, Eastern European community members were also offered health checks and short health assessments (known as 'MOT's) through community engagement and mobile clinics. The aim of this activity was to provide health assessments and information on available services to improve health conditions to Eastern European community members. Project staff set a personal health plan during health checks and also referred beneficiaries to other project activities.

- In Peterborough only, Eastern European community members were offered 12-week behavioural change programmes. The project aimed to support Eastern European community members to improve their health by offering advice and support on how to: lose weight through diet and sports; reduce alcohol consumption; and stop smoking. Where alcohol-misuse issues were identified, the project intended to refer beneficiaries to the structured alcohol reduction treatments outlined above. Project staff also set personal health plans with beneficiaries of behavioural change programmes.

Peterborough City Council contracted three external service-providers to carry out the project activities. Service providers were engaged at different times in each area and included:

1. **Change Grow Live (CGL) (from October 2017)** was contracted to carry out outreach work and engagement activities, upskill Eastern European community members and provide alcohol-related treatments including brief advice sessions and structural alcohol treatments in Wisbech;

2. **Aspire (January 2018)** was contracted to carry out outreach work and engagement activities, provide alcohol related treatments including brief advice sessions and structural alcohol treatments, upskill Eastern European community members, and

[29] In-treatment activities include all support and treatments provided to Eastern European community members misusing alcohol.

train project staff and other professionals working with Eastern European communities to deliver advice services in Peterborough and;

3. **Solution 4 Health (S4H) (from May 2018)** was contracted to carry out alcohol awareness campaigns, provide health checks and health MOTs and lifestyle and behavioural change programmes and training to project staff.

Project objectives

Project objectives were identified following a review of project documentation and a consultation between the Ipsos MORI Relationship Manager and Tackling Alcohol Misuse project staff. Following the consultation, the Ipsos MORI Relationship Manager developed two logic models to reflect differences in the delivery model used in the two locations. These were reviewed and agreed with project staff (Figure 2.1)[30]. The logic models outline planned activities and outputs and how these relate to project and CMF fund-level outcomes[31]. How the project aimed to contribute to CMF intermediate outcomes is outlined below, including longer-term outcomes where this outcome was expected or seen within the evaluation timeframe.

Through the planned project activities and outputs, the Tackling Alcohol Misuse project aimed to contribute towards the following **CMF intermediate outcomes for the local authority, service providers and project partners**:

- **Expanded and strengthened networks and partnerships:** The project aimed to create a network of local organisations and service providers, including GP surgeries, health clinics, community centres, Citizens Advice Bureaus and Jobcentres, who are aware of the support and services each organisation offers. Through an increased understanding among different services of the support available in the areas, the project hoped to increased signposting to other services. By strengthening partnerships and raising awareness, the project also hoped to increase the reach of activities to target beneficiaries who required support to improve their well-being, particularly Eastern European community members misusing alcohol.

Project service providers also aimed to establish new relationships with workplaces employing large numbers of Eastern Europeans, to provide brief advice sessions and behavioural change programmes to Eastern European employees. As well as improving health outcomes for Eastern European employees, these activities aimed to benefit employers through reducing the number of employees taking long-term sick leave due to health issues.

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[30] A logic model is a diagrammatic representation of a project which depicts the various stages required in a project that are expected to lead to the desired outcomes. The logic model in turn is used to inform the evaluation approach; specifically, what needs to be measured to determine whether outcomes are being met, and how.

[31] CMF fund-level outcomes are outlined in the Theory of Change in Appendix 2.

- **Increased coordination and cooperation between agencies:** through the expanded network outlined above, the project aimed to increase coordination and cooperation between agencies, by improving referral processes increasing signposting of service users between agencies.

- **Acquired expertise and structures in place to deal with local issues:** through the targeted engagement work and new pathways for support provided by the project, project staff aimed to gain knowledge about how to effectively support Eastern European migrants with alcohol misuse issues. The project aimed for this knowledge to feed back to the County Council to inform ways to tackle alcohol misuse and related issues among the Eastern European community in an efficient and sustainable manner. Through the partnerships outlined above, the project also aimed to increase information sharing on good practice in supporting Eastern European migrants between organisations and agencies in the area.

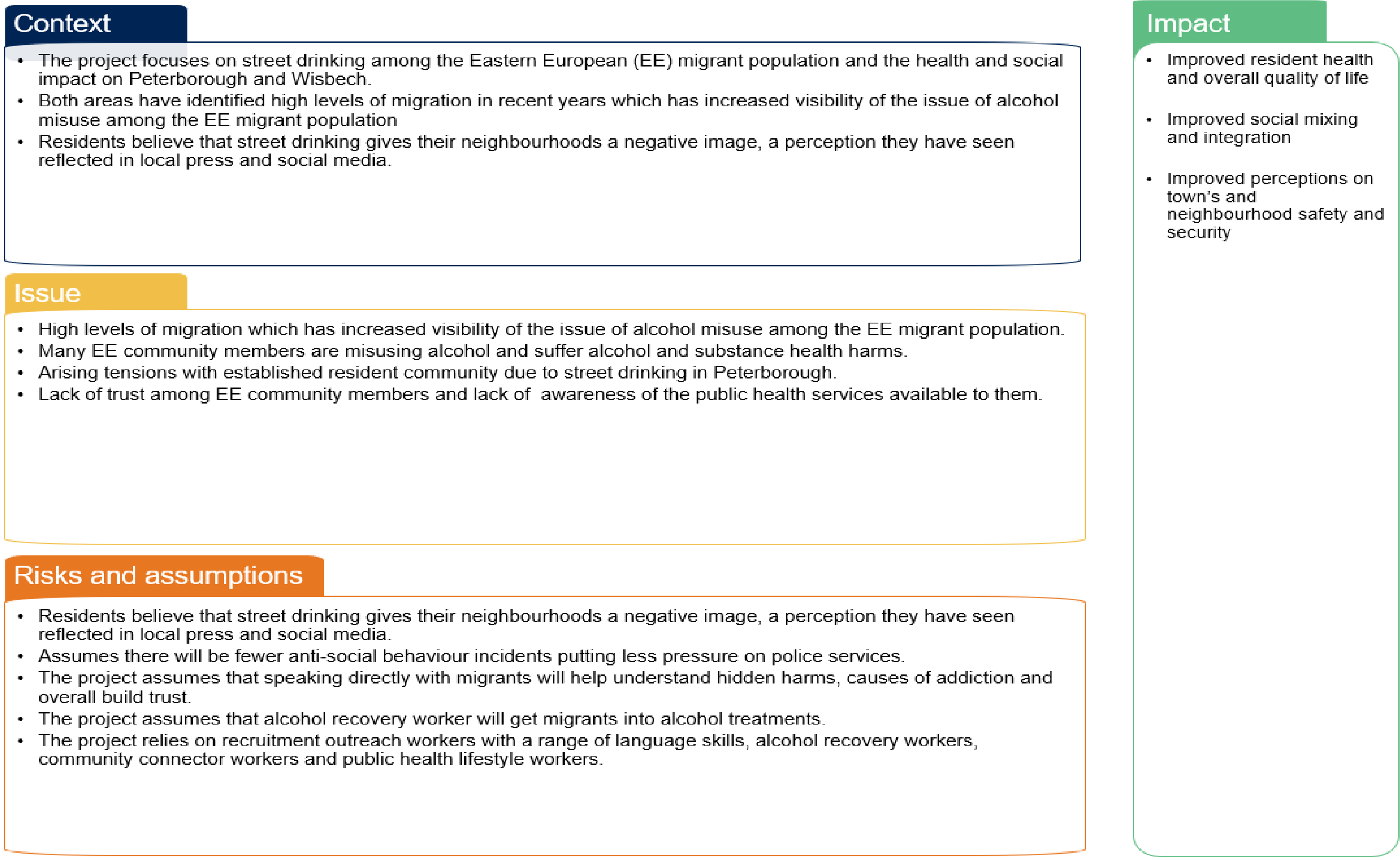
Project activities and outputs also aimed to contribute towards the following CMF intermediate outcomes for migrants:

- **Increased understanding and access to public services:** all project activities aimed to raise awareness and understanding of the available public services for addressing behavioural change and alcohol misuse among the Eastern European community, through information and advice sessions on which services are available (including sharing written materials outlining services), and working with other local organisations to increase referrals for support. Project staff also aimed to provide interpretation and translation services for beneficiaries to help them access local services where required. Through increasing understanding among beneficiaries and the wider Eastern European community, the project also aimed to increase the number of people independently and consistently accessing appropriate services. In the longer-term, the project aimed to contribute to the increased well-being of Eastern European community members living in Wisbech and Peterborough through successful treatments for alcohol misuse and other health issues.

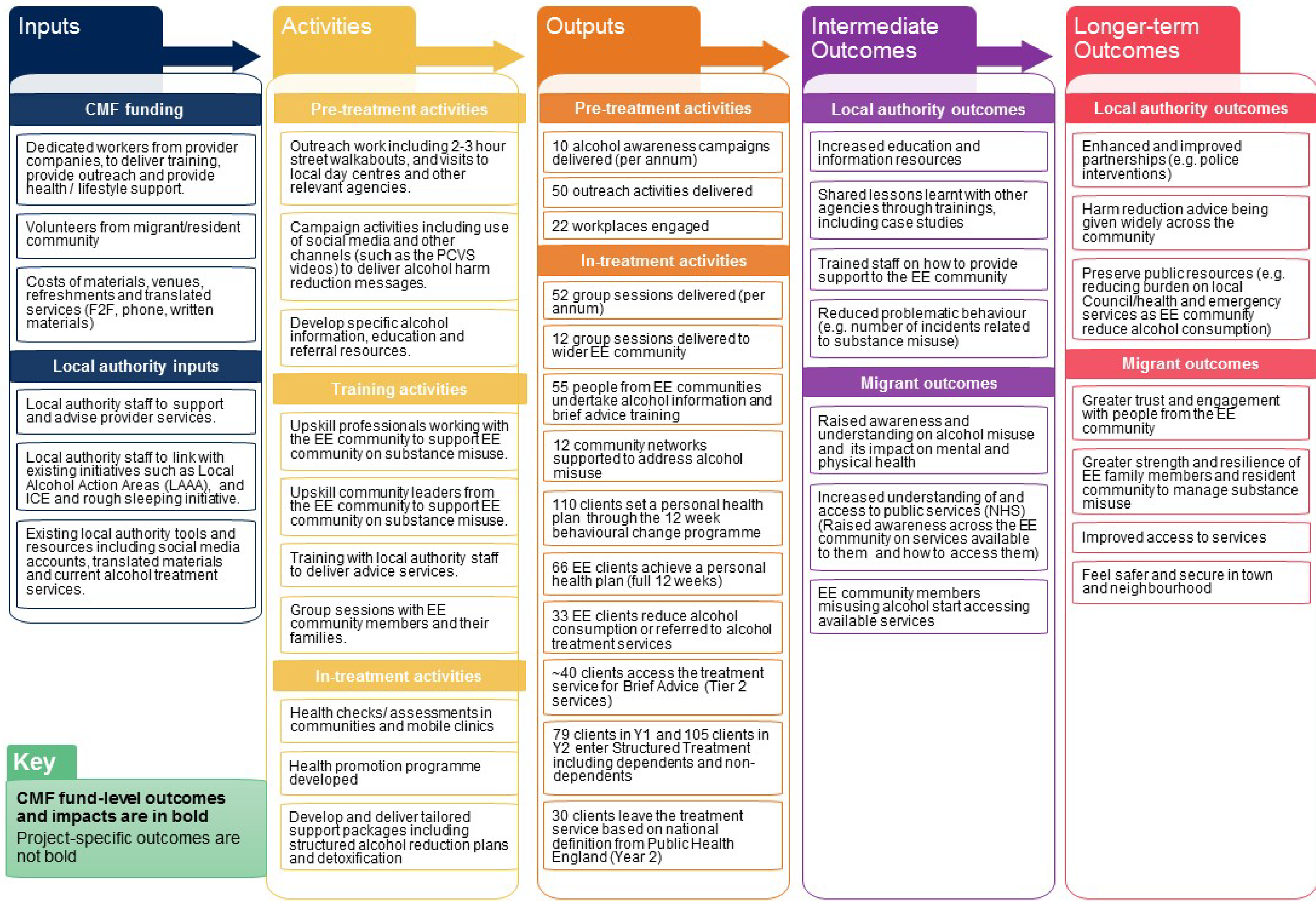
Project activities and outputs also aimed to contribute towards the following **CMF intermediate outcomes for residents**:

- **Improved public space:** through providing targeted support to the Eastern European community (including outreach and in-treatment activities), the project aimed to reduce the number of people misusing alcohol and subsequently reduce the number of street drinkers. Through reducing the number of street drinkers, the project aimed to reduce the number of alcohol containers left in public spaces. Moreover, the project aimed to work closely with a police community support officer (PCSO) to fine people drinking in defined locations under Wisbech's Public Spaces Protection Order (PSPO), to deter street drinking. Through reduced street drinking, the project also intended to reduce the number of anti-social behaviour incidents related to street drinking in both locations. This outcome also relates to the project level outcome "reduced problematic behaviour" linked to street drinking.

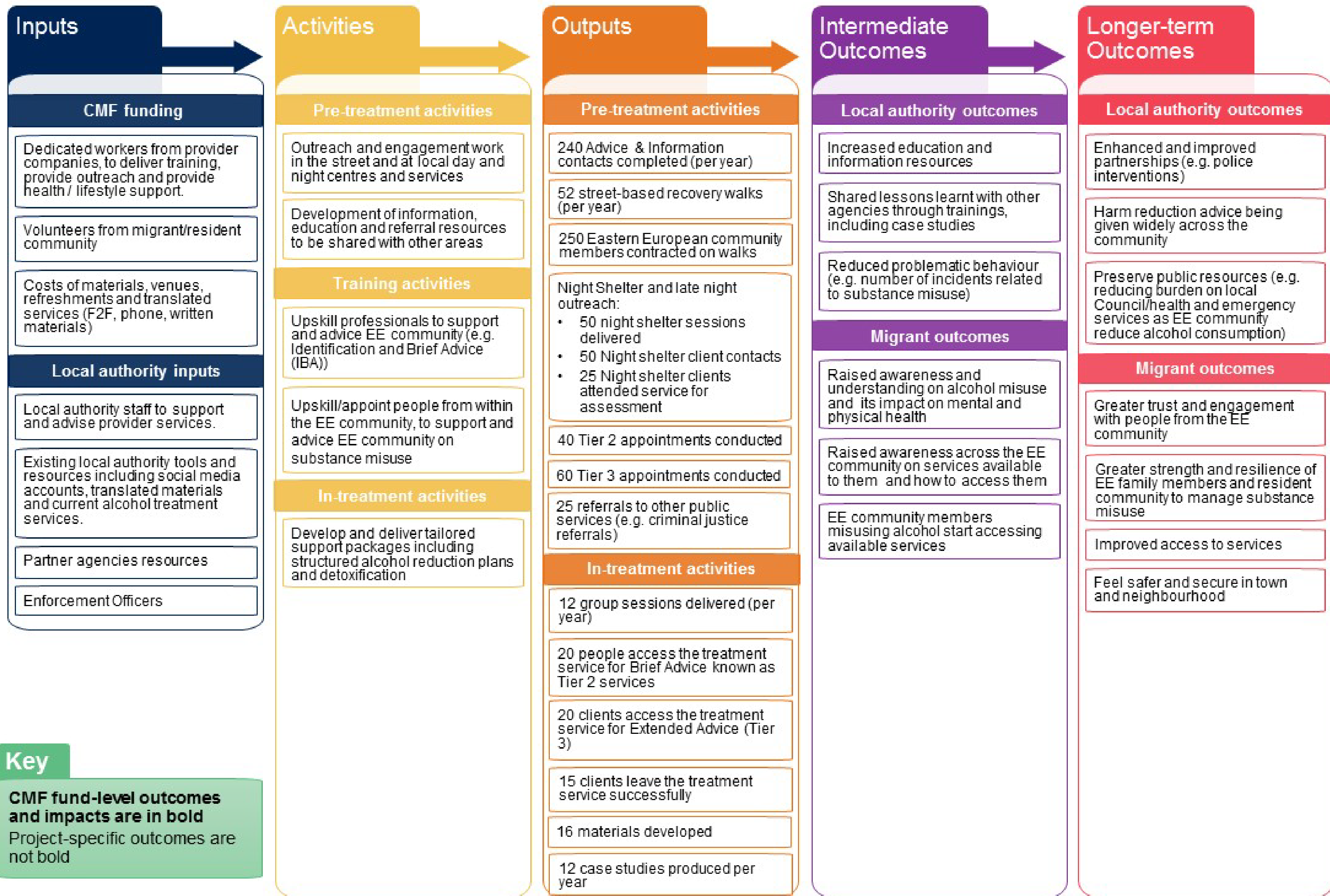
Figure 1.1: CMF Logic Models Tackling Alcohol Misuse



CMF Logic Model Peterborough



CMF Logic Model Wisbech



2 Methodology

This section outlines the methodology for the project-level evaluation of the Tackling Alcohol Misuse project.

Overview of evaluation approach

A theory-based approach was taken for the evaluation, which focused on reviewing and testing the outputs and outcomes within the project's logic models[32]. The suitability of different approaches was explored in an evaluation scoping phase. The possibility of implementing experimental evaluation designs, including Randomised Control Trials (RCTs), was explored and deemed not feasible at a fund level due to the broad range of projects that have funded across different regions and local contexts – this would have needed to have been built into the programme design from the outset. The feasibility of identifying local-level control groups was explored during individual project consultations. This was considered unsuitable as all Eastern European community members with alcohol misuse issues were eligible for the project, so no comparable group of non-participants could be identified. Given the hard-to-reach nature of this client group, it was not possible to identify a comparable group from a neighbouring area to act as a counter-factual.

Project-level outcomes were "mapped" onto relevant CMF-fund level outcomes contained in the overall fund-level Theory of Change (contained in Appendix 2). The evaluation approach was designed in consultation with project staff, including the development of an evaluation framework (contained in Appendix 1). Primary data was gathered through a mix of qualitative and quantitative approaches

In order to assess value for money, each of the 14 projects were initially assessed through the lens of an 8-step model (outlined in Appendix 1). The assessment involved a review of the availability and suitability of data collected at each of the 14 project sites. Consequently, each project was triaged to one of three methodological groupings:

1. **Cost benefit analysis (CBA):** Projects for which data on quantitative and monetizable outcomes was available met the higher threshold for Cost benefit analysis.
2. **Cost effectiveness analysis (CEA):** Where quantitative measures for outcome(s) existed, but no data (primary or secondary) was available to monetize the outcomes, cost effectiveness analysis was conducted.

[32] Theory-based approaches to evaluation use an explicit theory of change to draw conclusions about whether and how an intervention contributed to observed results. For more information, see:

https://www.canada.ca/en/treasury-board-secretariat/services/audit-evaluation/centre-excellence-evaluation/theory-based-approaches-evaluation-concepts-practices.html

3. **No feasibility for quantitative analysis:** Where there was no quantitative measure of outcomes available to the evaluation, neither cost benefit analysis nor cost effectiveness analysis could be conducted.

Two models were developed: the CBA model calculated costs relative to the monetizable benefits, while the CEA model calculated costs relative to the quantifiable outcomes achieved from each of the CMF interventions (without attempting to monetize these outcomes).

As there was no robust control (counterfactual) group against which to assess impact, artificial baselines were constructed. Where possible, input from project leads or secondary data was used to inform the assessment of the counterfactual. In the cases that this was not available, conservative estimates were made. Given the nature of the data used in the construction of the cost benefit and cost effectiveness models, the accuracy of results produced by the models should be interpreted with caution[33].

Further information on the methodological approach, including the evaluation framework, is contained in Appendix 1. Appendix 2 outlines the CMF fund-level Theory of Change. Appendix 3 outlines the qualitative and quantitative research tools.

Qualitative data

Qualitative data was gathered through interviews with beneficiaries, project staff, delivery partners and wider stakeholders, and a focus group with project beneficiaries. Project staff facilitated the recruitment of participants for qualitative research activities to minimise the need to share personal data as part of the evaluation. Table 2.1 provides the division of interviews planned and conducted per stakeholder.

Table 2.1 Interviews undertaken by Ipsos MORI

Type of interview	Interviews planned	Interviews conducted
Beneficiaries	10	10
Project staff	4	4
Delivery partners	Combined target (6)	5
Wider stakeholders	As above	1

[33] The Maryland scientific methods scale scores methods for counterfactuals construction on a scale of one to five (with five representing the most robust method). Due to the use of measures of additionally in the construction of the counterfactual, the approach taken for this analysis cannot be attributed a score. Therefore, the accuracy of results produced by the models should be interpreted with a high degree of caution. For more information, see: https://whatworksgrowth.org/public/files/Methodology/Quick_Scoring_Guide.pdf

Quantitative data collection

Quantitative data took the form of a pre- and post-beneficiary questionnaire for beneficiaries of structured treatments (52 received)[34]. The questionnaire was drafted by Ipsos MORI and administered by project staff. One service provider in Peterborough also carried out a pre- and post-survey on the psychological and physical health of Eastern European service users before starting the 12-weeks alcohol recovery treatments and after completion.

Monitoring and secondary data

Monitoring data on relevant project outputs was collected by the project and shared with Ipsos MORI. This included the number of information and outreach materials developed, outreach activities carried out and the number of beneficiaries accessing services.

Relevant secondary data collected by the project and delivery partners was identified during the project scoping phase. This included statistics from Cambridgeshire police, CCTV data and Public Health England data on alcohol related incidents; data on activities to identify alcohol containers; and hospital alcohol-specific admissions. In addition, the project provided secondary qualitative information in the form of case studies with examples of how beneficiaries had been supported (including how they were engaged, their recovery plan and what happened once they received support). This information was collated by the project and shared with Ipsos MORI towards the end of the evaluation period (January 2020).

Value for money assessment

Based on the available data on quantifiable and monetizable outcomes, the Tackling Alcohol Misuse project was selected for a CBA. Perceptions of project costs and benefits were also explored through qualitative consultations with staff and delivery partners. Where it was not possible to quantify monetizable outcomes, secondary data on potential monetizable benefits was also considered.

Methodological strengths

- The **breadth and depth of the qualitative data**, including end beneficiaries, project staff in both areas, delivery partners and wider stakeholders, which contributed to a well-rounded analysis of the project's activities and is a key strength of this evaluation.

- The **range of monitoring and secondary data** shared by the local authority and service providers, which provided further context and evidence on the achievement of CMF and project outcomes and some evidence of change over time.

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[34] Post-only questionnaires were intended for beneficiaries of Identification and Brief advice (Tier 2), but due to a communication error this was not carried out.

- **Strong communication between delivery staff and the evaluation team** allowed for a transparent and honest relationship which further strengthens the credibility of the evaluation itself.

- **Pre- and post-survey approach with beneficiaries**. A total of 28 pre- and post-surveys were completed in this evaluation allowing to compare changes in beneficiaries' behaviour towards alcohol and access to public services after the 12 weeks' behavioural change programme or structural alcohol treatments.

Methodological limitations

- **Participant self-selection bias:** participants could decide for themselves whether they wanted to take part in evaluation activities. Some beneficiaries contacted by one of the service providers did not participate in the scheduled interviews, however, other beneficiaries were interviewed and participated in the focus group.

- **Challenges coordinating delivery staff in multiple areas:** even though there was a strong communication between delivery staff and the evaluation team, some difficulties were experienced. The changes in project staff and the limited involvement of the local authority in day-to-day project activities, due to the small percentage of time the project lead had allocated to this project, made it difficult to coordinate some of the evaluation data collection activities, including collecting quantitative data. This limited data collection, as the two services providers offering brief advice sessions to beneficiaries did not complete post survey questionnaires with beneficiaries. One provider cited resourcing issues as they did not have an Eastern European outreach/recovery worker in post during the data collection phase. The other service provider cited a miscommunication with the central project team which meant they were unaware that surveys should be administered with beneficiaries of Brief Advice sessions.

- **It is difficult to measure change or judge attribution due to the lack of a counterfactual.** However, the pre- and post-survey provided evidence in two points in time allowing to assess changes in beneficiaries' behaviour towards alcohol and access to public services during the treatments.

- **It was only possible to conduct one focus group with beneficiaries involved in behavioural change activities in which they received information on alcohol harms;** however, none of the focus group attendees had experienced alcohol misuse issues. Thus, their level of awareness around alcohol harms could be assessed but it was not possible to explore the intended outcome of access to alcohol recovery treatments. Face-to-face interviews were carried out with beneficiaries involved in alcohol structural recovery treatments.

- **Inability to engage wider residents in the evaluation:** While the project intended to benefit wider residents through reducing street drinking, project activities did not directly engage wider residents beyond the Eastern European community. Therefore, it was beyond the scope of the evaluation to engage wider residents in primary research activities. Thus, the evaluation could not carry out primary data collection activities with longer-established residents.

Analysis and synthesis

Monitoring data shared by the project was mapped against the project’s intended output targets. Secondary data was mapped to relevant CMF fund-level and project-level outcomes to identify key findings.

Interview notes were systematically inputted into an analysis grid for each research encounter, allowing for more in-depth analysis of findings. There was one grid for each type of audience consulted (project beneficiaries and project staff and wider stakeholders). The grids follow the structure of the topic guide enabling the identification of relevant quotes for each element of the outcomes and process evaluation. A thematic analysis approach was implemented in order to identify, analyse and interpret patterns of meaning (or "themes") within the qualitative data, which allowed the evaluation to explore similarities and differences in perceptions, views, experiences and behaviours. Once all data had been inputted, evidence for each outcome and key delivery themes was brought together in a second analysis matrix to triangulate the evidence and assess its robustness.

Quotes in this report are verbatim and are used to illustrate and highlight key points and common themes. Quotes that contain personal information have been anonymised.

3 Key findings: delivery

Introduction

This section reports on the key findings from the evaluation in relation to how Tackle Alcohol Misuse was delivered. It begins with an assessment of progress made towards the intended outputs set out in the project logic model. This is followed by discussion of the success factors and challenges that were found to have impacted on project delivery and the achievement of outputs.

Was the project delivered as intended?

The table below outlines the target outputs determined at the start of the evaluation process, the actual output at the point of assessment and a determination of whether it was achieved or not[35]. Out of the 27 target outputs set, 18 were achieved or exceeded and nine were partially achieved.

Table 3.1: Achievement of project outputs

Area	Target output	Applicable for:	Output achieved	Completion measure
"Pre-treatment activities"[36]				
Peterborough	10 alcohol awareness campaigns delivered among eastern European communities (in 2018 and 2019)	S4H	Project monitoring data showed that 31 alcohol awareness campaigns were delivered from May 2018 to December 2019	Exceeded
	50 outreach walks carried out (over 3 years)	Aspire	Project monitoring data showed that 44 outreach walks were carried out during the evaluation period	Partially achieved (on-track)

[35] The completion measure is a subjective assessment by Ipsos MORI based on the extent to which the project has achieved its intended outputs – scored as follows: inconclusive; not achieved; partially achieved; achieved; exceeded. See Appendix 1 for further details.

[36] Pre-treatment outputs represent promotional and outreach activities to raise awareness around potential clients as well as activities to engage partners in service delivery

	22 workplaces engaged (over 3 years)	S4H	Project monitoring data showed that 12 workplaces were engaged	Partially achieved
Wisbech	240 Advice & Information contacts completed with people from the Eastern European community per year (2018 and 2019)	CGL	Project supplied monitoring information showed that there were: 38 contacts in 2017 (October to December) 255 contacts in 2018 474 contacts in 2019	Exceeded
	57 outreach walks carried out (2018 and 2019)	CGL	Project supplied monitoring information showed that: 3 recovery walks were undertaken in 2017 (October to December) 55 recovery walks were undertaken in 2018 69 recovery walks were undertaken in 2019	Achieved
	Contact made with 250 Eastern European community members through "walkabouts" (over 3 years)	CGL	Project supplied monitoring information showed that there were: 19 contacts on walks in 2017 (October to December 2017) 281 contacts on walks in 2018 317 contacts on walks in 2019	Exceeded
	50 Night shelter client contacts (over 3 years)	CGL	Project supplied monitoring information showed that there were: No client contacts in night shelters in 2017 90 contacts in 2018 109 contacts in 2019	Exceeded

	50 Night shelter sessions delivered (over 3 years)	CGL	Project supplied monitoring information showed: 1 session delivered in 2017 44 sessions delivered in 2018 53 sessions delivered in 2019	Exceeded
	25 Night shelter clients attend service for assessment (over 3 years)	CGL	Project supplied monitoring information showed: No attendances in 2017 9 in 2018 11 in 2019	Partially achieved
	25 Referrals to other public services (over 3 years)	CGL	Project supplied monitoring information showed: One referral in 2017 Total of 24 referrals to other public services in 2018. No referral data was recorded in 2019	Achieved
"In-treatment" activities[37]				
Peterborough	52 group sessions delivered to members of the Eastern European community (per year)	Aspire	18 sessions delivered in 2018 82 sessions delivered in 2019 From project supplied monitoring information	Partially achieved
	12 group sessions delivered to friends and family of the Eastern European	S4H	8 group sessions delivered in 2018 and 2019	Partially achieved

[37] In-treatment outputs include all activities related to service delivery

	community (over 3 years)		From project supplied monitoring information	
	55 brief advice sessions/trainings on alcohol (over 3 years)	Aspire and S4H	80 brief advice sessions/trainings on alcohol From project supplied monitoring information	Exceeded
	12 organisations supported to address alcohol misuse among eastern European communities (over 3 years)	S4H	22 organisations working with Eastern European community members supported From project supplied monitoring information	Exceeded
	110 Eastern European clients set a personal health plan and start 12-week behavioural change programmes (over 3 years)	S4H	187 Eastern European clients set a personal health plan From project supplied monitoring information	Exceeded
	66 Eastern European clients achieve a personal health plan and finish 12-week lifestyle/behavioural change programme (over 3 years)	S4H	101 Eastern European clients achieve a personal health plan and finished 12-week lifestyle/behavioural change programme From project supplied monitoring information	Exceeded
	33 Eastern European clients of behavioural change activities reduce alcohol content or referred to alcohol	S4H	22 Eastern European clients of behavioural change activities reduce alcohol content or referred to alcohol treatment services	Partially achieved (on-track)

	treatment services (over 3 years)		From project supplied monitoring information	
	50 Eastern European community members access the treatment service for Brief Advice (Tier 2 services) (over 3 years)	Aspire	70 Eastern European community access the treatment service for Brief Advice (Tier 2 services) From project supplied monitoring information	Exceeded
	79 beneficiaries enter Structured Treatment (over 3 years)	Aspire	148 beneficiaries entered Structured Treatment From project supplied monitoring information	Exceeded
	30 beneficiaries leave the structured treatment service successfully – Tier 3 (over 3 years)	Aspire	79 beneficiaries reduced their alcohol content and left the structured treatment service successfully – Tier 3 From project supplied monitoring information	Exceeded
Wisbech	52 group sessions delivered to members of the Eastern European community (per year)	CGL	10 group sessions were delivered with Eastern European clients in 2018 80 group sessions carried out and in 2019 From conversation with project staff	Partially achieved
	12 group sessions delivered to friends and family of the Eastern European community (per year)	CGL	In 2018 3 group sessions were delivered with friends and family of the Eastern European clients. In 2017, 7 group sessions were delivered with friends and family of the Eastern European clients.	Partially achieved

			From interview with project staff	
	20 people from the Eastern European community access Tier 2 alcohol services (over 3 years)	CGL	A total of 95 people accessed Tier 2 alcohol services From project supplied monitoring information	Exceeded
	20 people from the Eastern European community who access the treatment service for Extended Advice (Tier 3) (over 3 years)	CGL	20 people from the Eastern European community accessed Tier 3 services in 2017 21 people from the Eastern European community accessed Tier 3 services in 2018 28 people from the Eastern European community accessed Tier 3 services in 2019 From project supplied monitoring information	Achieved
	15 people from the Eastern European community leaving the treatment service successfully (over 3 years)	CGL	11 Eastern European clients discharged in 2018 28 Eastern European clients discharged in 2019 From project supplied monitoring information	Exceeded
	16 materials developed e.g. support packages, information, education and referral resources, etc. (over 3 years)	CGL	26 materials have been developed (i.e. leaflets with information on services) From conversation with project staff	Exceeded
	12 case studies on success stories produced	CGL	12 case studies produced (shared with Ipsos MORI)	Achieved

What worked in delivering the project?

There were four key elements that facilitated project delivery:

1. Recruiting staff from the Eastern European communities to build trust among community members;
2. Drawing on the expertise of partner organisations to engage beneficiaries and promote efficient and effective service delivery;
3. Having a holistic and flexible approach to support provision;
4. Recruiting target beneficiaries both face-to-face and through social media to raise awareness of and engagement with the project.

(1) Recruiting staff from the Eastern European community

According to project staff and wider stakeholders, recruiting outreach and recovery workers with community outreach experience and the right language skills contributed to building trust among the Eastern European community. In both locations, prior to the project service providers had experienced difficulties engaging Eastern European community members and believed that recruiting support workers from the Eastern European community had contributed to reducing cultural practices around alcohol consumption and language barriers.

> *"We have managed to break down some of the cultural and languages barrier by providing beneficiaries with outreach and recovery workers from Eastern Europe and access to information and treatment options in their own languages". Project staff, interview*

Project staff highlighted that Eastern European staff were able to explain the difference between services provided in the UK versus beneficiaries' home countries and communicate information to beneficiaries about how to they could improve their wellbeing without offending their cultural habits such as street-drinking with friends and family. Beneficiaries welcomed being able to speak to people with similar socio-economic backgrounds and in their own language and reported that they did not feel judged by staff. Stakeholders widely reported that speaking in their own language had encouraged beneficiaries to engage with the project and start accessing available services. Moreover, the project exceeded their target for the number of beneficiaries accessing structural alcohol treatments, which may demonstrate that project staff managed to build trust among the community and raise awareness around alcohol misuse and available services.

(2) Drawing on the experience and expertise of partner organisations

According to project staff, the development of a strong network of partners (including with GP surgeries, workplaces, and community centres) had enabled service providers to deliver services more effectively and efficiently. One staff member staff highlighted that a mapping exercise carried out at the start of the project helped to identify local

organisations providing relevant services to target beneficiaries. Through this exercise, staff reached out to relevant organisations to encourage and promote joint working. For example, staff in Wisbech identified that many service users suffered from Hepatitis C (a common condition among people with a high alcohol intake). Staff engaged a nurse from a local health clinic to attend drop-in services and provide vaccinations to beneficiaries. Some beneficiaries mentioned they had been vaccinated and reported feeling physically better because of it.

Project staff and partners reported that working with partners enabled the project to reach beneficiaries and encourage them to attend project services (including brief advice sessions and behavioural change programmes and in a few instances alcohol services). For example, service providers had collaborated with night shelters and a project funded by the Rough Sleeping Initiative to carry out joint outreach work in the community. Through this work, target beneficiaries were provided with relevant information and referred to alcohol treatments provided by the project. In Peterborough, staff and delivery partners reported that relationships with GP surgeries with high numbers of Eastern European patients, developed through the project, resulting in GPs referring patients directly to the project instead of generic drug and alcohol support. Staff also reported that working closely with GP surgeries and health clinics with high numbers of Eastern European patients had contributed to speedier health referrals and GP registrations.

(3) Holistic and flexible approach

A holistic and flexible approach was particularly important for the two service providers that facilitated alcohol treatments (Tier 2 and Tier 3). According to project staff, the project adopted a holistic approach to identifying the root causes of the problem and supporting beneficiaries to get the help they need, as well as providing specific services aimed at reducing or stopping alcohol and drug consumption.

> *"It is very hard to keep a firm structure with these individuals who might not even have a phone to be consistently contacted, so the project needs to be very flexible", Project staff, interview*

Project staff and wider stakeholders mentioned helping beneficiaries to access several public services including housing, employment and social benefits - but also more general advice and support. According to project leads, working closely with partners allowed them to have this holistic and flexible approach. For example, working in close collaboration with night shelters allowed them to offer beneficiaries the support they need to sort out their living situation, finding them in most cases a place to sleep in the meantime.

(4) Varied recruitment approach

Project staff reported that using both online and face-to-face recruitment approaches ensured that target beneficiaries were aware of the project and encouraged their engagement with services. Project staff reported that promoting the project in multiple languages on service providers' and community centres' Facebook pages was a successful and cost-effective method for engaging beneficiaries in lifestyle and behavioural change programmes. All focus group participants mentioned hearing about

the lifestyle and behavioural change programme through Facebook posts shared by friends.

A delivery partner in Wisbech reported that outreach work on the street was successful in providing target beneficiaries who had alcohol misuse issues with relevant information to encourage them to attend community centres and service providers' facilities. Project staff also reported that outreach work was effective in Wisbech as this resulted in beneficiaries in the same area sharing information about the project through word-of-mouth, which raised awareness and increased engagement with the project.

What were the challenges to delivering the project?

There were seven challenges to the delivery of the project:

1. The length of time required to recruit staff with the right expertise;
2. The length of time required to agree relevant preventative activities during the initial set up;
3. Cultural barriers to engaging Eastern European beneficiaries in volunteering activities;
4. Cultural stigma surrounding alcoholism as a barrier to engaging family and friends in group sessions;
5. Reluctance among some beneficiaries to engage with alcohol recovery treatments due to cultural understandings of appropriate alcohol use;
6. Challenges engaging workplaces; and
7. Limited engagement from the police community support officers, due to inability to enforce fines for street drinking.

(1) The length of time required to recruit staff

The local authority and project staff reported that it took longer than expected to recruit outreach and recovery workers from the Eastern European community because there were not many people with the language skills and experience in community outreach to fill the vacancies. The time it took to recruit Eastern European staff at the start of the project delayed the delivery of project activities in Peterborough.

Additionally, one of the service providers had to replace the outreach/recovery worker who left because they found another job opportunity and it took over four months to find a replacement. Project delivery reduced during this period due to a lack of staff capacity, resulting in the provider not reaching output targets for outreach work and sessions delivered. Project staff highlighted the importance of having a continuous service to ensure the trust built with Eastern European community members is maintained which meant that recruitment should have started earlier to avoid any gaps in service delivery.

(2) The length of time to agree preventative activities

Despite the efforts made by the project lead to start project activities on time, project staff reported that it took several months following the approval of the bid to agree relevant project activities, including the scope of preventive activities and how these would complement the structural alcohol treatments. Staff reported that this resulted in delays to project activities, which contributed to service providers not reaching the output targets for outreach work, the number of workplaces engaged, and the number of group sessions delivered to beneficiaries.

(3) Cultural barriers to volunteering

Project staff attributed barriers to Eastern European community members becoming mentors and 'community leaders' to the unpopularity of volunteering among the Eastern European community and a lack of interest among beneficiaries in unpaid work. This meant that it was not possible for the project to undertake planned activities to upskill beneficiaries to become mentors and/or community leaders and support their community to make lifestyle changes. Project staff recalled that they had not experienced these difficulties with wider non-Eastern European beneficiaries of alcohol reduction services; upskilling activities that were outside of this CMF project. One staff member in Peterborough stated that building an Eastern European community volunteer network remained a longer-term goal, beyond the project. Staff in Peterborough had identified two beneficiaries who were interested in developing mentoring skills for a generic volunteer role (not focused on alcohol reduction and clinical services) and suggested that this could be more attractive to beneficiaries, with the option to learn about wider topics.

(4) Cultural stigma surrounding alcoholism

Project staff and delivery partners found it difficult to engage family and friends of beneficiaries in planned group sessions due to the cultural stigma surrounding alcohol dependency. Staff reported that beneficiaries were reluctant to tell friends and family about sessions and did not want them to know that they were seeking treatment. Furthermore, some beneficiaries stated that they did not have family in the UK. As a result, planned activities with friends and family members of beneficiaries to raise awareness about how to support people with alcohol misuse issues were undersubscribed and the project delivered fewer sessions than planned. Nevertheless, in both locations some sessions with family and friends were carried out and some beneficiaries referred behavioural change and alcohol related treatments to friends and family, and some heard about these services through friends.

(5) Cultural barriers to engaging with alcohol recovery treatments

Staff reported that increasing understanding of the harms of high levels of alcohol consumption and persuading beneficiaries of non-structured treatments to engage with alcohol structural treatments was more challenging than expected. Project staff attributed the reluctance among some beneficiaries to engage in alcohol reduction services to a lack of understanding of how high alcohol consumption negatively impacts on health and has

wider impacts on wellbeing. Moreover, the project staff highlighted that beneficiaries tended to be reluctant to engage in alcohol recovery treatment because they had not heard about these types of alcohol recovery treatments before, as they did not have similar services in their home countries.

Moreover, the reluctance among Eastern European community members to get support to reduce alcohol consumption or stop drinking altogether was a challenge for project delivery. Only between 5% to 7% of Eastern European community members accessing alcohol structural treatments managed to complete them.

(6) Barriers engaging workplaces

Project staff encountered challenges engaging workplaces with high numbers of Eastern European community members and internal processes caused delays delivering project activities. Staff approached businesses with high numbers of Eastern European employees to engage them with the project in order to provide information on how lifestyle and behavioural change programmes could increase health outcomes and wellbeing among employees, thereby reducing employees going on long-term sick leave. While staff reported that employers were keen to engage with the project, their internal processes to get senior approval delayed activities taking place. Project staff explained that working with employers was a new approach for service providers, meaning that the lead in time required to build relationships had not been anticipated. Project staff believed that engaging workplaces would get easier over time as staff had gained a better understanding of employers' internal management processes and could factor this into future engagement strategies.

(7) Limited engagement from police community support officers

Project staff envisaged that fines under the PSPO (Public Spaces Protection Order) could act as a deterrent to street drinking in Wisbech and contribute to improved public spaces and a reduction in street-drinking incidents. A PCSO collaborated with the project through issuing fines to street drinkers in areas covered by the PSPO. However, project staff reported that the approach had not worked as street drinkers were not able or unwilling to pay fines and PCSOs did not have the authority to enforce them. According to project staff, alternative approaches were being explored through the project (but have not yet been implemented), including PCSOs signposting and encouraging Eastern European street drinkers to seek support with alcohol misuse.

4 Key findings: Outcomes

This section reports on the key findings from the evaluation in relation to progress made by Tackling Alcohol Misuse towards each of the intermediate outcomes set out in the project logic models[38]. It begins with an overview of how the project aimed to contribute towards the relevant outcome. This is followed by a summary of the evidence and a discussion of the factors that were found to have contributed to the achievement of project outcomes. Lastly, an assessment is presented of progress made by the project towards achieving each intended outcome.

Progress towards intended outcomes

The available evidence suggests that the project contributed towards achieving most of the intended local authority outcomes. The project also contributed towards immediate outcomes for beneficiaries and residents; namely, increased understanding and access to services for migrant beneficiaries and improved quality of public spaces. However, evidence suggests that the contribution of the project to increased wellbeing (longer-term outcome) has been more limited.

CMF fund-level local authority outcomes

INTERMEDIATE OUTCOME 1: EXPANDED AND STRENGTHENED NETWORKS AND PARTNERSHIPS

The project aimed to strengthen existing relationships between service providers and local community centres working closely with Eastern European community members, particularly community centres working on homelessness. The project also aimed to build new relationships with GP surgeries, health clinics, Citizens Advice Bureau and Jobcentres engaging the Eastern European community. Evidence towards the achievement of this outcome comes from interviews with project staff and delivery partners (including those who were already engaged with service providers and staff from organisations newly engaged through the project). While evidence is anecdotal and only assessed at one time-point, the range of participants and consistency in the evidence gathered suggests that it is reliable.

According to the project staff and delivery partners, the project had expanded its network of partners and organisations they collaborate with. In Wisbech, project staff reported that they started working with a clinic to provide beneficiaries with Hepatitis C vaccinations. Project staff and delivery partners identified a shared objective with a local health centre to deliver Hepatitis C vaccinations (part of the NHS target to eliminate Hepatitis C by 2025). Staff encouraged beneficiaries to get vaccinated, when a nurse was present at the service provider' premises twice a week. Project staff and a delivery partner reported that the collaboration was mutually beneficial. Beneficiaries welcomed getting the Hepatitis C vaccination and claimed to have improved sense of wellbeing. In Peterborough, project

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[38] Where expected during the project timeframe, evidence towards expected longer-term outcomes is also considered.

staff mentioned having engaged several workplaces that employ large number of Eastern European members. Staff reported that employees tended to go on long-term sick leave because of health issues related to alcohol misuse and smoking. The aim of these new collaborations was to provide Eastern European staff with information and services they might need to improve their health and wellbeing. Also, in Wisbech, the project started working with a Jobcentre, where Jobcentre staff asked claimants if they wanted to attend lifestyle or behavioural change programmes which could contribute to getting a job quicker.

Project staff reported they had overcome a reluctance among some GP surgeries to work closely with alcohol recovery treatments, due to a perception among some GP staff that engaging with beneficiaries with alcohol misuse issues could bring problems into their practice. Barriers were overcome through outreach workers attending GP practices with high numbers of Eastern European patients to explain in person how attending alcohol recovery treatment can reduce the number of patient appointments because of increased health outcomes. As a result of active engagement with GP practices, project staff reported that beneficiaries had been referred by their GPs to alcohol recovery services. Some of the beneficiaries also mentioned being referred to lifestyle and behaviour change programmes and alcohol recovery treatments by their GP.

According to project staff, the strengthening of the partners network (including with GP surgeries, workplaces, and community centres) enabled service providers to deliver services more effectively and efficiently through joint outreach work, swift provision of medicines and vaccines and on-site health checks and MOTs. Partnerships also enabled service providers to offer a holistic support service, beyond alcohol recovery services, through signposting and referring beneficiaries to other services they needed to access (e.g. housing support).

> *"It is important to link up with other organisations working with Eastern European community members to bring a comprehensive service". Project staff, interview*

According to several project staff and wider stakeholders, relationships with community centres had also been strengthened through the project. These relationships were strengthened because of joint outreach work and recovery workers running information sessions at community centres to inform and engage Eastern European community members. In Peterborough, staff reported that referrals already took place between service providers and community centres prior to the project, however, through running alcohol information sessions in community centres as part of the project, direct support through information sessions had been made available to the Eastern European community. Staff also felt that by working in community centres, staff and volunteers at the centres had improved their understanding of available alcohol recovery services. In both locations, engaging partners in outreach work was made possible by ensuring support was complementary to service user needs. For example, in Peterborough, project staff carried out outreach work together with a night shelter which allowed the project to provide information on alcohol misuse to Eastern European community members drinking on the streets but also find them a place to sleep if they needed.

Based on the assessment outlined above, there is strong evidence to support that the project has contributed towards strengthening networks and partnerships and went some way to creating new partnerships with local employers. Project staff in both areas agreed that the project had been most successful in its contribution towards this outcome, compared to other outcomes. The project contributed towards the outcome through identifying shared objectives with local support organisations and workplaces to increase the amount of support available to beneficiaries.

INTERMEDIATE OUTCOME 2: INCREASED COORDINATION AND COOPERATION BETWEEN AGENCIES

As a result of the strengthened and increased networks (outlined above) the project aimed to increase the coordination and cooperation between organisations supporting Eastern European community members in Wisbech and Peterborough. Project staff felt that joint working and coordination was necessary as alcohol misuse tends to be linked to other issues such as unemployment and homelessness. Therefore, beneficiaries required holistic support for multiple needs (such as housing, benefits or employment as well as health). Evidence towards the achievement of this outcome comes from interviews with project staff and delivery partners. While evidence is anecdotal and only assessed at one-time point, the range of participants and consistency in the evidence gathered suggests that it is reliable.

According to project staff and delivery partners, their work in this project had increased cooperation and coordination among organisations providing services to Eastern European community members. The project contributed to this increased cooperating and collaboration through joint outreach in the community, delivering information sessions in community centres, speeding up access to GP services and sharing materials on available services. As outlined above, existing partnerships with community centres had led to joint outreach work and co-delivery of information sessions to Eastern European members along-side other activities run by community centres. Project staff and partners reported joint working meant that advice could be provided to beneficiaries on a range of issues beyond health or alcohol reduction (such as housing advice). Moreover, project staff highlighted that the strengthened relationships with local GPs and health clinics enabled them to register beneficiaries at the GP surgery quickly, so they could access alcohol recovery treatments, and also receive other health treatments, such as Hepatitis C vaccinations. Working with GPs also enabled projects to engage beneficiaries. In Peterborough, project staff ran mobile clinics for alcohol advice and short health assessments close to, or directly at, GP surgeries. Evidence from case studies demonstrates that some beneficiaries accessed alcohol recovery treatments after receiving initial support at a mobile clinic. Staff also reported that GP surgeries had experienced a reduction in the number of booked appointments by some Eastern European patients.

There is evidence to suggest that signposting between service providers and other services, and vice versa strengthened as a result of the project. Project staff and delivery partners mentioned signposting beneficiaries to each other's services and to services such as housing and job centres. Output data (Table 4.1) also illustrates that project staff referred and signposted beneficiaries to other services during the project; which

demonstrates collaboration and coordination among delivery partners but also beyond these.

The evidence outlined above suggests that the project has contributed towards increasing collaboration between project service providers and wider health services in both areas.

INTERMEDIATE OUTCOME 3: ACQUIRED EXPERTISE TO DEAL WITH LOCAL ISSUES

The project aimed to increase local expertise to address alcohol misuse among the Eastern European community through training newly recruited outreach and recovery workers to provide project alcohol reduction services. The project aimed to continue building staff expertise through knowledge exchange sessions and sharing case studies on good practice and clients' "success stories" between service users and areas. The project also aimed to share the lessons learnt across partners through training and information sessions. Evidence towards the achievement of this outcome comes from interviews with project staff and delivery partners. While evidence is anecdotal and only assessed at one-time point, the range of participants and consistency in the evidence gathered suggests that it is reliable.

From the evidence gathered from project staff interviews, staff increased their expertise and knowledge through knowledge exchange activities between partner organisations, as well as through collaborating with wider local services. Delivery partners and wider stakeholder mentioned feeling more confident sharing information about the alcohol recovery services available and explaining what these services entailed, as a result of the written information provided by the project. However, some delivery partners mentioned that they would have welcomed additional support about how to talk to people who are heavy drinkers and how to persuade them to access alcohol recovery treatments, which was identified as a challenge (outlined in Chapter 3 above).

Some project staff highlighted that most of their knowledge and expertise about how to meet the needs of beneficiaries had been acquired on the job rather than through formal training. However, some project staff in Peterborough recalled receiving training on alcohol misuse, safeguarding and mental health, which they had found useful. Project staff in Wisbech reported that they were not offered trainings within the organisation and instead had been trained on the job. Project staff also drafted case studies to illustrate how beneficiaries had been supported by the project, in order to showcase the different routes and support available. The case studies showcase some success stories. However, when asked about how the project had facilitated learning, staff and delivery partners did not mention the success stories.

According to delivery partners, project staff had shared promotional materials about the harms of alcohol and how to explain this to service users and the behavioural change and alcohol recovery treatments provided by the project. Beneficiaries in both locations confirmed they had received information about behavioural change programmes and alcohol recovery treatments through their GPs and night shelters

As a result of materials produced about local services, delivery partners felt well-informed of the services available locally and reported that they were able to disseminate this information to target beneficiaries. Moreover, they also acknowledged knowing how and where to refer Eastern European community members for support beyond what the project provided (such as housing and mental health support). However, one delivery partner

stated that they were aware of local services before the project and therefore this had not increased their knowledge.

Apart from trainings and materials developed to increase expertise to deal with local issues, the project staff also identified some service gaps when providing support to Eastern European community members. Project staff in Wisbech identified a gap in housing support to Eastern European community members as mainstream housing services in Wisbech were only provided in English and many Eastern European living on the streets were found to mistrust services.

> *"Beneficiaries told me that in the past they tried to access the service but because of the language barrier they just fell out, they didn't think it would help them". Delivery partner, interview*

This resulted in the decision to create a dedicated housing team to support the Eastern European community. The housing team and the alcohol recovery team worked closely together to ensure beneficiaries of the project received housing support if they needed it.

The evidence outlined above suggests that the project has contributed towards increasing the expertise of staff and wider local stakeholders to address the local issue of alcohol abuse and other support needs of the Eastern European community in both areas.

CMF fund-level migrant outcomes

INTERMEDIATE OUTCOME 1: INCREASED UNDERSTANDING AND ACCESS TO PUBLIC SERVICES

The project aimed to raise awareness and understanding among the Eastern European community living in Wisbech and Peterborough about the impact of alcohol misuse on their mental and physical health. By building awareness and understanding, the projects aimed to increase use of available public services, particularly preventive health services and alcohol related services provided through the projects but also wider support services in the local areas. Evidence towards the achievement of this outcome comes from interviews with project staff, delivery partners interviews and a focus group with beneficiaries, beneficiary survey data and case studies. While the majority of the evidence is anecdotal, the pre- and post-survey data allowed and assessment of beneficiaries' knowledge and use of public services at two-points in time. The survey sample is too small to infer statistical significance of findings or be representative of the wider population, therefore results must be interpreted with caution and viewed as indicatively only. However, the range of participants and consistency in the evidence gathered suggests that it is reliable.

All interviewed beneficiaries were aware of the effects of alcohol on their health. Most beneficiaries claimed to understand alcohol harms better than before they received support through the project, which they attributed to the information and support received from service providers. Additionally, beneficiaries interviewed and that participated in the focus group were aware of the different alcohol related services available to them. Case study evidence also indicated an increased awareness and understanding around the negative effects of alcohol among beneficiaries.

Delivery partners and project staff mentioned observing a change in many beneficiaries' knowledge and awareness of alcohol harms. They mentioned how many beneficiaries understood the negative effects of alcohol on their health; as well as the potential knock-on effects of alcohol abuse on other areas of their lives, such as their housing situation and

ability to secure or hold down a job. Some beneficiaries reported an increased understanding of the harms associated with heavy drinking due to information provided by project staff. They mentioned this had led to a reduction in their alcohol consumption. Moreover, case study evidence linked beneficiaries' increased knowledge and understanding around alcohol harms and reduction of alcohol intake to the information received through the project (on alcohol harms and heathy diets). Information on healthy diets included information on the number of calories alcohol has which helped some beneficiaries, particularly those that were not heavy drinkers, to reduce the number of units they drank per week.

Moreover, a few interviewed beneficiaries argued that knowing more about the harms of alcohol made them feel more confident to talk about their alcohol-related problems. However, other beneficiaries stated that they could not attribute their reduced drinking to the support received through the project, instead seeing other changes in their lives as influential, including starting a new relationship, job or home.

> *"I can speak freely about my problems [during sessions with my support worker] and I welcome this freedom" Beneficiary, interview*

Pre- and post-surveys show an increase in beneficiaries' confidence in discussing their alcohol and substance misuse which suggest that beneficiaries were not only aware about alcohol harms but also their ability to address their alcohol misuse. Thus, showing positive signs of the project's contribution to increased well-being. Over half of beneficiary survey respondents who had received structured treatments reported that they felt "very" or "somewhat" confident discussing alcohol and substance misuse with a doctor or nurse, compared to over a quarter of pre-questionnaire respondents at the start of treatment. However, following treatment a quarter stated that they did not feel very confident.

A few beneficiaries interviewed also mentioned that their increased confidence allowed them to talk more freely with friends about their alcohol problems and mentioned referring friends and family to behavioural change and alcohol related treatments, while others reported hearing about the project through friends. Most of survey respondents also said they would share what they have learnt during the treatment with others. Moreover, two project staff claimed to be surprised by how many beneficiaries referred their friends and contacts alcohol recovery services. They mentioned that this word-of mouth had been a successful channel to engage with potential beneficiaries. Also, they believed beneficiaries recommending services to friends was a sign that their activities were helping the Eastern European community in both locations. However, a few delivery partners mentioned that Eastern European community members did not feel confident sharing their experiences with family and friends because they worried about what their reactions would be.

Wider stakeholders also mentioned that the project had contributed to increase understanding and access to wider public services through a holistic approach. Service providers supported beneficiaries to address wider issues linked to alcohol misuse, including signposting and referral to other local support organisations, such as the homelessness team established in Wisbech during the project. According to delivery partners and wider stakeholder, understanding the underlying causes of alcohol misuse and addressing these helped to contribute to longer-term improved health outcomes. Moreover, delivery partners and staff mentioned that beneficiaries were encouraged to be more self-sufficient by motivating them to learn English by signposting them to ESOL classes.

> *“General encouragement is provided to help clients to improve their language skills. Mostly those who are homeless don’t speak English and there it is incredibly difficult for them to get support.” Delivery partners, interview.*

A small number of beneficiaries also recalled being supported to access wider services, such as housing and welfare. One beneficiary credited the project for helping him to liaise with social services so that his child wasn’t taken into care. However, project staff and wider stakeholders reported that some beneficiaries did not feel confident using public services and others simply decided not to use them. Staff attributed this to low confidence related mainly to limited knowledge of English, but also because of a limited understanding of how some public services operate, particularly on income and housing support.

In terms of access to services, some beneficiaries mentioned they were helped to register with a GP surgery and were supported to access GP services through the project. This support included help booking appointments and being accompanied by recovery workers at GP appointments. Project staff and delivery partners confirmed having helped beneficiaries register with a GP, set up appointments and accompanied them to GP appointments. Moreover, project staff mentioned having to help beneficiaries translate documents and accompanying them to appointments as interpreters, even though it was not part of their job. Nevertheless, they mentioned that translation and interpretation support could have been more extensive they had more staff capacity.

Project staff reported that they encountered some Eastern European rough sleepers through street walks who needed support to register with a GP; this was particularly the case in Wisbech. Beneficiaries stated that project staff helped them navigate available public services by acting as interpreters and translating information received from the GP. One staff member described how they initially attended appointments with beneficiaries to ensure they were familiar with the process, before encouraging them to access services independently.

> *“First time I go with them to the GP and show them how everything works, the second time I’m trying to help only at times when they struggle, the third time I’m just staying on the side waiting for the result and with some of my clients it actually worked, the clients are not coming after my help anymore". Delivery partner, interview*

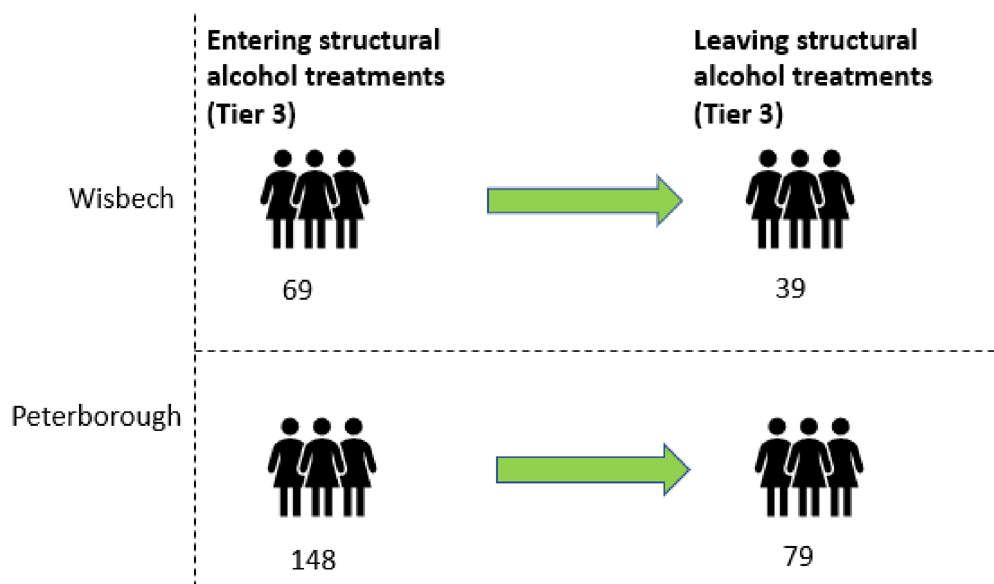
Project staff mentioned that the outreach work had built trust among street drinkers and rough sleepers and encouraged engagement with the project, particularly in Wisbech. Beneficiaries mentioned that they had accessed project services (including one-to-one briefing sessions and alcohol structural treatments) because they were able to speak about their alcohol problems in their own language and did not feel like they were being judged. However, project staff highlighted that it was difficult to get heavy drinkers engaged with behavioural change activities. One of the reasons being they didn’t enjoy discussing their alcohol misuse at group sessions, but that many other beneficiaries who drank had reduced their alcohol consumption. Most of the focus group participants stated that they had reduced or stopped drinking alcohol because of the high alcohol content and negative health effects.

Project staff and wider stakeholders mentioned how some Eastern European community members remained hesitant to get involved in alcohol structural recovery treatments, as high alcohol consumption was not considered problematic in some Eastern European countries. Monitoring data provided showed that 55% of beneficiaries completed alcohol recovery treatments overall. From the 69 Eastern European clients that entered Tier 3 services in Wisbech, 39 completed the full structural treatment and in Peterborough from

the 148 that entered, 79 completed their treatments. The completion rate among non-Eastern European clients that completed Tier 3 treatments from those who entered treatment is lower that for non-Eastern European clients (48%). In Peterborough, whilst the project was running, 835 non-Eastern European clients entered structural treatments and 398 left it successfully. According to project staff and delivery partners, some of the hesitation among Eastern European community members around accessing structural alcohol treatments could potentially be overcome with continued outreach and targeted services in both areas. According to project staff in Wisbech, additional staff capacity would have contributed to increasing the number of beneficiaries completing structural alcohol treatments.

Interviews and surveys with beneficiaries demonstrated that some beneficiaries still had limited confidence when accessing public services because of language and cultural barriers. Around 7 out of the 29 survey respondents did not to feel able to use the health services, which correlated with six of them having difficulties understanding English. However, four respondents felt more able to use the health services than at the baseline.

Figure 4.1: Beneficiaries of structural alcohol treatments[39]



The evidence outlined above indicates that the project has contributed to greater awareness and understanding of the harms of alcohol misuse among target beneficiaries, although cultural barriers to behavioural change remain prevalent, suggesting that more work in this area is needed. The evidence also suggests that the project has increased access to wider services in Peterborough and Wisbech, to address health issues and wider support needs of the Eastern European community. The evidence also suggests that the project has contributed to the following project level-outcomes: building awareness and understanding of alcohol misuse and its impact on mental and physical health amongst the

[39] This figure was created using monitoring data

Eastern European community and getting Eastern European community members to access behavioural change programmes and alcohol related treatments.

CMF LONGER-TERM OUTCOME 1: INCREASED WELL-BEING

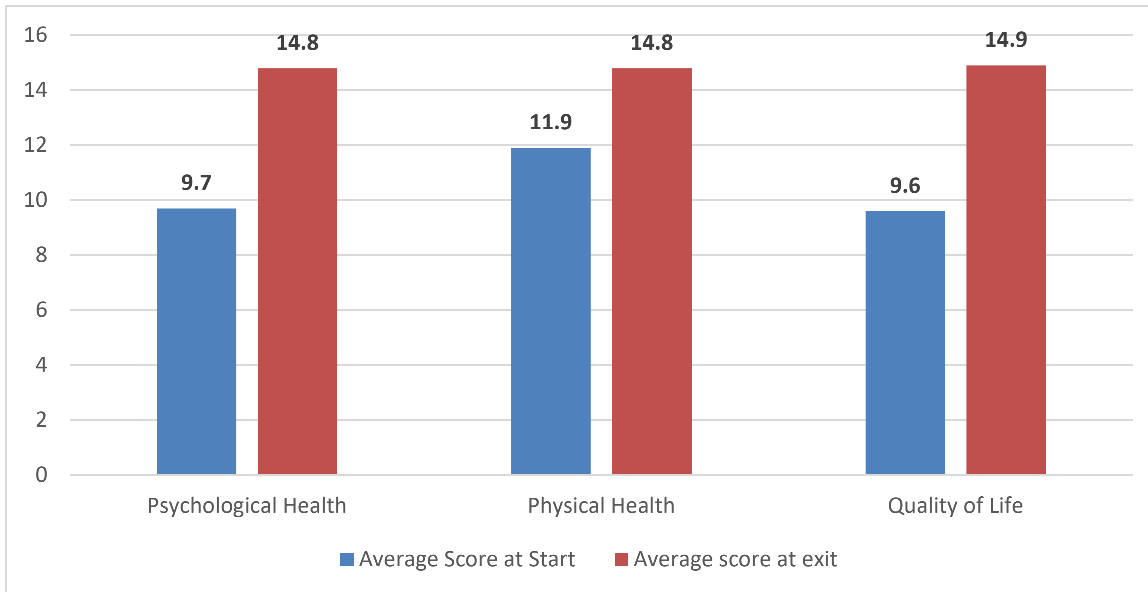
The project aimed to increase the well-being of Eastern European community members living in Wisbech and Peterborough by providing them with targeted services to address underlying health issues and support needs, linked to alcohol misuse. Evidence towards the achievement of this outcome comes from interviews with beneficiaries, pre- and post surveys, treatment outcome profile (TOPs) assessments carried out by one of the service providers and secondary data. The evidence must be interpreted with caution due to the small sample size for the quantitative data and reliance on secondary data sources.

Most of the beneficiaries interviewed, who had attended one-to-one sessions and structural alcohol treatments, reported reducing their alcohol consumption and feeling physically better as a result. Some beneficiaries attributed their changed behaviour to the support and advice provided by recovery workers while others did not think the project was the cause of the change or unique cause of change, but other changes in their lives like finding a partner or a job. A few beneficiaries also reported that their mental health had improved as a result of having someone to talk to about their problems, resulting in fewer suicidal ideations.

The project had limited success in encouraging beneficiaries to participate in community activities. Out of 29 survey respondents, 11 reported taking part in voluntary or community activities (such as sports clubs, religious activities and voluntary activities) with no changes between pre and post survey results. This evidence suggests that beneficiaries did not become more aware of how sports and other community activities could contribute to their physical and mental wellbeing.

Treatment outcome profile (TOPs) assessments carried out by one service provider in Peterborough with 46 beneficiaries at the start and at the end of alcohol structural treatments shows an increase in the average score when it comes to psychological and physical health as well as quality of life.

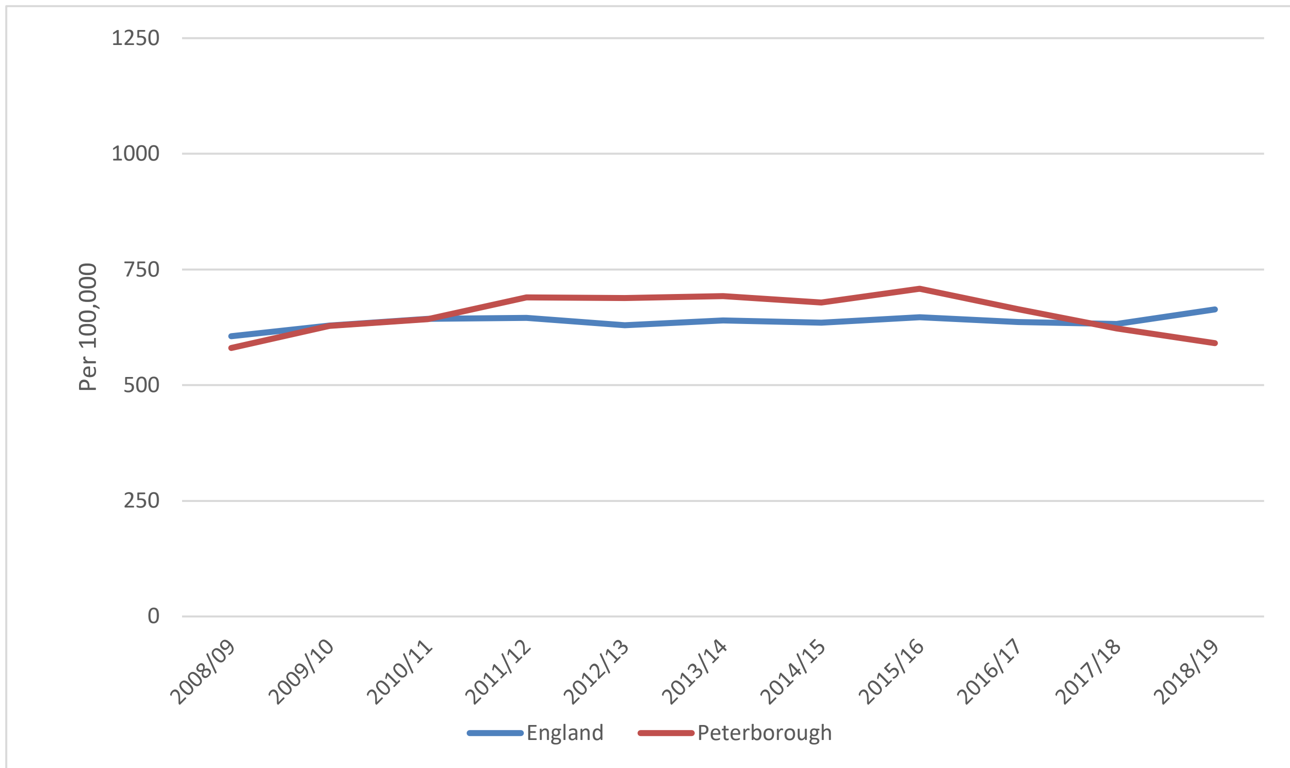
Figure 4.2: Well-being of structural alcohol treatments' beneficiaries in Peterborough



Source: Treatment Outcome Profile (TOPs) assessment carried out by CGL. Base size: 46

According to data from Public Health England, there was a reduction in the number of hospital admissions due to alcohol specific conditions during the project period in Peterborough, dropping below the England average for the first time in a decade. According to project staff, this reduction in the number of admissions for alcohol specific conditions in Peterborough could, to an extent, be attributed to the project. As highlighted in the area context section, Peterborough City Hospital (PCH) reported a high number of Eastern European patients with severe health problems attending A&E services in 2016. According to figure below, the overall number of admissions for alcohol specific conditions in Peterborough had dropped substantially since 2016. Although the data does not specify ethnicity or country of origin, project staff could not give examples of other external factors that may have contributed to this decrease.

Figure 4.3: Number of admissions for alcohol specific conditions in Peterborough

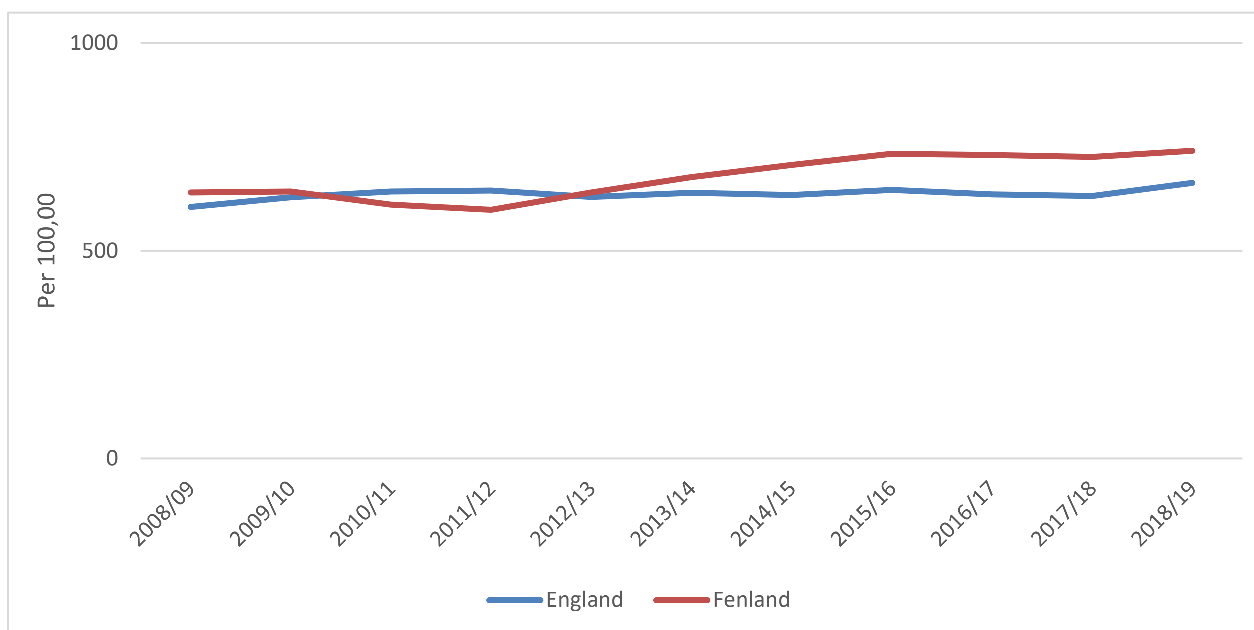


Source: Public Health England

Contrary to the situation in Peterborough, the number of admissions for alcohol in Fenland during the period of the project has increased. In the five Wisbech wards the number of admissions remained quite high in 2017/18 with an average of 1,444 people per 100,000 being admitted to hospital for alcohol-specific related conditions (Figure 4.4 below)[40].

[40] Wisbech ward data was provided by Local Authority, analysts broke down data on the number of admissions for alcohol-specific conditions in Fenland by wards.

Figure 4.4: Number of admissions for alcohol-specific conditions in Fenland



Source: Public Health England

The evidence outlined above suggests that the project has contributed to increased physical and mental wellbeing of beneficiaries, which qualitative evidence and reduced A&E attendance indicates was a result of activities to reduce alcohol consumption and improve health.

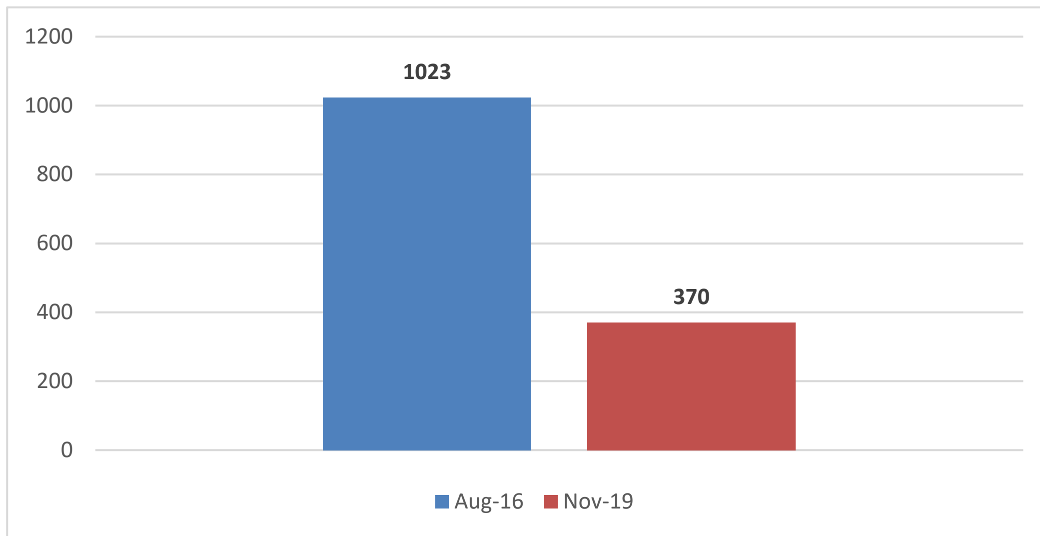
CMF fund-level residents' outcomes

INTERMEDIATE OUTCOME 1: IMPROVED QUALITY OF PUBLIC SPACE

The project aimed to improve public space in Peterborough and Wisbech through reducing street drinking by providing structured treatments for alcohol misuse. In turn, the project aimed to reduce littering related to street drinking and other alcohol related incidents (such as anti-social behaviour and public urination). Evidence to assess this outcome is limited to secondary data provided by the local authority. As wider resident views were not directly explored through the evaluation, it is beyond the scope of the evaluation to assess whether the reduced incidents of street drinking and associated littering have resulted in improved perceptions of public space among residents as a whole.

According to data on alcohol related litter count provided by the local authority, the number of discarded containers found in Wisbech reduced from 1023 in 2016 (August) to 370 in 2019 (November). These are the only two points in time when data was collected by the local authority and no further data collection points were planned. While this is a substantial decrease which could in part be due to the outreach work carried out by service providers, the time of the year when these litter counts were carried out also needs to be taken into account, as more people tend to drink outside in summer than in winter, thus figures tend to be higher during the summer months. Findings should therefore be interpreted with caution. The figure below shows the number of containers collected in one week in August in 2016 and in November 2019.

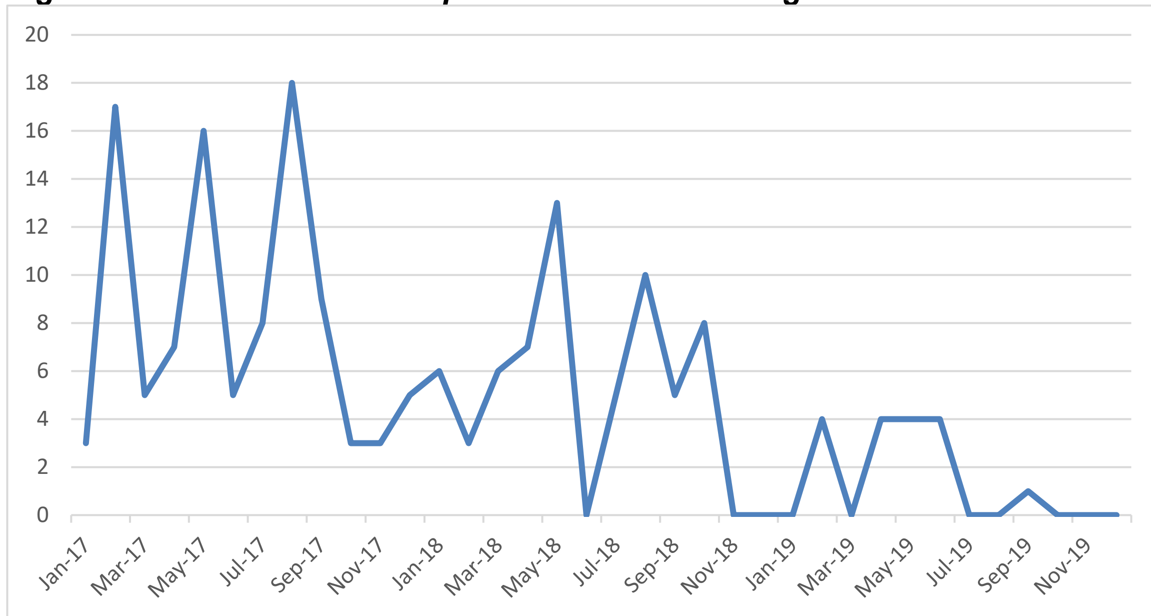
Figure 4.5: Number of alcohol containers collected



Source: Alcohol related litter count, Cambridgeshire County Council

Police incident reports also show a decrease in street drinking reports in three central wards of Wisbech where street drinking was identified as an issue (figure 4.6 below)[41]. The advice and support provided to street drinkers in Wisbech could have contributed in part to the reduction in littering and street incidents. According to project staff, there are no other factors that would have contributed to high littering and street drinking levels lapart from a large concentration of street drinkers in the area.

Figure 4.6: Police Incident reports on street drinking

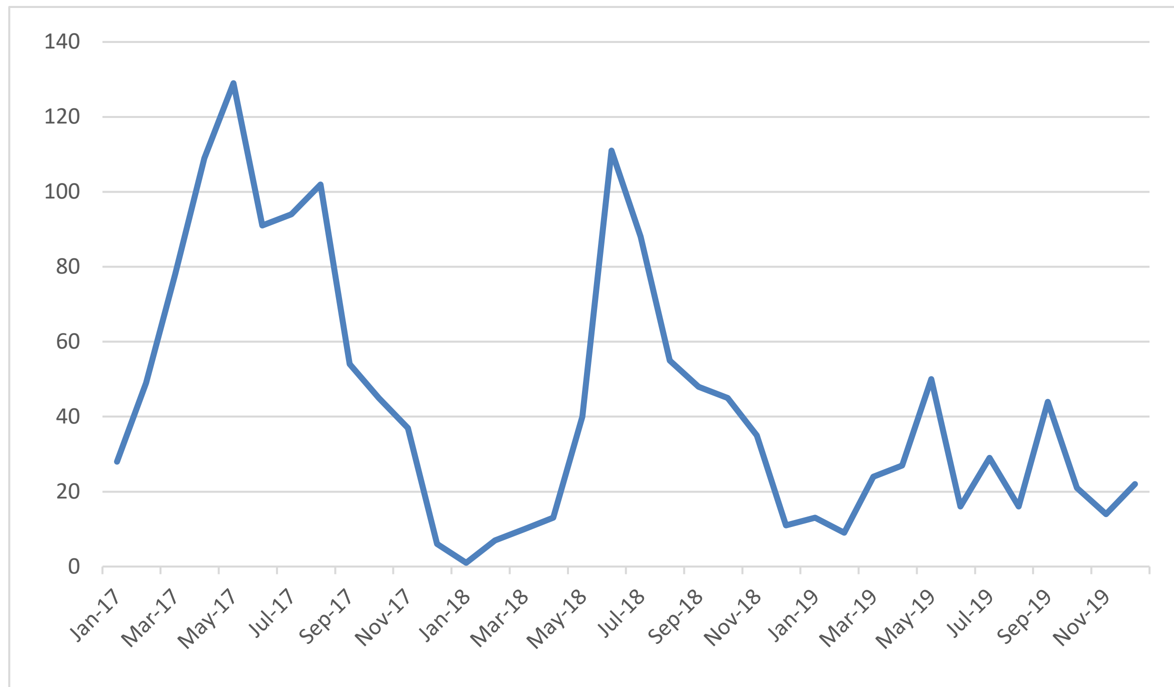


Source: Cambridgeshire Police

[41] Data for Peterborough was requested but could not be provided by the project.

Moreover, the CCTV data provided by the local authority shows a decrease in the recoded number of street drinking incidents in Wisbech since July 2018 (Figure 4.7).

Figure 4.7: CCTV data related to street drinking



Source: Cambridgeshire Police

In the Fenland District Council residents' surveys carried out quarterly in 2018 and 2019 street drinking was identified as one of the top four concerns (often the first or second concern) for residents. Thus, while the available data suggests that street drinking incidents and associated littering have been reduced, which could in part be due to the outreach work conducted through the project, the survey results suggest that street drinking remains a concern among residents. The results of council residents' surveys are not enough however to assess to what extent the reduction in street drinking incidents and littering has resulted in perceptions of public space among wider residents. However, evidence suggests an objective improvement in street drinking and associated littering.

Unintended outcomes

The evaluation found evidence of two unintended outcomes as a result of Tackling Alcohol Misuse. There is some evidence to suggest that the project improved housing advice and resolved housing issues in both areas. Project staff mentioned working with partners to provide support to Eastern European rough sleepers. Project staff referred beneficiaries with housing problems to the Citizens Advice Bureau where they received help to fill out forms to apply for housing benefits. In Wisbech, the service provider created an in-house homelessness team to provide beneficiaries with the advice and support to resolve their housing issues. This was confirmed by beneficiaries who mentioned receiving housing

advice and support from service providers. Out of the 29 survey respondents, 20 reported feeling “very confident” or “somewhat confident” to access services compared to 10 survey respondents in the baseline[42].

Progress towards longer-term outcomes

This section gives a short overview of how likely the projects activities will contribute towards longer-term outcomes. This is informed by the direction of change depicted in the logic model (see figure 2.1) and is valid given the assumptions in the logic model are met. There was some evidence to suggest that the project had contributed towards improving the quality of public places by contributing to a reduction in littering and street incidents. This suggests the project will lead to an improved cleanliness and quality of the local area and reduced crime and antisocial behaviour in the longer-term, if these effects are sustained.

[42] Seven survey respondents at the baseline said either they did not know if they were confident or not while three went from somewhat confident to very confident.

5 Key findings: Value for Money

Introduction

Cost-Benefit analysis (CBA) was conducted in order to assess value for money of the CMF funds granted to the Tackling Alcohol Misuse project. The assessment weights the project's total economic costs against its monetizable social benefit.

The analysis used project data and secondary data to monetise the benefits accrued by each project strand. As there was no control (counterfactual) group against which to assess the impact of the project, artificial baselines were constructed (outlined in more detail below). Given the nature of the data used in the construction of the cost benefit and cost effectiveness models, the accuracy of results produced by the models should be interpreted with caution[43].

In addition to the cost-benefit analysis an additional secondary data search was undertaken to further inform the value for money assessment. This assessment is supplemented by perceptions regarding value for money gathered through qualitative consultations with staff, stakeholders and beneficiaries.

For more information on the methodological approach, see Chapter 2 and Appendix 1.

This assessment does not take into account non-monetizable benefits of project outcomes (such as increased knowledge and expertise of staff, or quality of space), which are explored in Chapter 4.

Value for money assessment

Cost benefit analysis

For the Tackling Alcohol Misuse project, the social benefits were captured through three domains: productivity saving, improved individual wellbeing and a reduction in crime as a result of a reduction in alcohol dependency. As such, the outcome of interest identified was the number of individuals supported to reduce alcohol dependency. This outcome was selected on the basis that there is a logically sound and well-evidenced link between a reduction in alcohol dependency and monetizable social benefits[44] in the form of costs related to crime and productivity and those costs incurred by the NHS as a result of alcohol dependency.

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[43] The Maryland scientific methods scale scores methods for counterfactuals construction on a scale of one to five (with five representing the most robust method). Due to the use of measures of additionally in the construction of the counterfactual, the approach taken for this analysis cannot be attributed a score. Therefore, the accuracy of results produced by the models should be interpreted with a high degree of caution. For more information, see: https://whatworksgrowth.org/public/files/Methodology/Quick_Scoring_Guide.pdf

[44] http://www.ias.org.uk/Alcohol-knowledge-centre/Economic-impacts/Factsheets/Estimates-of-the-cost-of-alcohol.aspx

Over the lifetime of the project, 22 clients of behaviour change activities reduced their alcohol consumption or were referred to alcohol treatment services and 85 beneficiaries left structured treatment services successfully across the two areas. In the model, considerations are made of what proportion of these individuals would have entered treatment without the project[45]. When calculating the longer-term benefit, adjustments are made to take into account predicted alcohol relapse rates for those completing treatment[46].

As a conservative estimate, the benefits of a reduction in alcohol dependency are limited to five years. Secondary data from the Greater Manchester Combined Authority (GMCA, formerly New Economy) Unit Cost Database and the Institute of Alcohol Studies estimated that the cost of alcohol dependency to the NHS, per year, per dependent drinker is £2,883. Calculations based on this data set derived an estimated saving of £9,030 from a reduction in harm related to crime and a productivity saving of £5,765 per dependent drinker. This results in a total economic cost of £17,708 per year per dependent drinker.

Table 5.1 below summaries the monetized value of the estimated benefits resulting from the Tackling Alcohol Misuse project.

Table 5.1: Monetizable benefits from the Tackling Alcohol Misuse project

Benefit	Value
Estimated productivity saving from a reduction in alcohol dependency	£101,237
Estimated NHS cost savings from a reduction in alcohol dependency	£76,695
Estimated saving from a reduction in alcohol dependency related crime	£241,040
Total economic benefit from project delivery	**£418,972**

The costs associated with achieving the £418,972 economic benefit to society included the cost of pre-treatment activities (outreach and engagement work, delivering alcohol harm messages, and the development of information, education and referral resources), training activities and in-treatment activities (the development and delivery of tailored support packages and the contracting of three external service-providers to carry out project activities). These costs totalled £283,347. A more detailed breakdown of the isolated and attributed costs can be found in table 5.2 below.

[45] The counter factual is incorporated into the cost figures provided

[46] Estimated based on figures from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1976118/

Table 5.2: Costs associated with the Tackling Alcohol Misuse project

Cost	Value
Cost of pre-treatment activities	£70,837
Cost of training activities	£42,502
Cost of in-treatment activities	£170,008
Total cost of project delivery	**£283,347**

Dividing the total benefits of project delivery by the by the total costs presented above derives a cost-benefit ratio of 1.48. This assessment suggests that every £1 of CMF funding returned on average £1.48 of monetizable economic benefit to society.

The estimated ratio of 1.48 infers that the measured project's benefits outweigh its costs. In addition, there are several key points that should be considered alongside this figure:

1. **Only monetizable benefits have been included within the analysis of benefits:** Estimated benefits were assessed based on measured and monetizable outcomes. Therefore, some direct and indirect social benefits may not have been captured through the CBA modelling. These are explored in Chapter 4.

2. **Attention must be paid not just to the ratio itself, but to whom the benefits and costs are accruing:** The benefits in this analysis accrue to a vulnerable minority population. From a social perspective, the intervention is thus acting to reduce inequality, and as such may be preferred to an alternative intervention with a marginally higher Cost-Benefit ratio, but where the benefits accrue to a less vulnerable population.

Secondary data analysis

In addition to the benefits presented above, there is evidence that the project contributed to outcomes that were not possible to monetize in the cost-benefit analysis due to a lack of available data on beneficiary outcomes. Analysis of secondary data therefore provides wider context to the CBA presented above.

In addition to alcohol reduction, the project provided support and advice to promote healthy behaviours, including healthy eating and smoking cessation. While data was not available on outcomes from these interventions, both obesity and smoking have been shown to incur a significant economic cost to society. For instance, smoking is estimated to incur a societal cost of roughly £1,900 per smoker per year, and smoking cessation

interventions are often found to be highly cost effective[47]. Moreover, Public Health England estimates the total social cost of obesity to be £27 billion per year[48]. It is harder to determine whether weight management interventions are cost effective. Many of the costs related to obesity are incurred over the long term and as such, significant cost savings provided by interventions are dependent on the weight loss being maintained in the long run. However, due to the significant social cost of obesity, only very small weight reductions in the long-term are needed in order to incur a return on investment for most weight-loss programmes[49].

Qualitative assessment of project costs and benefits

Project staff and delivery partners highlighted various activities undertaken to minimise costs and promote efficient use of funding. As mentioned in section 4.1.1, most of the outreach activities were carried out in collaboration with external organisations. Staff reported that this joint-outreach approach worked well as it was based on the shared goals of supporting the target group and thus was mutually beneficial, as outreach workers from both organisations were able to refer individuals to a wider range of support services, at no extra costs.

The project was also felt to minimise costs by delivering alcohol recovery activities at a range of venues run by delivery partners (including civil organisations, GPs and employers). This facilitated engagement of the target beneficiary group, as well as reducing overheads from venue costs.

Project staff and delivery partners also mentioned that having outreach and recovery workers who spoke relevant languages saved on project translation and interpreters costs.

All project staff and delivery partners interviewed agreed the project would not have gone ahead without CMF funding. While the commissioned service providers offered generic substance and alcohol misuse support services, staff and partners reported that this was unable to meet the needs of Eastern European community members due to barriers to engagement. This required a proactive approach, including the identification of staff with a specific skill set suited to the role, which would not have been possible without the additional funding and capacity afforded by the CMF funding. Staff felt that without the targeted support provided by the project, more Eastern European community members would have presented to A&E services.

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[47] Cancer Research UK, The Economic Case for Local Investment in Smoking Cessation. Available at https://www.cancerresearchuk.org/sites/default/files/economic_case_for_local_investment_in_smoking_cessation_printed_version.pdf

[48] PHE, Health Matters: Obesity and the Food Environment. Available at: https://www.gov.uk/government/publications/health-matters-obesity-and-the-food-environment/health-matters-obesity-and-the-food-environment--2#:~:text=The%20costs%20of%20obesity&text=It%20is%20estimated%20that%20the,and%20the%20judicial%20system%20combined.

[49] NICE, 2014, Maintaining a healthy weight and preventing excess weight gain in children and adults. Cost effectiveness considerations from a population modelling viewpoint. Available at: https://www.nice.org.uk/guidance/ng7/evidence/report-1-cost-effectiveness-considerations-from-a-population-modelling-viewpoint-8735005

6 Conclusions and lessons learned

This chapter outlines key learnings from this project around achieving delivery outputs and wider outcomes. The key barriers and enablers are also highlighted. There is also a discussion around some of the main attributes of the project, including for whom it benefited, the larger context in which it was created, and future directions in terms of replicability, scalability and sustainability.

What works?

The evaluation found three main components that facilitated the project delivery and achievement of outcomes:

1. Experienced staff to build trust among the Eastern European community members;
2. A strong collaboration with partner organisations allowed the project to draw from partners experience and expertise, and
3. A flexible approach to meet beneficiaries' needs and having several recruitment channels aided delivery of the project.

A cost benefit analysis estimates that the monetizable benefits of the project were greater than the total costs attributed to these outcomes.

- One successful component of this project was having project staff with the language and community outreach experience to deliver outreach and engagement activities as well as preventive work and alcohol treatments. This allowed the project to build trust among the targeted community and awareness around alcohol harms and services available.

- Furthermore, the strong network of partners allowed project staff to deliver services more effectively and efficiently by, for example, carrying out joint outreach work. It also contributed to the range of services that project staff could provide beneficiaries beyond alcohol related services by referring or signposting them to other services.

- Street outreach work and social media promotion activities helped project staff to recruit Eastern European community members with different needs. Face-to-face contacts on the streets or at community centres contributed to engaging beneficiaries with alcohol misuse issues, while campaigns on social media contributed to engaging beneficiaries in lifestyle and behavioural change programmes.

- A cost benefit analysis of monetizable project outcomes related to reduced alcohol dependency estimates that every £1 of CMF funding returned on average £1.48 of monetizable economic benefit to society.

Key barriers encountered included:

1. **Cultural barriers to engaging Eastern European beneficiaries in volunteering activities, and**
2. **Cultural stigma surrounding alcoholism, which created a barrier to engaging family and friends in group sessions.**

Due to the unpopularity of volunteering among the Eastern European community and a lack of interest among beneficiaries in unpaid work, the project could not upskill beneficiaries to become mentors and/or community leaders as originally planned.

Moreover, cultural stigma surrounding alcohol dependency hindered project staff in raising awareness among family and friends of beneficiaries. As a result, planned activities with friends and family members of beneficiaries were undersubscribed and the project delivered fewer sessions than planned.

There were several drivers which contributed towards beneficiaries' understanding about how alcohol misuse can negatively impact their health and engaged them to access available services.

The most important aspect was having experienced Eastern European outreach and recovery workers reaching out to beneficiaries directly. Face-to-face encounters through outreach work and mobile clinics were particularly effective, allowing Eastern European outreach and recovery workers to build trust amongst the Eastern European community in Wisbech and Peterborough, and encourage them to access available services. Apart from direct contact through outreach work and mobile clinics, promotion of services through social media channels in several Eastern European languages was useful to inform beneficiaries about services available to them, particularly preventative services offered through the behavioural change programmes.

The strengthened partners network also allowed projects to engage beneficiaries more effectively, either via referrals to their services or directly engaging with them at partners' premises (e.g. night shelter where Brief Advice sessions were carried out). Through strengthening of the partners network (including with GP surgeries, work places, and community centres), project staff were able to deliver services more effectively and efficiently through: joint outreach work, swifter provision of medicines and vaccines, on-site health checks and MOTs, as well as offering a flexible approach tailored to the needs of beneficiaries. Project staff and wider stakeholders mentioned helping beneficiaries to access several public services including housing, employment and social benefits - but also more general advice and support on how to improve their health conditions.

Finally, another important aspect of the project delivery related to how the project staff improved knowledge and expertise to deal with local issues. This was achieved through working closely with partners sharing experiences and best practices and by identifying

gaps in the services offered to Eastern European community members. For example, in Wisbech, the project staff identified a gap in housing support to Eastern European community members and decided to create a housing team to specifically support them in finding a suitable home.

For whom?

The key beneficiaries of this project were Eastern European community members, and, to a lesser extent, service providers and the local authority. Residents may have benefited from the project indirectly, although the data to infer benefits to residents is limited. There were several project activities that seemed to have benefited some Eastern European community members more than others.

- The outreach work carried out by this project was beneficial in building trust among Eastern European community members drinking on the streets, many of whom were also rough sleepers. The project encouraged them to attend brief advice sessions and, where possible, alcohol recovery treatments while also supporting them with their housing and other needs. Combining outreach work with partners offering housing support worked well, as alcohol misuse among Eastern European community is not only cultural but tends to be interconnected to other personal problems.

- Health checks and MOTs helped project staff to assess the level of alcohol support that Eastern European community members needed, if any. After health checks and MOTs, Eastern European community members were offered either preventive support services to improve their health and wellbeing which covered aspects of alcohol misuse depending on the needs of beneficiaries, or directly alcohol recovery services (Tier 2 and Tier 3).

- The project also tried to use behavioural change programmes (preventative work) as a springboard to taking up alcohol treatments, however, this element did not work as expected. Project staff mentioned that very few Eastern European community members involved in behavioural change programmes wanted to be referred to alcohol treatment programmes. However, Eastern European community members who misused alcohol and attended preventive work, generally reduced their alcohol consumption. Moreover, partners would refer beneficiaries with alcohol problems to the service providers offering alcohol services and preventative services.

The project aimed to contribute to reduce the tension caused by street drinking between Eastern European community members and the wider local resident population. In Wisbech, the number of containers in the street and street drinking incidents reduced, which may have contributed to fewer tensions between resident population and improve people’s feelings on public safety. However, there is no evidence to suggest this has been the case.

In what circumstances?

This project arose out of a need to provide Eastern European community members living in Wisbech and Peterborough with alcohol recovery services and wider public services to address their needs. There is a strong consensus among stakeholders that without this project Eastern European community members in Wisbech and Peterborough would have not received the information and advice on alcohol harms and would not have had access to available public services when they needed them.

The project carried out different activities to build trust among the community members which worked well in both locations, such as reaching beneficiaries at community centres. However, building trust and reaching out to Eastern European community members at outreach walks worked more effectively in Wisbech, which has a small population and street drinkers tend to be based in tightly defined public spaces. This enabled the team to speak to the same Eastern European community members and get them to trust the services. In Peterborough this was less effective, as street drinkers were not always concentrated in the same locations.

Could the project be replicated?

The project could be replicable in other areas where street drinking is a recurrent problem, as well as in areas where alcohol related hospital admissions are high – particularly among a residents' cohort.

There are several important aspects of the project that would contribute to its replicability in other areas.

- The number of organisations carrying out similar services and other services to the selected residents' cohort. A mapping and assessment of organisations working with the selected residents' cohort would need to be carried out, to understand what services other organisations provide and ensure they are complementary to the project. If there are several community centres working in the area with a concrete residents' cohort; the experience of the project would suggest that there would be a better chance that project can engage beneficiaries.
- Workers with the right set of skills need to be recruited. To carry out some of the project activities, workers need to have the right language skills to work with the specific community and build trust and understanding, as well as experience with community outreach and engagement.
- Ensuring continuity of outreach and alcohol recovery work. As outreach and recovery workers with the right set of skills are not abundant, there needs to a clear plan to ensure continuity of service to ensure beneficiaries do not lose trust if support workers leave.

Could the project be scaled up?

The project could potentially be scaled up by recruiting more outreach and recovery workers in both areas. Project staff suggested they could have reached more beneficiaries with greater staff capacity and felt there is still a need to inform Eastern European community members about alcohol harms and help them to access alcohol recovery services.

Is there evidence of sustainability beyond the lifetime of the project?

The project invested in building a strong network of partners to provide a flexible and more holistic service to beneficiaries. According to project staff, this network will be sustained beyond the project. Project staff also intended for the materials that had been developed through the project (including scratch cards to identify the level of alcohol use) to continue to be used by delivery providers and wider services, which may help to sustain the network of partners and services provided. Project staff also highlighted that developed materials related to harm reduction information were relevant for a wider group and could be used to help the wider population engage in alcohol recovery treatments, leading to a better chance of recovery.

However, all project staff and delivery partners highlighted that the continuity of targeted alcohol recovery services and behavioural change programmes for the Eastern European community relied primarily on the identification of future funding. Project staff felt that the role of outreach and recovery workers from the Eastern European community should be embedded into the work of the commissioned services providers. Delivery partners mentioned that some elements of the project could be embedded into the alcohol recovery mainstream services, but that this normally takes a long time. Project leads felt that further work was needed to continue break down the cultural barriers to engaging with alcohol reduction services in the Eastern European community and reach others who still require support. Thus, the local authority applied for a further round of CMF funding to continue the project. However, project leads were unsure how the project activities would be sustained beyond the funded period. Delivery staff felt that most activities could not be funded through the Public Health annual budget due to the specific focus and targeted approach taken.

7. Appendix 1: Methodology and technical note

Evaluation Methodology

Qualitative evidence

Qualitative data collection included focus groups and interviews with staff, beneficiaries and wider stakeholders, outlined below.

- **Focus groups.** One focus group was carried out with beneficiaries involved in behavioural change programmes at S4H premises. The beneficiaries that participated in the focus group were identified and selected by project staff. Participants were involved in behavioural change activities, normally carried out in groups, thus having a focus group was considered the most appropriate approach. Participants received information about alcohol harms during the behavioural change programmes on weight loss or to stop smoking. However, none of them misused alcohol. Thus, the effects of the behavioural change activities on the access to alcohol recovery treatments or reducing alcohol consumption were not assessed but only their level of awareness around alcohol harms and services.

  Initially, two focus groups were going to take place with beneficiaries. However, one was dropped as project staff highlighted beneficiaries involved in alcohol recovery treatments felt more comfortable talking about their alcohol problems in one-to-one encounters. Moreover, beneficiaries spoke different languages, which made a focus group less suitable and more logistically difficult.
- **Interviews with project staff, beneficiaries and other stakeholders (including delivery partners and wider stakeholders).** Face to face interviews were carried out with beneficiaries, project staff and other stakeholders as well as phone-interviews with project staff and stakeholders. For the face to face interviews with project beneficiaries, the evaluation team was supported by interpreters. A total of 20 interviews were carried out: 10 with beneficiaries, four with project staff including the local authority, six with delivery partners and one with a wider stakeholder. All interviews were recorded, and transcripts drafted.

Quantitative evidence

The evaluation drew on the pre- and post-surveys completed by beneficiaries of behavioural change programmes and alcohol structural treatments as well as post surveys completed by beneficiaries of alcohol structural treatment. The beneficiaries were selected by the project staff during the data collection phase. The survey questionnaires were distributed by project staff from August to November 2019 initially, but some also asked beneficiaries to complete post survey questionnaires in January 2020 due to low response rates.

Initially, post only questionnaires were going to be filled in by Brief Advice clients and former clients Tier 2 service users. However, the service providers carrying out brief advice session did not manage to complete questionnaires with service users. Moreover, one of the service provider had used an outdated version of the post questionnaire due to a change in staff which meant the updated questionnaire was not received.

Secondary data and monitoring information

Monitoring information was received from the three service providers, which included information on all intended outputs. This was collated and shared by the local authority project team. The monitoring data was recorded monthly or annually depending on the internal reporting requirements of each organisation.

Local authority project staff also shared statistics on the number of admissions for alcohol-specific conditions for both locations, and other secondary sources only for Wisbech. The latter included data on the number of containers found on the streets, police data on street-drinking incidents and CCTV data on street drinking. The local authority did not have similar data for Peterborough, however the effects of the outreach work and other project activities in Wisbech could be linked to a decrease in street-drinking because Wisbech is a small town however the same contribution could not have been drawn in Peterborough.

Additionally, one service provider carried out treatment outcome profile (TOPs) assessments with 46 Eastern European community members, supported by the project, at the start and at the end of alcohol structural treatments to assess their psychological and physical health as well as quality of life. This data was shared with the relationship manager.

Value for money assessment

In order to assess the feasibility of a cost-benefit analysis (CBA) or cost-effectiveness analysis (CEA) each of the 14 projects were assessed using the 8-step process below.

Based on this assessment, each project was triaged to one of three methodological groupings:

1. Cost benefit analysis (CBA): Where data on quantitative and monetizable outcomes was available, a cost-benefit analysis was conducted;
2. Cost effectiveness analysis (CEA): Where quantitative measures for outcome(s) existed, but no data (primary or secondary) was available to monetize the outcomes, cost effectiveness analysis was conducted; or
3. No feasibility for quantitative analysis: Where there was no quantitative measure of outcomes available to the evaluation, neither cost benefit analysis nor cost effectiveness analysis could be conducted. In this case, a qualitative assessment of project costs and benefits was undertaken based on analysis of staff, stakeholder and beneficiary perceptions from qualitative consultations. Secondary data on potential monetizable benefits was also reviewed.

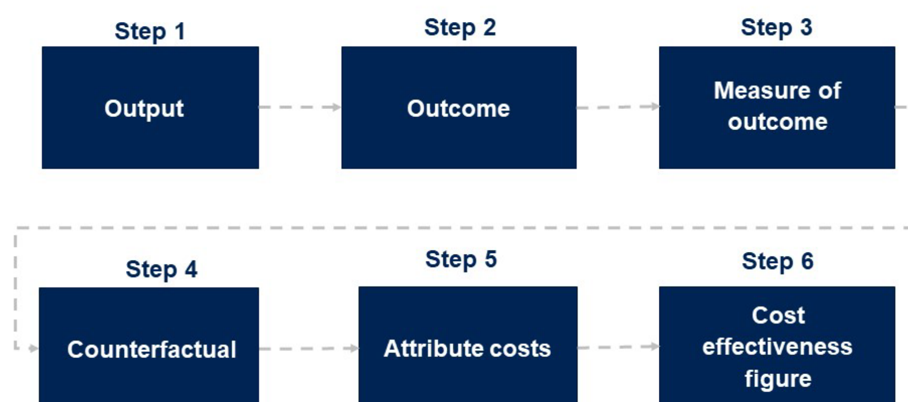
Eight step model for reviewing project outputs and outcomes

Cost-benefit analysis followed an eight-step process:

1. Identify the projects outputs (e.g. number of individuals provided with housing support)
2. Identify the achieved projects outcomes and the outcomes which are monetizable
3. Identify monetary values for each outcome from existing data sources
4. Assign a counterfactual case for the outcomes to estimate the number of outcomes achieved in the absence of the project; derived through primary information collection or secondary data analysis
5. Monetize the outcomes by multiplying the monetary value of each outcome by the number of additional outcomes achieved
6. Estimate the persistence of the outcome (i.e. is this a one-off benefit or ongoing, and how long does the benefit persist for into the future?)
7. Calculate the total monetary benefits (cost savings) by summing the total benefit for each outcome (including fiscal savings, public sector efficiency savings and public value benefits), accounting for any duplication of benefits across different categories.
8. Compared the total estimated monetary benefits to the total costs of the project, to estimate the estimated Benefit to Cost Ratio (BCR).

Cost effectiveness analysis followed a six-step process, outlined on the next page.

The process for conducting the cost-effectiveness analysis follows the six key steps outlined below.



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1. Identify the projects outputs
2. Identify the achieved projects outcomes
3. Identify quantifiable values for each outcome
4. Assign a counterfactual case for the outcomes to estimate the number of outcomes achieved in the absence of the project. This is derived through primary information collection or secondary data analysis.
5. Attribute costs using a breakdown of the project costs. Costs that are related to the outcomes identified in Step 3 can be isolated and attributed to the relevant outcomes.
6. Calculate the cost-effectiveness figure of the project outcome, by dividing the outcome by the cost attributed to it to derive the cost per unit of that outcome.

Two models were developed using Excel. The CBA model calculated costs relative to the monetizable benefits. The CEA model calculated costs relative to the quantifiable outcomes achieved from each of the CMF interventions (without attempting to monetize these outcomes).

As there was no robust control (counterfactual) group against which to assess impact, artificial baselines were constructed. Where possible, input from project leads was used to inform the assessment of the counterfactual and in the cases that this was not available, conservative estimates were made. A hierarchy of counterfactual options are outlined below. Given the nature of the data used in the construction of the cost benefit and cost effectiveness models, the accuracy of results produced by the models should be interpreted with a high degree of caution.

Counterfactual development: hierarchy of counterfactual options

Counterfactual development

Assigning a counterfactual

In order to assess value for money for a project we must compare the project's outcomes against a baseline or counterfactual scenario. The aim of the counterfactual is to replicate--as close as possible-- the outcomes that would have been achieved in the absence of the project. A hierarchy of counterfactual options are presented below:

1. **Randomised, blinded control group.** Individuals are randomly assigned to two groups at the start of an intervention. This is the gold standard in trial design.
2. **Matched comparator group**. Individuals receiving the intervention are matched with non-participants, and the outcomes of participants and non-participants are compared. Matching methodologies include Propensity Score Matching. This aims to imitate, as far as possible, the random allocation of an RCT.
3. **Historical baseline.** Using the same outcomes over the period prior to the intervention to form a counterfactual case. However, this method does not control for temporal variation.
4. **Baseline proxied by secondary data.** Using published evidence such as researched measures of additionality, or other identified data points, to represent the baseline scenario.

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Analysis / synthesis of findings

Secondary data and monitoring data shared by the project was analysed to extract key findings related to achievement of outputs and outcomes.

Interview and focus group notes were systematically inputted into an analysis grid for each research encounter, allowing for more in-depth analysis of findings. There was one grid for each type of audience consulted. The grids follow the structure of the topic guide enabling the identification of relevant quotes for each element of the outcomes and process evaluation. A thematic analysis approach was implemented in order to identify, analyse and interpret patterns of meaning (or "themes") within the qualitative data, which allowed the evaluation to explore similarities and differences in perceptions, views, experiences and behaviours. Once all data had been inputted, evidence for each outcome and key delivery themes was brought together in a second analysis matrix to triangulate the evidence and assess its robustness.

Qualitative approaches explore the nuances and diversity of perceptions, views, experiences and behaviours, the factors which shape or underlie them, and the ideas and situations that can lead to change. In doing so, it provides insight into a range of perceptions, views, experiences and behaviours that, although not statistically representative, it nonetheless offers important insight into overarching themes.

Project-level evaluation framework

	Who will measure it?	Peterborough/ Wisbech/ Both	When will it be measured?	Target	Data source						
					Monitoring information	Statistics and other secondary sources	Surveys pre/post treatments	Focus group with beneficiaries	Interviews with project staff	Interviews with beneficiaries (migrants who participate in training activities and treatment sessions)	Interviews with other stakeholders wider stakeholders including delivery partners
Outputs											
Alcohol awareness campaigns delivered among Eastern European communities	*Project*	*Peterborough*	*Per year*	*10*	*x*						
Outreach walks carried out	*Project*	*Peterborough*	*Per year*	*50*	*x*						
Workplaces engaged that employ Eastern European staff	*Project*	*Peterborough*	*Per year*	*22*	*x*						
Advice and Info contacts completed	*Project*	*Wisbech*	*Per year*	*240*	*x*						
Outreach walks carried out	*Project*	*Wisbech*	*Over 3 years*	*57*	*x*						
EE community members contracted on walks	*Project*	*Wisbech*	*Over 3 years*	*250*	*x*						

Night shelter client contacts	*Project*	*Wisbech*	*Over 3 years*	*50*	*x*						
Night shelter sessions delivered	*Project*	*Wisbech*	*Over 3 years*	*50*	*x*						
Night shelter clients attend service for assessment	*Project*	*Wisbech*	*Over 3 years*	*25*	*x*						
Referrals to other public services	*Project*	*Wisbech*	*Over 3 years*	*25*	*x*						
Group sessions delivered to members of the Eastern European community	*Project*	*Peterborough*	*Per year*	*52*	*x*						
Group sessions delivered to friends and family of the Eastern European community	*Project*	*Peterborough*	*Per year*	*12*	*x*						
People from Eastern European community undertaking training including alcohol information and brief advice training	*Project*	*Peterborough*	*Per year*	*55*	*x*						
Community networks supported to address alcohol information and brief advice training	*Project*	*Peterborough*	*Over three years*	*12*	*x*						
EE clients setting a personal health plan	*Project*	*Peterborough*	*Over three years*	*110*	*x*						

EE clients achieving a personal health plan	*Project*	*Peterborough*	*Over three years*	*66*	*x*						
EE clients reducing alcohol content or referred to alcohol treatment	*Project*	*Peterborough*	*Over three years*	*33*	*x*						
EE community members who access brief advice sessions	*Project*	*Peterborough*	*Over three years*	*50*	*x*						
EE community members who enter Str. Treatment	*Project*	*Peterborough*	*Over three years*	*79*	*x*						
EE community members completing treatment	*Project*	*Peterborough*	*Over three years*	*30*	*x*						
Group sessions delivered to members of the Eastern European community	*Project*	*Wisbech*	*Per year*	*52*	*x*						
Group sessions delivered to friends and family of the Eastern European community	*Project*	*Wisbech*	*Per year*	*12*	*x*						
EE community members that had access to treatment service (Tier 2)	*Project*	*Wisbech*	*Over three years*	*20*	*x*						
EE community members that had access to treatment	*Project*	*Wisbech*	*Over three years*	*20*	*x*						

service (Structured treatment)											
EE community members completing treatment	*Project*	*Wisbech*	*Over three years*	*15*	*x*						
Materials developed	*Project*	*Wisbech*	*Over three years*	*16*	*x*						
Case studies	*Project*	*Wisbech*	*Over three years*	*12*	*x*						
Short-term Outcomes											
Raised awareness and understanding on substance misuse and its impact on mental and physical health	*Projects*	Both	N/A	*Not determined*			x	x	*x*	*x*	*x*
Raised awareness across the Eastern European community on services available to them and how to access them	*Projects*	Both	N/A	*Not determined*			x	x	x	x	x
EE community members misusing substances start accessing available services	*Projects*	Both	N/A	*Not determined*			x	x	x	x	x
Increased education and information resources	*Projects*	Both	N/A	*Not determined*					x		x

Shared lessons learnt with other agencies through trainings, including case studies.	*Projects*	Both	N/A	*Not determined*					x		x
Trained staff on how to provide support to the Eastern European community	*Projects*	Both	N/A	*Not determined*					x		
Reduced problematic behaviour (e.g. number of incidents related to substance misuse)	*Projects*	Both	N/A	*Not determined*		x					

Outputs achievements

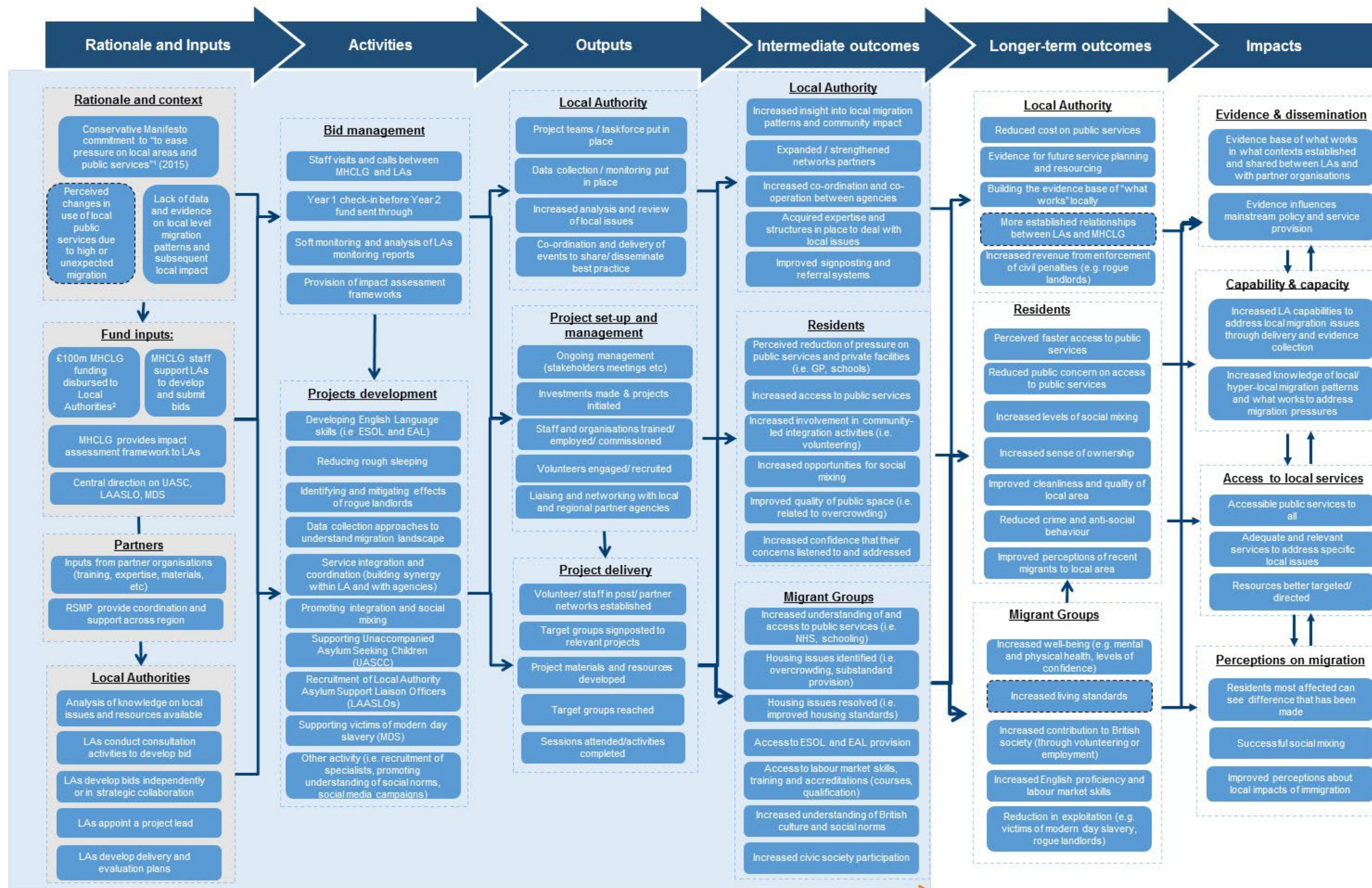
Ipsos MORI undertook an assessment of the project's success in achieving its intended outputs based on consideration of the evaluation evidence generated. There are five measures that this assessment can take and that have been consistently applied throughout the individual project evaluations. These measures are based on the definitions below.

Table: 7.1 Definitions of achievement measures

Achievement measure	**Definition**
Not achieved	The evidence indicates that the output has not been achieved
Partially achieved	There is some evidence to infer some of the output may have been achieved.
Partially achieved (on track)	The output has not been achieved at the time of the evaluation, however there is evidence to suggest that the output will be achieved within the time frame of the project.
Achieved	There is evidence to conclude that the output has been achieved.
Exceeded	This refers to output where monitoring information shows projects exceed their target outputs.
Inconclusive	There is not sufficient evidence to provide a robust assessment of progress towards project outputs.

Appendix 2: CMF Theory of Change

Controlling Migration Fund Overall fund-level Theory of Change



1.Conservative Manifesto https://www.bond.org.uk/data/files/Blog/ConservativeManifesto2015.pdfp31
2.An additional £40m is investing in direct enforcement action against people in the UK illegally and is not within the scope of this evaluation

Overall CMF logic model

Rationale is linked to activities and these are linked to outputs, outcomes and impacts.

Rationale

Context:

- There was a Conservative Manifesto Commitment to ease pressures on local areas and public services; There was a public perception that there were changes in the use of local public services due to high or unexpected migration; Local of data and evidence on local level migration patterns and subsequent local impacts.

Fund inputs:

- £100 million from MHCLG disbursed to Local Authorities; MHCLG staff support LAs to develop and submit bids; MHCLG provides impact assessment framework to LAs; Central direction on UASC, LAASLOs

Partners:

- Inputs from partner organisations (training, expertise and materials etc); RSMP provides coordination and support across the region.

Local Authorities:

- Analysis of knowledge on local issues and resources available; LAs conduct consultation activities to develop bid; LAs develop bid independently, or on strategic collaboration; LAs appoint a project lead; LAS develop delivery and evaluation plans.

Activities:

Bid management:

- Staff visits and calls between MHCLG and LAs; Year 1 check-ins before year 2 fund sent through; Monitoring and analysis of LAs monitoring reports; Provision of impact assessment frameworks

Project development:

- Developing English language skills (ESOL and EAL); Reducing rough sleeping; Identifying and mitigating the effects of rogue landlords; Data collection approaches to understand migration; Service integration and coordinating (building synergy within LA and with agencies); Promoting integration and social mixing; Supporting Unaccompanied Asylum Seeking Children; Recruiting local authority asylum support liaison officers; Supporting victims of modern day slavery; Other activities (recruitment of specialists, promoting social norms and social media campaigns)

Outputs

Local Authority:

- Project teams/ taskforces; data collection/ monitoring information; increased analysis and review of local issues; coordination and delivery of events to share and disseminate best practice

Project set up and management:

- Ongoing management; investments made and projects started; staff trained; volunteers engaged and recruitment; liaising and networking with local and regional agencies

Project delivery:

- Volunteers in post and networks of partners established; target groups sign posed to relevant projects; project materials and resources developed; target groups reached; sessions attended and activities completed.

Intermediate outcomes

Local authority:

- Increased insights into local migration patterns and community impacts; Expanded and strengthened network partners; increased coordination and cooperation between agencies; acquired expertise and structures in place to deal with local issues; improved sign posting and referral systems

Residents:

- Perceptions of reduced pressured on local public services; increased access to public services; increased involvement in community led integration activities; increased opportunities for social mixing; improved quality of public space; increased confidence that concerns are being listened to

Migrant groups:

- Increased understanding of and access to public services; housing ussyes identified; housing issues resolved; access to ESOLand EAL provision; access to labour market, skills and training, and accreditation; increased understanding of British culture and social norms, increased civic participation.

Long term outcomes:

Local Authority:

- Reduced cost of public services; evidence for future service planning and resourcing; building the evidence base of work works locally; increased revenue from enforcement of civil penalties

Residents:

- Perceived faster access to services; reduced public concern on access to public services; increased level of social mixing; increased sense of ownership; improved cleanliness and quality of local areas; reduced crime and anti-social behaviour; improved perceptions of recent migrants to local area.

Migrants groups:

- Increased well-being (mental health) levels of confidence; increased living standards; increased contributions to British Society; Increased English proficiency; Reduction in exploitation

Impacts:

Evidence and dissemination:

- Evidence base of what works in what contexts and shared between LAs and partners; evidence influence mainstream policies an service provision

Capability and capacity:

- Increased LA capabilities to address local migration issues through delivery of evidence collection; Increased knowledge of local hyper local migration patterns and what works to address migration pressures.

Access to local services:

Accessible public services to all; adequate and relevant services to address specific local issues; resources better targeted and directed

Peceptions on migration:

- Residents most affected can see difference that has been made; successful social mixing; improved perceptions of local impact of immigration.

Appendix 3: Research tools

CMF quantitative tools

Post-only questionnaire

Purpose of this survey

Ipsos MORI, an independent Market Research Company, is conducting an evaluation of the Controlling Migration Fund (CMF) on behalf of DLUHC. As part of this evaluation we are looking at how funded projects are working, including the Tackling Alcohol Misuse project. The purpose of this questionnaire is to gather anonymous information to understand how the project has affected people taking part. This information will be used as part of the evaluation of the project. Please do not write your name anywhere on this document. **Your date of birth is required so that we can link the questionnaire you completed at the beginning of the treatment with the questionnaire completed at the end of the treatment and will not be used to identify you.** More information about how we use and process data and your rights is contained in the privacy notice and information sheet. Filling out the questionnaire indicates your consent to share this information with Ipsos MORI, who will report to DLUHC.

Date of survey completion: __________

Date of birth: _______________

1. **Which of the following treatments have you accessed? PLEASE TICK ALL THAT APPLY.**
   - ☐ One-off advice
   - ☐ 12-week alcohol and substance misuse treatment
2. **Which of the following best describes your level of English language? PLEASE TICK ONE BOX ONLY**
   - ☐ I can speak and communicate easily
   - ☐ I understand but cannot communicate
   - ☐ I have difficulties understanding English
   - ☐ Prefer not to say

To what extent do you agree or disagree with the following statements?

3. **"I feel able to use the health services I need to" PLEASE TICK ONE BOX ONLY**
   - ☐ Strongly agree
   - ☐ Somewhat agree
   - ☐ Neither agree nor disagree
   - ☐ Somewhat disagree
   - ☐ Strongly disagree
   - ☐ Don't know

4. **“I know how to access the health services when I need to" PLEASE TICK ONE BOX ONLY**
    - ☐ Strongly agree
    - ☐ Somewhat agree
    - ☐ Neither agree nor disagree
    - ☐ Somewhat disagree
    - ☐ Strongly disagree
    - ☐ Don’t know
5. **“I know how to access alcohol and substance treatments available to me” PLEASE TICK ONE BOX ONLY**
    - ☐ Strongly agree
    - ☐ Somewhat agree
    - ☐ Neither agree nor disagree
    - ☐ Somewhat disagree
    - ☐ Strongly disagree
    - ☐ Don’t know
6. **How confident, if at all, do you feel about doing the following? PLEASE TICK ON BOX IN EACH ROW.**

	Very confident	**Somewhat confident**	**Neither**	**Not very confident**	**Not at all confident**	**Don’t know**
Discuss alcohol or substance misuse issues with an NHS doctor or nurse						
Go to the police about an offence that may have been committed against you						
Go to your local council to seek advice on accommodation or council services						
Attend a job centre to seek						

employment advice						

7. **To what extent do you agree or disagree that you can interact with people from different backgrounds to your own in your local area? By your area I mean within 15 minutes' walk from where you live. PLEASE TICK ONE BOX ONLY**
   - ☐ Strongly agree
   - ☐ Somewhat agree
   - ☐ Neither agree nor disagree
   - ☐ Somewhat disagree
   - ☐ Strongly disagree
   - ☐ Don't know
8. **To what extent do you agree or disagree that your neighbourhood is a place where people from different backgrounds get on well together? PLEASE TICK ONE BOX ONLY**
   - ☐ Strongly agree
   - ☐ Somewhat agree
   - ☐ Neither agree nor disagree
   - ☐ Somewhat disagree
   - ☐ Strongly disagree
   - ☐ Don't know
9. **Which types of community activities, if any, are you involved in?**
   - ☐ Volunteering
   - ☐ Sports club
   - ☐ Youth club
   - ☐ Religious group (e.g. local church, local mosque)
   - ☐ Other [please specify] …………….
   - ☐ None
   - ☐ Don't know/prefer not to say
10. **What do you hope to achieve through this treatment?**

Post- Survey questionnaire

Purpose of this survey

Ipsos MORI is an independent Market Research Company. Ipsos MORI is conducting an evaluation of the Tackling Alcohol Misuse project on behalf of the DLUHC.The purpose of this questionnaire is to gather anonymous information as part of the project-level evaluation. More information about how we use and process data and your rights is contained in the information sheet.

Date of survey completion:

Date of birth:

1. **Which of the following treatments have you accessed? PLEASE TICKE ALL THAT APPLY.**
   - ☐ One-off advice
   - ☐ 12-week alcohol and substance misuse treatment
2. **Which of the following best describes your level of English language?**
   - ☐ I can speak and communicate easily
   - ☐ I understand but cannot communicate
   - ☐ I have difficulties understanding English
   - ☐ Prefer not to say

To what extent do you agree or disagree with the following statements?

3. **"I feel able to use the health services I need to" PLEASE TICK ONE BOX ONLY.**
   - ☐ Strongly agree
   - ☐ Somewhat agree
   - ☐ Neither agree nor disagree
   - ☐ Somewhat disagree
   - ☐ Strongly disagree
   - ☐ Don't know
4. **"I know how to access the health services when I need to" PLEASE TICK ONE BOX ONLY.**
   - ☐ Strongly agree
   - ☐ Somewhat agree
   - ☐ Neither agree nor disagree
   - ☐ Somewhat disagree
   - ☐ Strongly disagree
   - ☐ Don't know
5. **"I know how to access alcohol and substance misuse treatments that are available to me". PLEASE TICK ONE BOX ONLY.**
   - ☐ Strongly agree
   - ☐ Somewhat agree
   - ☐ Neither agree nor disagree
   - ☐ Somewhat disagree
   - ☐ Strongly disagree
   - ☐ Don't know
6. **How confident, if at all, do you feel about doing the following? PLEASE TICK ON BOX IN EACH ROW.**

	Very confident	Somewhat confident	Neither	Not very confident	Not at all confident	Don't know
Discuss alcohol or substance misuse issues with an NHS doctor or nurse						
Go to the police about an offence that may have been committed against you						
Go to your local council to seek advice on accommodation or council services						
Attend a job centre to seek employment advice						

7. **To what extent do you agree or disagree that you can interact with people from different backgrounds to your own in your local area? By your area I mean within 15 minutes' walk from where you live. PLEASE TICK ONE BOX ONLY**
   - ☐ Strongly agree
   - ☐ Somewhat agree
   - ☐ Neither agree nor disagree
   - ☐ Somewhat disagree
   - ☐ Strongly disagree
   - ☐ Don't know
8. **To what extent do you agree or disagree that your neighbourhood is a place where people from different backgrounds get on well together? PLEASE TICK ONE BOX ONLY**
   - ☐ Strongly agree
   - ☐ Somewhat agree
   - ☐ Neither agree nor disagree
   - ☐ Somewhat disagree
   - ☐ Strongly disagree
   - ☐ Don't know

9. **Which types of community activities, if any, are you involved in?**
    - ☐ Volunteering
    - ☐ Sports club
    - ☐ Youth club
    - ☐ Religious group (e.g. local church, local mosque)
    - ☐ Other [please specify]
    - ☐ None
    - ☐ Don't know/prefer not to say
10. **Which one of these applies to you?**
    - ☐ I would share what I have learnt during the treatment with my friends and/ or family
    - ☐ I would not share what I have learnt during the treatment with my friends and/ or family
    - ☐ I do not know

CMF qualitative tools

Participant	Research method	Outcomes measured
Project leads	Interviews	All intermediate outcomes (1-5) All longer-term outcomes (1-2)
Delivery partners	Interviews	All intermediate outcomes (1-5) All longer-term outcomes (1-2)
Wider stakeholders	Interviews	Intermediate outcomes (1-3)
Beneficiaries	Interviews and focus group	Intermediate outcomes (4-5) Longer-term outcome 1