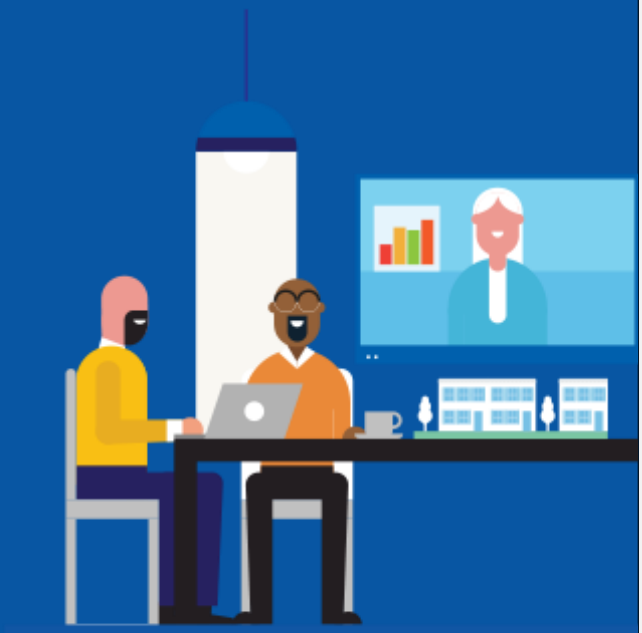
CAMPBELL TICKELL

CAMBRIDGE CITY COUNCIL

# Cambridge - Rough Sleeper Drug and Alcohol Treatment Grant (RSDATG) Evaluation

**FINAL REPORT**

November 2023



# Content

## 1. Introduction

1.0 Campbell Tickell (CT) has been commissioned to provide an impact evaluation of the National Rough Sleeping Drug and Alcohol Treatment Grant (RSDATG) in Cambridge and Peterborough and to produce a report for each Council.

1.1 RSDATG is a national Government funding programme, overseen by the Office of Health Improvement and Disparities (OHID) and funded jointly by the Department for Levelling Up Housing and Communities (DLUHC) and OHID. This funding is targeted at the local authorities identified by DLUHC and OHID as having the highest numbers of people placed into emergency accommodation during the Covid 19 pandemic and/or sleeping rough and/or at risk of sleeping rough or, latterly, based on numbers experiencing rough sleeping and is aiming to contribute to the government's ambition to end rough sleeping by the end of this Parliament (2025). Homelessness is also associated with poorer drug and alcohol treatment and overall poorer health outcomes.

1.2 The grant is awarded to fund specialist support for individuals to access and engage with drug and alcohol treatment and move towards longer-term accommodation, supporting the work of wider homelessness and rough sleeping funding. The grant gives local discretion regarding how resources are allocated to tackle substance use amongst rough sleepers and homeless people. Each local authority has designed its RSDA treatment approach to suit its local context.

1.3 Cambridge City was identified as one of 43 priority areas under phase one of the scheme and Cambridgeshire County Council was awarded funding in 2021 under the terms of this grant as the council holds responsibility for commissioning drug and alcohol treatment services. Total actual spend on the Cambridge project to the end of 2022/23 is £644k. This includes project staffing inpatient/rehab costs and commissioning costs. The grant allocation for 2023/24 is £494,805. Grant funding is due to end in March 2025.

1.4 The evaluation has examined the coverage and quality of RSDATG funded services, identified challenges and lessons learned to improve engagement of rough sleepers in drug and alcohol services. In Cambridge, this involves the HeaRT team, managed by Change Grow Live (CGL). The HeaRT team provides support and assistance to individuals who are homeless and are struggling with drugs or alcohol use and who can be hard to engage or resistant to engaging with treatment services. The evaluation has also examined the contextual factors affecting the implementation and outcomes of the interventions.

1.5 The evaluation was required to look at the performance data collected and develop a baseline that could be used for measuring impact over the subsequent two years of the grant and to inform lessons learned as well as any re-design and future commissioning decisions.

1.6 Some of the known and perceived challenges in both Cambridge and Peterborough include lack of workforce capacity (particularly in outreach and specialist roles). A lack of local residential rehab facilities and inpatient detoxification waiting lists that can be long and challenging for rough sleepers with complex issues to engage with. Community detox has proven difficult to deliver to complex patients who are not in stable accommodation, giving

rise to clinical safety considerations that have proved challenging to address to date (although we understand work in on going to develop a workable approach).

1.7 We were also asked to examine access to primary care and psychological health services and to identify how far trauma informed services are being delivered and the impact of peer support and how this capacity could be increased. There are a number of vulnerable groups such as sex workers, migrants, LGBTQ+ that require dedicated and tailored support and the CT team were asked to identify how far the service was tailored to the needs of these groups and any changes required to improve access.

1.8 The evaluation brief required Campbell Tickell (CT) to develop a theory of change and logic model for the RSDATG (set out in detail in Appendix 3) and use this to establish a series of outcomes and performance indicators. These to be used to develop a baseline of performance figures that would enable future measurement of service performance.

1.9 CT was also required to conduct a process evaluation and to examine service user experience, workforce experience and partnership/local system experience.

1.10 We were required to produce two reports, one for Cambridgeshire County Council and one for Peterborough City Council and to highlight areas of common interest or learning. Section 7 highlights linkages or areas where a combined effort would be beneficial.

### How the evaluation was conducted in Cambridge

1.11 Work has consisted of the following:

- One to one and group discussions. Initial meetings were held with 15 stakeholders to identify relevant issues. Meetings with members of the Cambridge HEaRT team and HEaRT team manager. These discussions were an opportunity to gain insights as to how RSDATG funding has impacted on service outcomes for rough sleepers/people at risk of rough sleeping with substance use issues, including service delivery changes. The full list of stakeholders consulted with and participants is contained at Appendix 1.
- A review of relevant documents (see Appendix 2 for list of documents reviewed).
- A face to face workshop held in May 2023, attended by stakeholders from the HEaRT team, Cambridgeshire County Council, other housing and support providers. This discussed the draft Theory of Change and logic model developed by Campbell Tickell and informed development of outcomes measures for future evaluation. The list of participants is contained at Appendix 1.
- Analysis of data: OHID quarterly returns for 2022/23,and Client Information Review, Sub-Intervention Review, and Treatment Outcome Review (CIR/SIR/TOPS) reviews completed for RSDATG clients working with the HEaRT team and data for the period April 2021- July 2023
- A survey of people with lived experience – carried out by Peer Mentors of the HEaRT service.

- Evidence Review. This considers best practice in relation to: harm reduction, housing-related support, trauma-informed care, psychosocial interventions and peer support and people with multiple needs. A separate report setting out the findings from this has been provided.

1.12 We would like to thank all who have participated and given their time to this evaluation.

## 2. Background

### Aims of the RSDATG

2.1 The evaluation process begins with the purpose of the RSDATG, which has been set out as:

1) **Outreach** – people are supported to access and engage in drug and alcohol treatment.

2) **Continuity of care** - people receiving drug and alcohol treatment have continuous high-quality care from emergency through to longer-term accommodation.

3) **Capacity building** - local drug and alcohol treatment systems build resilience and good practice to continue to meet the long-term needs of populations vulnerable to rough sleeping.

### The RSDATG Service in Cambridge

2.2 The service in Cambridge is delivered by a specific team (HEaRT), working within the overall substance use treatment service commissioned from Change Grow Live (CGL). As of August 2023, the RSDATG staffing structure consisted of the following staff:

1 FTE Team Leader
0.67 FTE Project Manager
6 FTE Recovery Workers (one of whom leads on work with homeless women)
0.59 FTE Peer Mentor Coordinator
0.6 FTE Clinical Psychologist
0.4 FTE Psychologist
0.5 FTE Prescribing doctor
0.5 FTE Nurse (post recruited November 2023, but vacant at August 2023)

2.3 The Project Manager and Peer Mentor Coordinator posts are currently occupied by the same person. It should also be noted that the service has a social worker resource funded by CGL outside of the RSDATG grant.

2.4 The Team Leader and Project Manager posts are line managed by CGL Service Lead, Cambridgeshire.

2.5 Key features of the RSDATG-funded service are:

1) An aim for caseloads of c. 20-30 individuals, rather than of around 90 clients within the wider CGL service.

2) A flexible route into the service and access to same day prescribing, supported by joint assessments between the Clinical lead and support workers.
3) An assertive outreach focus, including through the outreach van which operates in the city centre.
4) A holistic and trauma informed approach - which responds to people's practical needs, as well as treatment requirements, e.g. food parcels, clothes; allows people to return to the service and be re-scripted if they have come off their script.
5) Input from specialist roles. In Cambridge this includes a clinical psychologist.

## 3. Theory of Change and logic model

3.1 The Theory of Change is set out in detail in Appendix 3. It was developed using the RSDATG grant conditions, as well as through a workshop with RSDATG staff, partner organisations and commissioners. The Theory of Change includes indicators that can be measured through performance data, and we have set out the baseline performance for these. There are also indicators that require qualitative assessment, which could be self-assessment, and those that require a mixture of the two, (qualitative and quantitative). The Theory of Change at Appendix 2 is colour coded:

- Green = domains that can be checked for trends using data only
- Orange = domains which would require some self-assessment or other qualitative input to evidence outcomes
- Yellow = domains requiring a mix of data and qualitative input.

**The format for the Theory of Change**

3.2 The Theory of Change is set out as a logic model identifying a rationale (set out below) inputs, outputs/activities, outcomes and a set of KPI measures across three key domains:

- Client experience
- Systems and Service (including workforce, partnerships and collaboration)
- Long-term change.

**Theory of Change rationale**

3.3 The Theory of Change in underpinned by the following rationale:

3.4 People who are currently sleeping rough or are at risk of sleeping rough, who also use substances in a harmful way, often face many challenges to reducing harm and sustaining a tenancy. These include: long-term trauma, a history of engagement with the criminal justice system, and mental health issues, which can themselves be the cause of harmful substance

use. The complexity of people's needs can make it hard for people to engage with services, and all services in Cambridge need to work in a multi-agency partnership approach to ensure that every opportunity to engage and re-engage with clients is taken.

3.5 The HEaRT service, as part of that multi-agency partnership, should enable service users to feel empowered, to co-design their support and treatment plan. The service should treat people with dignity, respect and care and work in a way that builds service users' trust and confidence in the service.

3.6 Wraparound support from the HEaRT service, alongside input from committed partner agencies, should help service users to minimise harmful substance use. This in turn will support the overall goals of the RSDATG programme around reducing harmful use, entering and sustaining treatment and increasing service users' abilities to access and sustain long-term housing.

3.7 The rationale above was refined through the workshop and has been used to develop five core outcomes that the service is working to achieve:

- **The development of a trusting relationship with service users, which leads to a sustained active contact with the service.**
- **An increase in the number of people in the cohort gaining the benefit of treatment for their drug and alcohol use.**
- **An increase in the proportion of the cohort that engages in safer and more stable drug and alcohol use.**
- **An increase in health and wellbeing among the cohort**
- **An increase in those living in accommodation that they feel is safe and secure.**

3.8 The suggested KPI measures provide an approach for future evaluation and monitoring.

3.9 The Theory of Change brings together outputs and outcomes within three domains: Client Experience; Systems, Service, Partnerships and Collaboration and Long-term Change. This will enable a comprehensive review, which provides evidence of progress towards meeting RSDATG grant outcomes and which reflects the importance and impact of wraparound support and other multi-agency working – such as access to housing, health and wellbeing services – in achieving client outcomes.

3.10 The Theory of Change promotes a robust, data-driven approach to assessment, whilst also including the perspectives of service users and stakeholders.

3.11 Many of the indicators included within the Theory of Change can be gathered through utilising existing data and reporting. This can be supplemented with additional qualitative and quantitative data, to provide a more comprehensive picture of progress and successes.

# 4. Outcomes Evaluation and monitoring tool

## Data analysis

4.1 Our data analysis has consisted of an analysis of OHID date that RSDATG services nationally report on a quarterly basis to OHID using a template that captures a series of snapshots of performance. This means that it is very difficult to identify trends over time. We have also carried out a data analysis based on data from CIR/SIR/TOPS for RSDATG clients drawn from the CGL Criis data system. This section sets out the findings from each of these data analyses.

## OHID returns.

4.2 The HEaRT service provides quarterly monitoring returns to OHID on eight indicators and also provides demographic data.

4.3 For the purposes of the evaluation we have utilised data relating to the four quarters of 2022/23. The OHID data is a snapshot of the overall cohort during the quarter. It therefore does not illustrate the extent to which the caseload in a given quarter is the same or different from that in previous and subsequent quarters. Campbell Tickell has taken the average over the four quarters of 2022-2023 for each indicator and used this as the primary data for analysis.

4.4 This analysis was carried out with a view to assess how well each of the RSDATG services in the two locations (Peterborough and Cambridge) are performing. Performance here has been defined in relation to the objectives of the RSDATG, which relate specifically to providing wraparound support to reduce or stop the drug and/or alcohol use of rough sleepers and individuals at risk of rough sleeping. Measures of performance in this analysis therefore relate to the different means by which this support is provided such as harm minimisation and scripts, support for mental health and interventions around physical health and accommodation.

4.5 Campbell Tickell has set out below the findings from the analysis and additionally provided a data report in Power BI to enable Cambridge commissioners to carry out future analysis of OHID data.

## Findings from analysis of OHID data

4.6 **Demographics.** Data indicates that 79% of clients were male. The most common ethnicity during the period was White British (87% of total clients). The most common age bracket was 35 – 44 years old (47% of clients).

4.7 **Engagement of potential cohort.** Data indicates that a total of 137 people (rough sleepers and people at risk of rough sleeping) have engaged with the HEaRT service during 2022/23. This represents 62% of the potential caseload. The service has worked with 44.7% (21/47) of total rough sleepers and 66.1% (115/174) of total people at risk of rough sleeping.

4.8 **Caseload by cohort.** During 2022/23, a very high proportion of the cohort were at risk of rough sleeping rather than rough sleeping (84%). Of the total 137 people, 21 people (16%) were rough sleepers and 115 (84%) were at risk of rough sleeping.

4.9 **Accommodation status at triage**. This data records the accommodation status of 130 clients. These Clients were accommodated in a range of accommodation types: Settled (38), Temporary (33), Supported housing (26) and Emergency (13). Of these, 14 people were rough sleeping. The accommodation status of 6 people was not known.

4.10 **Substance use at assessment.** This records data relating to 213 individuals who were assessed for substance misuse. Of these, 92 (43.2%) were involved in polydrug use and 121 (56.8%) were involved in single drug use, there were 56 alcohol users at assessment.

4.11 **HRA: Housing needs assessments.** A high proportion of those needing a housing assessment when they entered the service (62%) had received one by Quarter 4 2022/23.

4.12 **Engagement with mental health treatment.** 82 people are recorded as needing mental health treatment. Of these, 31 people (37% of the total needing treatment) received this.

4.13 **Engagement in structured treatment.** A steady number of new starts of treatment were achieved – on average 20% of those requiring this each quarter. The average quarterly proportion of the cohort in any form of structured treatment was 65%.

4.14 **Retention in structured treatment.** A very high proportion of people (93%) were retained in treatment.

4.15 **Treatment completions.** The total number of people successfully completing treatment as a proportion of the total cohort engaged during 2022/23 was 5%.

### NDTMS, TOPS data and CGL Criss data

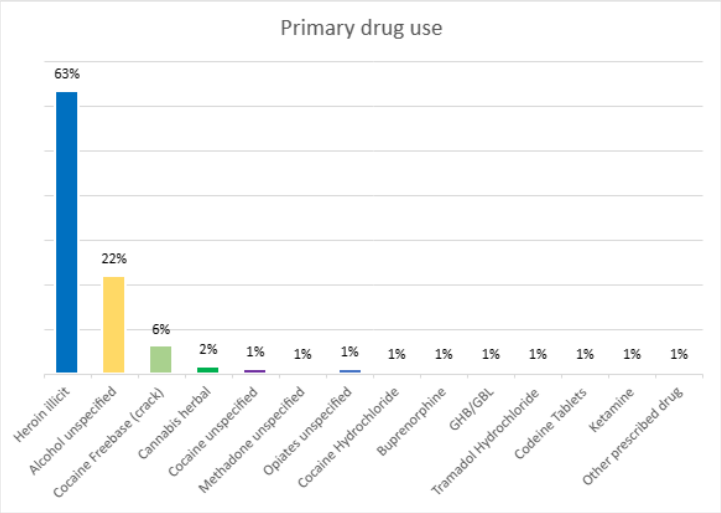
4.16 This relates to data from CIR/SIR/TOPS reviews completed for RSDATG clients and staff/client data contained on CGL's Criis case management system and relating to the period April 2021-July 2023. Data tables are attached as Appendix 4, there is also a table comparing date from Cambridge with Peterborough at Appendix 7, this is purely for information.

4.17 This data evidences individual level change for RSDATG clients by comparing results from the service user's first CIR/SIR/TOPS review after joining the RSDATG service to their latest one recorded on the system. NB: only a proportion of the total cohort (178 individuals) has received CIR/SIR/TOPS Reviews.

4.18 **Demographics.** This data indicates that 80% of clients have been male – a similar proportion to that in the OHID returns, 88% of the cohort identified as heterosexual, while 3% identified as gay/lesbian and 1% as bisexual. The proportions of the cohort from ethnic minority groups is very low: 85% of clients identified as White British, 8% were Other White and 1% were White Irish. The remaining 5% came from all other ethnic groups, with 1% not stated.

4.19 **Drug and poly drug use.** Data indicates a high proportion of clients (76%) were using two drugs and 38% of clients were using three drugs.

4.20 **Primary drug use.** Data indicates that illicit heroin use is the most common primary drug used (63%) while 22% of people had problematic alcohol use.

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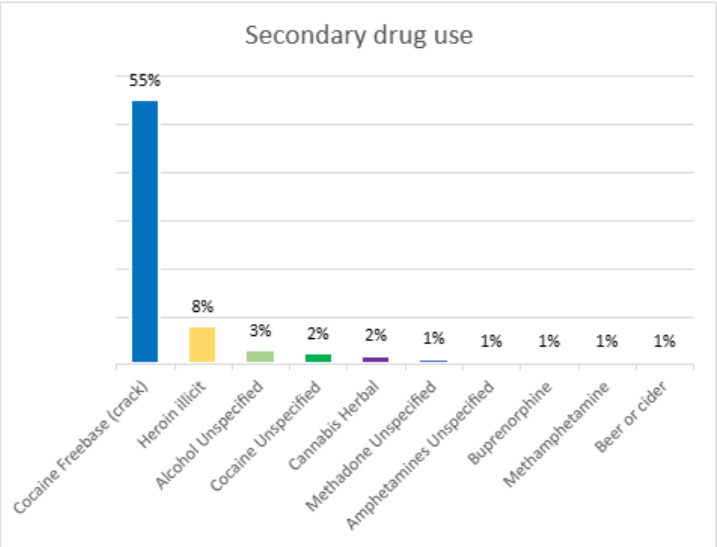
4.21 **Secondary drug use.** The main secondary drug was crack cocaine (55% of clients).

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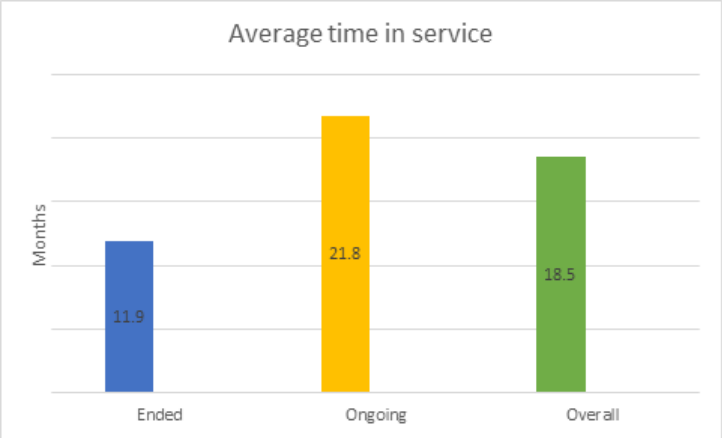
4.22 **Length of time engaged with service.** Data indicates that clients remain in the service for a significant length of time - an average of 18.5 months; that a high proportion of those who are engaged with the service remain in treatment for longer than 12 months.

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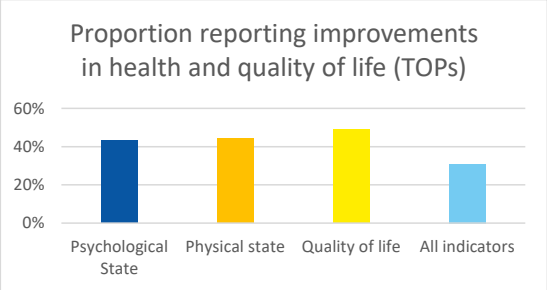
4.23 **Reduction in drug use.** Data indicates the service is making good progress around reducing risky drug taking behaviour (across the 46 individuals who use drugs intravenously there was a 32% reduction in the average number of days injecting within the past 28 days) and reduced use of primary drug across the cohort (an average 80% of service users reduced their use of their primary drug in the 28 days prior to reviews). This includes 33% of crack users and 21% of opiate users who reduced their use.

4.24 The average consumption of opiates reduced by 18%, cocaine by 22% and alcohol by 14%.

4.25 **Harm reduction, health and wellbeing.** 28% of people were immunised against Hep B at their first review; this rose to 39% by the time of the most recent review, a percentage increase of 43%. For Hep-C 62% of the cohort were offered and subsequently accepted a test for Hep-C, and of those who tested positive, 90% then went on to receive treatment.

4.26 The proportion of people reporting improvements in their physical health since they joined the service was 44%, in relation to their psychological health was 43% and in overall quality of life was 49% of the total cohort.

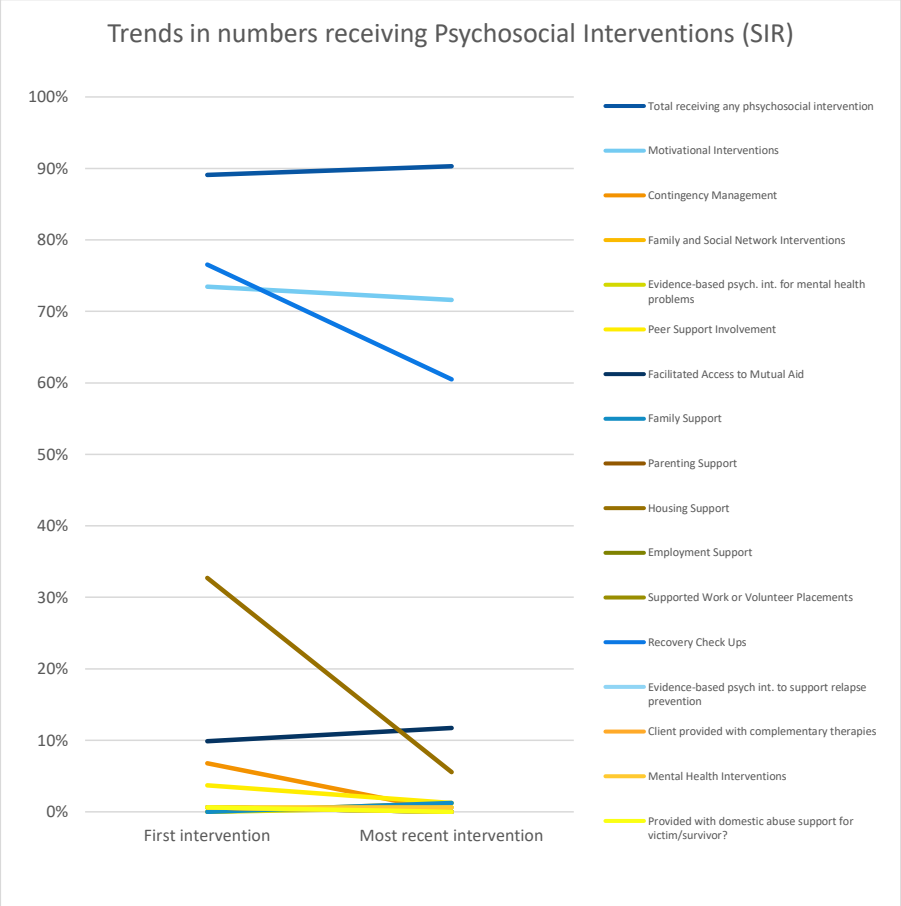



4.27 There is a very high rate of GP registration (93%).

4.28 The rate of issuing Naloxone to those who use opioids is only 23%.

### Findings relating to psychosocial interventions.

4.29 Data indicates a very high proportion of clients (more than 90%) have received psychosocial interventions. The most common of these has been a motivational intervention.

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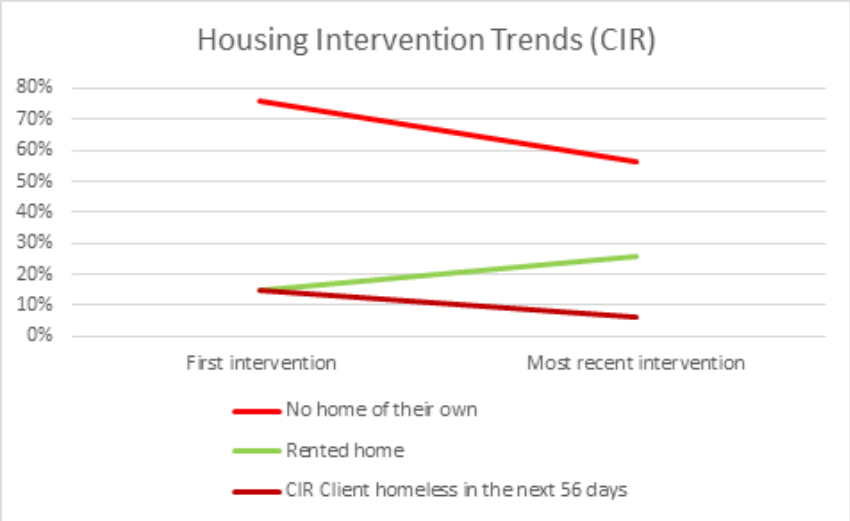
### Findings related to Accommodation status

4.30 There has been a significant increase in the proportion of the cohort living either in a rented home or other type of accommodation (up 80%) and a decrease in the number of clients with no home of their own (down 25%). This translated into an overall decrease in risk of homelessness within the next 56-days of 58%.

4.31 There was also a reduction in the number of people with an acute housing problem (down 26%) and a decrease (down 33%) in the number of clients either housed in unsuitable accommodation or at risk of eviction.

4.32 There were 8 people who were in a home of their own at the first review, but this had increased to 33 at the latest review. This represents a positive rate of change of 73%.

4.33 There were also 8 people at risk of homelessness at their first review, while this had increased to 13 by the time of latest review. This may be due to the increased number of people who were housed, which would lead to a higher number of people in the cohort who could be at risk.




## Establishing Future Monitoring Framework and Setting Performance Targets

4.34 The evaluation has considered the performance data currently collected and developed a baseline which can be used for measuring impact over the subsequent two years of the grant funding, to inform lessons learned and future re-design and commissioning decisions.

4.35 We set out below a suggested future monitoring framework based on what has been ascertained through the evaluation and based around current outputs and outcomes.

4.36 All information required for the monitoring framework is available on CGL's internal data collection system but will require different reporting/data to be pulled off in different ways. We therefore anticipate this will require discussion with CGL as the service provider.

4.37 We suggest working to a six-monthly timeframe for submitting additional returns/reports, in addition to the the existing quarterly OHID reports.

4.38 **Proposed Future Performance Framework – KPIs and data set for future monitoring**

4.39 We set out below our proposed approach for a future performance framework for the service.

**A selection of indicators from quarterly OHID returns** – using the Power BI report supplied by Campbell Tickell. These will include:

- The size of the open caseload
- Gender, ethnicity, age band, and primary drug used balance of the open caseload
- Proportion of potential cohort engaged in the service
- Proportion of caseload who are rough sleeping
- Proportion of the cohort registered with a GP.
- Proportion of caseload in need of a housing needs assessment who received it (amended quarter by quarter)
- Proportion of the cohort in any form of structured treatment
- Number of people within the cohort accessing treatment who have not previously done so – expressed as a proportion of those needing to access treatment at the start of the Quarter
- Proportion of those in need of mental health treatment, who were not already receiving treatment prior to the RSDATG service but who have successfully engaged with treatment since receiving the RSDATG service
- Proportion of the cases that end in an unplanned exit.

4.40 With the exception of the housing needs assessment indicator, we propose all indicators are expressed as an average of all quarterly results for the year on a cumulative basis.

### A selection of indicators from the CIR/SIR/TOPS reviews

4.41 As these will require new reports to be written we recommend utilising a small number of indicators within each of the five outcome areas**:**

- Proportion of the cohort showing a reduction in the number of days using their primary drug in the previous 28 days between their first and latest review.
- Percentage change in the proportion of the cohort in receipt of pharmacological interventions at their latest review in comparison to their first review
- Percentage change in the average score in relation to self-perception of physical health/psychological health/overall quality of life between the first and latest reviews
- Percentage change in the proportion of the cohort in a “home of their own” at their latest review in comparison to the situation at the first review
- Proportion of the cohort sustaining engagement with the service for at least 12 months
- Proportion of the cohort who are offered and subsequently accept a test for Hep-C.

4.42 The indicators will be drawn on a six-monthly basis from CIR/SIR/TOPS reviews. This will involve: agreeing rules on recording and reporting on contacts to be recorded on the Criis database; consideration of how to maintain basic records and reports relating to service users who are not subject to TOPS and other reviews.

### Recording and reporting of Contacts

4.43 To maintain records for clients not subject to TOPS reviews we suggest CGL is supplied with a spreadsheet with a list of fields. These could include:

- date of entry to the RSDATG service,
- date of case closure,
- treatment status at start of service,
- current treatment status,
- date of entering treatment,
- housing status at start of service and current housing status,
- mental health status at start of service and current status.

### Cambridge City Homelessness Database

4.44 Cambridge has a homelessness database based on Salesforcce (INFORM). We recommend this resource (INFORM) is also used as a basis for evaluating the service going forward. We suggest that the primary value of the database is in monitoring the detail of the cohort's housing history, including time spent rough sleeping rather than accommodation (supported housing, other temporary accommodation or settled housing). It should also be possible to monitor housing-related events such as referrals to accommodation, notices to quit and evictions etc.

### Service User Feedback

4.45 We suggest a short annual service user feedback survey, based around the five core questions used in this baseline evaluation, ie:

- I feel that I have an input into my treatment plan.
- I have trust and confidence in the staff I work with
- Engaging with the service has had a positive impact on my life and view of the future
- I feel that my general health has improved since working with the service
- I would recommend the service to a friend.

4.46 We would recommend an additional question relating to a specific service element, which could be varied for each survey. For example, in this evaluation we focussed on service users' interaction with the peer mentor service.

### Stakeholder Feedback

4.47 As a parallel exercise we recommend a short stakeholder feedback survey, focussing on process issues and the effectiveness of working within the wider system. We recommend the survey is on-line and made available to all relevant stakeholders, to increase participation rates.

4.48 We consider this approach and combination of KPIs, supports the shared Cambridge and Peterborough drug and alcohol priorities (last updated April 2022), particularly in relation to Prevention and Early Intervention (screening and delivering brief interventions), Harm Minimisation, Treatment & Recovery (increasing access to mental health support).

## 5. Process Evaluation

5.1 The process evaluation has focussed on examining the three core areas of user experience, service and workforce development, system development, including the strength of partnerships and collaborative working and any operational improvements required and achieved.

### Findings relating to user experience.

5.2 The HEaRT service provides outreach and in-reach support in a range of settings. These include:

- Street-based work. This includes: prescribing via the specialist doctor; the outreach van service – currently operating a Wednesday afternoon session in the city centre
- Drop-ins and other work in first and second stage temporary accommodation projects and day centres
- Home visits to people in longer-term settled accommodation.

5.3 The previous CGL mainstream service operated a low threshold approach, which encouraged engagement with the service. RSDATG funding has significantly enhanced the team's capacity and enables it to deliver a genuinely outreach-driven service, which is more flexible and proactive than its predecessor, for example being less based around appointments at CGL's office or other support service.

5.4 Stakeholders agree this change significantly increases accessibility for potential clients, supports the development of trusting relationships with HEaRT staff and increases client engagement and re-engagement with the service.

5.5 The expansion of in-reach work has improved relationships with hostel staff and this is perceived as directly impacting on service delivery and client outcomes. As long as clients are motivated to make positive changes around their substance use, support can be put in place before they reach crisis point and this helps reduce evictions from supported accommodation. Another specific benefit highlighted relates to clients who lose a script. HEaRT team involvement means they can now replace this rapidly, rather than needing to travel to a GP practice in another part of Cambridge.

5.6 Stakeholders also highlighted the positive impact of the new outreach approach in terms of engagement with prison leavers and people being discharged from hospital.

5.7 The outreach van is viewed as a key element of this new approach. It offers food and drink and access to multiagency support involving outreach, housing and dual diagnosis staff, GP and nurse.

5.8 The outreach van is highly popular with clients and promotes word of mouth referrals into HEaRT. As a result of its success, CGL is seeking to expand the service – holding more outreach sessions and engaging with additional services, such as Cambridge Women's Resource Centre. This will further increase accessibility and engagement for rough sleepers.

5.9 HEaRT's psychology service provides a range of support to clients, staff in the HEaRT team and other homelessness services. This includes: reflective practice sessions, assessing training needs around trauma-informed support and providing regular sessions around this for frontline staff; casework support which helps staff explore how they can embed trauma-informed practice. The team also provides direct support to a small number of clients and is developing a palliative care offer.

5.10 The psychology service is viewed as delivering a number of benefits. It helps to embed trauma-informed care across homelessness services in Cambridge. Reflective practice sessions provide staff with time out to explore the impacts that frontline work has on them and share ideas on cases and this assists with complex case resolution. This leads to increased staff understanding and empathy with clients' complex issues, improves staff resilience around working with these, with possible additional positive impact on staff sickness levels.

5.11 The very small number of recorded BAME and LGBTQ+ clients means it is not possible to assess the impact of the expanded outreach approach on service take-up by these groups.

5.12 Discussions highlighted a small group of entrenched rough sleepers with substance use and/or very poor mental health, who have no insight into their issues and who are completely disengaged from all services. Further work is needed to explore how these clients could be engaged with the HEaRT service. This is likely to require a comprehensive multi-agency approach.

### Engagement with structured treatment.

5.13 Discussion with HEaRT staff indicates that the team views rough sleepers as being significantly different from clients within CGL's mainstream service. The focus of work with rough sleepers is therefore on sustaining engagement with the service and harm reduction, rather than seeking high rates of successful treatment completion.

5.14 HEaRT operates a very flexible approach to casework and support. For example, needs assessments are often carried out through several short, informal conversations, rather than the standard practice of a single hour-long session. Clients who disengage from the service at any point are offered several opportunities to re-engage before their case is closed. HEaRT may also move cases from Tier 3 (structured) to Tier 2 (outreach/naloxone/needle exchange focus), giving clients a month to re-contact the service before case closure.

5.15 The provision of needle exchange and naloxone via the outreach van has increased take up of these interventions. The HEaRT team is involved in providing naloxone training for frontline hostel staff. This increases capacity and reduces the risk of overdose. Hep-C testing and treatment also provided via HEaRT reduces the risks of serious health damage.

5.16 Many stakeholders highlighted that the new HEaRT service has significantly speeded up access to Opiate Substitute Treatment and the value of the prescribing GP in enabling this. The team's practice around same-day prescribing has been showcased as good practice at CGL's national conference and with colleagues in CGL's mainstream service in Cambridge. HEaRT staff indicated they would like to increase access to Buvidal, as this removes the need for daily pick up or supervision of medication from a community pharmacy.

### Access to detox and rehab.

5.17 The team has a dedicated budget for detox and rehab. National guidelines (republished February 2023) seek to promote flexibility around pathways into detox and rehab. These factors are viewed as helping to increase access to this provision.

5.18 Whilst there are no detox units in Cambridge, the HEaRT team is able to access placements out of area via CGL's mainstream service. HEaRT is also developing a hostel-based community detox model.

5.19 There is an understanding that rough sleepers require additional preparation for detox, due their complex needs. This and the community detox model will require additional staff capacity. We understand the prescribing GP is currently exploring options, including use of agency staff for night shifts.

5.20 Discussions identified that there have been some barriers to accessing in-patient detox and rehab, due to lack of suitable discharge accommodation. This has meant some clients have not been able to benefit from this treatment. The most significant issue has related to Housing Benefit entitlement. More recently, confirmation has been sought and obtained from Cambridge City Council that Housing Benefit will continue for the duration of the rehab placement (up to 12 months). Housing providers have committed to be as flexible as possible to keep 'beds' open for individuals on their return and consider the most appropriate accommodation setting for their needs on discharge to sustain their recovery journey. HEaRT is also developing a panel system, involving a senior social worker, accommodation provider and nurse to consider the preparatory needs of those interested in rehab and aftercare provision.

### Access to primary and mental health; impacts on health and wellbeing and treatment sustainment.

5.21 The availability of a prescribing GP and nurse support facilitates access into screening and other primary care interventions. Stakeholders highlighted the contributions these make to improving clients' physical and psychological health.

5.22 Support from HEaRT psychologists builds staff confidence in supporting clients around mental health issues, including where it has not been possible to access help from statutory mental health services.

5.23 A proportion of HEaRT clients have multiple needs, which may relate to their physical and/or mental health. The HEaRT team is able to facilitate access to support for people with co-

morbid conditions via the Dual Diagnosis team. This includes support around stabilising behaviour and finding temporary accommodation.

5.24 However, discussions highlighted structural barriers in accessing statutory mental health services. These barriers chiefly relate to service capacity and very high thresholds for support. Services are perceived as being crisis-focused. Stakeholders also identified difficulties in accessing support for people with personality disorder, as the statutory team (Personality Disorder Community Service) is viewed as unwilling to work with people in active addiction and with challenging behaviour.

5.25 Similar barriers were identified in relation to accessing assessment and support from Adult Social Care services.

5.26 These factors are likely to negatively impact on HEaRT service users' health and wellbeing; their ability to engage with and sustain treatment outcomes.

### Peer support.

5.27 The HEaRT team has a peer mentor service. Peer mentors provide evidence of HEaRT's commitment to supporting the user voice and are an additional resource for one to one discussions/casework with clients. Their presence is a shift for HEaRT service users, which is likely to increase their trust and confidence in the service and helps build a different type of recovery pathway. As of August 2023, six peer mentors have been trained and one is in post. A number of peers have lived experience of rough sleeping or homelessness and this enables trusted relationships to be developed with service users.

5.28 There is an acknowledgement that development of the peer mentor service has involved much hard work and 'leaps of faith' and that there is a need to maintain a focus on longer-term risks and potential opportunities.

5.29 Wider stakeholders are highly supportive of the peer mentor service. However, there is some anxiety about how peer mentors will be involved in direct client support work. The role and remit of peer mentors therefore needs to be clarified to increase take-up and impact.

### Other accommodation issues

5.30 As outlined above, HEaRT provides in-reach support to clients and staff in homeless hostels which helps to stabilise clients and increases the likelihood they will sustain this accommodation. We also understand HEaRT has a very positive relationship with the Housing First service in Cambridge.

5.31 HEaRT staff ensure clients have made a successful transition to stable housing before closing cases or handover to CGL's mainstream service.

5.32 We understand HEaRT is a weekday only service and this can be problematic in terms of supporting clients who have been evicted at weekends.

## Findings relating to workforce experience

### Workforce recruitment and retention

5.33 The expanded HEaRT team and new roles have significantly increased capacity and reduced client caseloads. This enables the team to offer a more person-centred approach to support and which can work across all supported accommodation projects.

5.34 Discussion with HEaRT staff indicates that considerable time and effort has been taken to recruit staff with the right skills and experience to deliver the service. This has slowed the progress towards intended objectives. However, the team considers it is now on track to meet these.

5.35 There are no specialist workers in the HEaRT team leading on work with BAME and LGBT clients. Given the small number of recorded clients in these groups, this would not appear necessary at the moment.

5.36 One of the Recovery Coordinators leads on work with women clients. This is encouraging engagement from women who are rough sleeping and hidden homeless. The lead worker is aiming to replicate the methodology recently used in London to more accurately understand the extent and nature of women's rough sleeping in Cambridge.[1]

5.37 Discussions highlighted the value of recruiting the following additional staff to sit within the HEaRT team:

- A part-time social worker, to provide support with safeguarding issues
- A skills development and social activity programme worker (possibly delivered by peer mentors).

5.38 Discussions also highlighted the value of the following additional resources:

- Psychologist support, to ensure delivery of good quality monthly support across all hostels in Cambridge
- In lieu of access to statutory services, support for staff to enable them to work more effectively with service users who have mental health issues.

5.39 In relation to mental health support, HEaRT have considered the possibility of this being through the psychologist service. However, there are concerns that this might dilute the impact of the current dedicated role. Therefore, more consideration is needed of how best this work can be incorporated within the HEaRT team or if additional funding should be sought from outside the team to provide resources.

[1] Women's Rough Sleeping Census. More information available at: Boroughs proud to support the women's rough sleeping census | London Councils

### Staff training.

5.40 As outlined above, the HEaRT team delivers naloxone training to frontline hostel staff. The psychologists deliver training around trauma-informed care and provide other support to frontline staff. The HEaRT team as a whole acts as a learning resource for others. This increases expertise and capacity in the wider homelessness system. It is highly likely that these resources have increased workforce expertise and capacity and will increase the overall impact of the HEaRT service on positive outcomes for clients with substance suse issues.

### Multi-agency meetings.

5.41 Weekly multi-agency case meetings take place. These are well-attended by relevant stakeholders, including the nurse practitioner, hostels and housing teams. These facilitate information-sharing, action planning and accountability between partners.

5.42 The HEaRT team's clear remit to work with rough sleepers/people at risk of rough sleeping and its visibility/regular presence at local hostels and day centres are both viewed as having a strong positive impact on partnership/joint working.

5.43 The HEaRT team is co-located in a single building with the street outreach team (SOT)and the Cambridge Access Surgery (CAS) and the multi-agency outreach van support this approach.

5.44 Stakeholders described how the HEaRT team's involvement has improved the consistency of multiagency casework with clients. They highlighted the positive impact of this change for people with complex needs, especially those with mental health and dual diagnosis needs, leading to a more consistent approach to supporting clients.

### Integrated data collection

5.45 Discussions did not highlight particular concerns in this area. Stakeholders raised there is a possible need to re-shape OHID outcomes measures, to enable greater reflection on HEaRT's work around relationship building with clients and sustaining engagement with the service, rather than the current focus which is more on completing treatment.

### Findings relating to partnerships and local system experience.

5.46 Stakeholders describe the local context as being of good quality frontline homelessness services, with a strong commitment to partnership working from statutory and voluntary sector agencies. Stakeholders spoke of a truly collaborative spirit between partners and of people working together to achieve the same outcomes. This includes joint training sessions where people come together as peers, in non-competitive way and in a spirit of exploring issues and mutual learning.

5.47 The provision of wraparound support from HEaRT and partners agencies is intended to help minimise harmful substance use, thus supporting people's entry into treatment, access to and sustainment of longer-term housing.

5.48 The development of the Streets to Home pathway – which includes supported accommodation and the 451 high-support controlled drinkers' project – is viewed very positively in terms of improving joint working between accommodation providers, CGL and more recently the HEaRT team, including information-sharing (eg: notification of people who are at risk of eviction due to substance use), day to day support and move on access for rough sleepers in Cambridge.

5.49 However, stakeholders also identified that these arrangements are challenging to maintain in the current environment of decreasing funding and resources and the temporary nature of much grant funding, which makes services vulnerable to cuts or closure. Some stakeholders also pointed to the difficulty of providing an integrated service for multiply disadvantaged people within the context of a two-tier (county and city) administrative system, with split responsibilities for elements of service commissioning and delivery.

5.50 Discussions highlighted a series of systems issues which may impact on service users' ability to enter and sustain accommodation. These include:

- Insufficient overall supply and choice of high support accommodation/providers. This is linked to repeat homelessness for people with complex needs
- Insufficient supply of Housing First accommodation
- Insufficient consideration and discussion of the suitability of move-on options offered to clients with substance use issues
- Lack of move-on support – the current tenancy sustainment service does not offer long-term support and there is insufficient focus on clients' developing independent living skills; this creates a risk of social isolation and tenancy breakdown
- The need for a separate accommodation pathway for women, as local hostels can be chaotic and male-dominated.
- Poor practice around evictions – some providers are viewed as being too quick to evict on the grounds of service charge arrears, which are ultimately driven by substance use and need to be tackled from this perspective.

5.51 The situation outlined above in relation to the capacity and culture of statutory mental health services and, to a lesser extent Adult Social Care, is impacting on the ability to provide genuine wraparound support for clients with multiple needs.

### User experience

5.52 The HEaRT service, as part of a multi-agency partnership, should treat people with dignity, respect and care and work in a way that builds their trust and confidence in the service and helps them feel empowered.

5.53 The work has sought to hear from people with direct experience of using the HEaRT service a service user survey. Survey questions sought to understand the extent to which the HEaRT service treats people with dignity, care and respect and works with them in a way that builds their trust and confidence in the service and helps them to feel empowered.

5.54 The survey attached as Appendix 5 consisted of six questions containing a series of statements. The questionnaire was developed in consultation with the peer mentors and was used by them to gather feedback, a £5 Greggs voucher was offered to any client who completed the questionnaire. Respondents were asked to indicate their level of agreement to each question. Respondents were also given an opportunity to add comments.

5.55 The questionnaire was completed by 14 people from the HEaRT service. Findings are set out below.

**Q1. Input into treatment plan.**

5.56 All 10 respondents who responded to this question strongly agreed/agreed with this statement.

> *Cambridge has been brilliant. It's the easiest. I've not felt they've wanted control. They've let me be in control.*

5.57 Two comments related to scripting. One client was dissatisfied they had not been able to immediately access the methadone dosage they were seeking. A second client was dissatisfied that scripting was tied to ongoing attendance at meetings with a HeaRT worker.

**Q2. Trust and confidence in HEaRT staff.**

5.58 All 9 people who responded to this question strongly agreed or agreed they had trust and confidence in HEaRT staff.

> *I do trust the HEaRT team – they are always so kind, helpful and supportive. They do have eyes literally everywhere and know what I am up to though!*

5.59 Other comments reflected service the that the HEaRT team are reliable and follow through on agreed actions.

**Q3. Impact of engagement with HEaRT on clients' view of life and the future.**

5.60 All 13 people who responded to this question strongly agreed or agreed with this statement.

5.61 Respondents appreciated the intensity of support provided by HEaRT staff – including psychosocial support, which helped them better understand behaviours and to prevent relapse.

> *Without CGL, my recovery would not work*
> *Talking with them about my hopes for the future and them telling me I can do it spurs me on*
> *They make me look to the future and think anything is possible.*

5.62 One client additionally highlighted the impact of accessing hostel accommodation and another the outreach van in changing their perspective on life.

**Q4. Perceptions of improvement in general health since working with HEaRT**

5.63 8/14 people replying to this question perceived a positive impact, giving an overall positive response rate of 53%.

5.64 Comments indicated the positive impact on mental health due to HEaRT's support around income maximisation and around physical health due to fewer infections.

5.65 One client considered they were too early in the recovery process to perceive any benefits, whilst others did not understand how HEaRT could help in this way.

**Q5. Recommendation of the HEaRT service to a friend.**

5.66 All 11 people who responded to this question strongly agreed or agreed with this statement.

5.67 Clients praised staff's overall knowledge and expertise. One client stated that staff 'hassled' him, but considered this positively. Two people felt that relationships with staff were negatively impacted by staff turnover.

**Q6. Engagement with peer mentors.**

5.68 Three people had engaged with a peer mentor, 5 had not and 6 people did not reply to this question. One person felt this had been a positive experience and one did not. The third client did not respond to this question.

5.69 People who had engaged with a peer mentor indicated that they felt comfortable speaking to them. One also commented positively about the practical support they had received around accessing health services.

5.70 Two comments were received from clients who had not wished to engage with a peer mentor. One stated the reason for this was that they had been unwilling to 'discuss [my] personal stuff' with them.

**Additional comments.**

5.71 Clients highlighted the value of trauma-informed support in terms of helping clients develop trusting relationships, discuss sensitive issues and deal with mental health issues.

5.72 One client additionally highlighted the need for psychosocial support as well as pharmacological interventions to help clients address the reasons why they use drugs and achieve lasting change.

5.73 Another raised the importance of the psychologist service:

*I think every service should have a psychologist …. Whether someone's been through trauma or not, by the time they're coming off the stuff their mind and body is so numb to everything. I think a lot of people don't realise because they don't understand what's happened to their mind.*

## 6. What is working well and areas for development

6.1 The process evaluation indicates that HEaRT's service model has enabled the team to offer immediate, multi-agency interventions. This has increased access to drug and alcohol support, as well as primary care and accommodation.

6.2 The low-threshold and multiagency approach offered by the outreach van has been a particularly successful element of the service.

6.3 The psychologist service has also been highly successful. The review provides evidence of its effectiveness in embedding trauma-informed care and increasing the skills and confidence of HEaRT and other frontline staff. This is also reflected in responses to the service user survey.

6.4 The success of the HEaRT service to date is underpinned by a highly flexible approach to casework and support and excellent partnerships with temporary accommodation and other support providers in Cambridge.

6.5 Clients responding to the online survey indicate a high level of trust and confidence in the service. They also indicate the importance of providing an assertive/persistent approach to support, which is trauma-informed and which offers psychosocial as well as pharmacological interventions.

6.6 The service has been effective at engaging and working with female substance users. Work is being undertaken which will enable identification of women who are hidden homeless and this should lead to greater engagement with this group.

6.7 BAME and LGBTQ+ clients make up only a small percentage of the client caseload. It is understood that this is an accurate reflection of the local rough sleeping and wider homelessness population. However, this also means it is less possible to draw conclusions around the effectiveness of the service model with this groups.

6.8 Available data indicates the service is successful in engaging a high proportion of clients in structured treatment, reducing risky behaviour around substance use and primary drug use.

6.9 The service is also successful in terms of health and wellbeing outcomes, including: Hep B and Hep C treatment and self-reported improvements in physical psychological and overall quality of life.

6.10 Current reporting does not enable us to analyse the demographic and support needs profile of those who are accessing or not accessing treatment during a given quarter. It would be useful to explore if available data can give us more information, to build understanding of the reasons for non-engagement in treatment and any barriers.

6.11 There are some acknowledged barriers to accessing inpatient detox and rehab, which relate to the need to ensure clients have safe, suitable housing to return to after this intervention. HEaRT's work to set up a new multiagency panel should help this address this issue.

6.12 The peer support offered by HEaRT is valued by clients who have used it. It is recognised that peer support needs further development to generate uptake. This will include working with

frontline homelessness staff to promote the model and reassure them of the benefits of peer mentors being involved in direct support work with clients.

6.13 HEaRT's current staff resources are sufficient to maintain small caseloads and a highly responsive service, which can deliver intensive support to those clients who need it. HEaRT staff have identified the need for possible additional resources in relation to reflective practice sessions and mental health support – seeking to fill gaps due to lack of statutory service capacity.

6.14 It is not currently possible to evidence the impact of the service in terms of reducing drug-related deaths. We recommend this is a future KPI and that learning from any drug-related deaths/incidents is fed back into reflective practice sessions and informs the Cambridge & Peterborough Drug and Alcohol priorities.

## 7. System development

7.1 The evaluation has highlighted the good partnership working that already exists in Cambridge, including within the Streets to Home pathway and joint training between HEaRT and frontline homelessness staff.

7.2 The evaluation has identified structural issues which may impact on HEaRT's ability to ensure continuity of care for all the potential cohort. There is a need for more joint ownership of issues and support, particularly from statutory mental health services, to ensure homeless clients are viewed as people with multiple disadvantage.

7.3 The two-tier system of administration in Cambridgeshire separates commissioning of homelessness services from other commissioned support services. This makes it more complex to find solutions for people. Organisations may employ mental health and substance use staff who are not sufficiently linked into secondary mental health and other services.

7.4 Insufficient supply of high support accommodation, Housing First and tenancy support provision can act as a barrier to exiting homelessness and treatment engagement. The evaluation also highlights the need for effective accommodation pathways for people leaving prison and hospital.

7.5 Cambridgeshire & Peterborough Changing Futures programme operates a Trusted Person approach. This enables people who face multiple disadvantage to access all the support they need without repeating discussion of their experiences. The Trusted Person uses an individual's story to secure support from all relevant teams and professionals across the system; also sharing success stories which can be repeated and barriers/mistakes which can be avoided in future.

7.6 We think there would be a particular value in exploring this approach in Cambridge in relation to assessing the suitability of move-on options and ensuring tenancy support is provided.

### Process evaluation protocol

7.7 A process evaluation protocol has been developed as part of this evaluation this is attached as Appendix 6. If Cambridge and Peterborough RSDATG services where to be continued beyond the current grant period we believe that this provides a framework for future evaluation of the service performance in each area and can, if implemented as a peer evaluation framework, provide opportunities for shared learning and development across both areas.

## 8. Areas of synergy and linkages with Peterborough RSDATG

### Areas of strength/success in both areas

8.1 There are a number of common features across Cambridge and Peterborough that contribute to the success of the RSDAT services. These are:

- The small caseloads of each service promote an assertive, persistent and responsive approach which is required to engage with this cohort. Staff have the time and capacity to engage and re-engage with people who drop off the service and this has definitely increased access to drug and alcohol treatment for this cohort.
- In addition to lower caseloads, the low threshold and harm reduction focussed approach is effective in increasing engagement for this cohort and in sustaining engagement.
- The availability of primary care staff within the service has increased clients' health and well-being across both services.
- Both HEaRT and Aspire services play a wider role in their local systems, bringing additional benefits in terms of upskilling frontline homeless staff (in HEaRT, the psychologists specifically have impacted positively on Trauma Informed Care practice across local services, and are developing palliative care practices).
- In both services the Peer Mentor support is highly valued by those who use it and we believe has scope to be further developed and embedded in the service model.
- Effective multi-agency working is essential to engage the smaller number of clients with complex needs. Multi-agency working has been enhanced by the specialist roles in each service. In Peterborough the social worker role has increased access to Adult Social Care assessments and support for clients. In Cambridge the psychologists service has contributed (as outlined above). Conversely, it has been difficult to access statutory mental health services in both areas, where there has not been a specialist mental health worker attached to the teams.

### Areas for further consideration

8.2 We consider there are a small number of areas where practice could be strengthened to improve the services. Three areas to highlight are: the alignment of local accommodation pathways, stronger strategic leadership across the system for working with this cohort, and the focus of performance data.

8.3 The drug and alcohol treatment pathway needs to be aligned with the local accommodation pathway (or vice versa) for rough sleepers/single homeless people to ensure there is:

- Sufficient high support provision,
- Provision for people in active addiction,
- Arrangements to ensure that people returning from inpatient detox and rehab can access suitable accommodation,
- Sufficient move-on accommodation with support, and
- Effective hospital/prison discharge pathways.

8.4 There needs to be a strengthening of strategic leadership to develop the local system and enable improved working with the cohort of people who have multiple needs. This should cover homelessness, health (and the ICB role in relation to Inclusion Health), Public Health, and Adult Social Care.

8.5 Data recording needs to highlight the achievement of softer outcomes, e.g. sustainment in treatment, reduction in use, improved health and wellbeing, engagement with other services and with communities of support rather than focus on achieving targets for treatment completions.

### Areas where sharing learning and resource pooling could be beneficial for Cambridge and Peterborough services

8.6 Both services have developed peer mentor roles and our evaluation has found that those clients who have worked with peer mentors have found them beneficial. There is scope to build the peer mentor offer further to support people to continue their engagement with treatment, to act as role models and provide hope for recovery. We also consider there is potential for Cambridge and Peterborough services to work together to develop the peer mentor role and ensure it is fully scoped, to develop and deliver training programmes and to ensure that front-line staff understand the value of the peer mentor role to the service, as well as its limitations and boundaries and relationship to the support worker role.

8.7 There is also an opportunity to establish a Community of Practice across Peterborough and Cambridge to showcase good practice and casework successes in each area and to explore the challenges and barriers faced by each service within a solution focussed peer support environment. This might include sharing learning around obtaining Care Act assessments that has been facilitated by the social worker in the Peterborough team and the development of practice around palliative care in Cambridge. We would suggest consideration is given to having twice yearly 'showcase and learning' events are held where both Peterborough and Cambridge teams are brought together.

8.8 The evaluation protocol set out in Appendix 6 could also be used an opportunity to learn from each other's practice.

## 9. Recommendations

9.1 In addition to the Monitoring Framework and Performance Targets set out above, we recommend the following to support on-going implementation and achievement of outcomes during the remainder of the programme:

### User experience

9.2 Seek to expand the outreach van service through partnerships with homelessness services in Cambridge and exploring the use of volunteers and peer mentors as drivers.

9.3 Explore how entrenched rough sleepers and rough sleepers with complex needs can be supported to engage with the service. This is likely to include close joint working with the Street Outreach Team and mental health services. We recommend utilisation of the Trusted Person approach developed by Changing Futures as a means of developing effective multi-agency working arrangements for this part of the cohort.

9.4 Utilise findings from the women's rough sleeping census to explore how women with substance use and other support needs can be supported to access the service. This is likely to include joint working with Cambridge Women's Resource Centre.

9.5 Continue to develop accommodation pathways for people using inpatient detox and rehabilitation and examine access to detox for those with clinical complexity as well as subsequent accommodation routes.

9.6 Review access to inpatient detox for clinically complex clients and explore the potential to provide a local inpatient detox bed to enhance this

9.7 Develop the peer support service and ensure that staff in frontline homelessness services have opportunities to discuss any concerns and can be supported around these through their organisations.

### Workforce experience, partnerships and system development

9.8 Seek to expand the psychologist service, to enable additional support for frontline homelessness staff and seek funding for a part-time social worker within the HEaRT team. We understand that the stretched nature of statutory services' resources makes this challenging. It may be possible to draw on objectives set out in the Cambridgeshire & Peterborough Drug & Alcohol Priorities 2022 – 27 and Health & Wellbeing Strategy, which understand the need to develop a whole systems approach and to address health inequalities for people with substance use needs, to argue for additional resources for these roles.

9.9 With Cambridgeshire County Council, review practice around evictions within supported accommodation projects and seek to develop a city/county-wide protocol or similar approach which will seek to reduce evictions through a multi-agency approach.

9.10 With the County Council, explore if any additional resources can be found to extend the length of tenancy support for people with higher/more complex needs.

9.11 In relation to data:

- Explore how the Cambridge City Homelessness database can be utilised to support future service evaluation
- Introduce monitoring around drug-related deaths through mortality reviews into deaths, which can be used to aid system learning and drive through changes required to reduce future risk of drug-related deaths
- Utilise street count and other data to understand the impact of the service on reducing local rough sleeping
- Explore with CGL the apparent low rate of Naloxone issue and the apparent low rate of housing needs assessments completed

9.12 Carry out mortality reviews into drug-related deaths to aid system learning and drive through changes.

## APPENDIX 1 - STAKEHOLDERS AND CONSULTEES

| Organisation | Role |
|---|---|
| CGL | Clinical Psychologist |
| CGL | Clinical Psychologist |
| CGL | HEaRT Team Leader |
| CGL | Prescribing Clinician |
| It Takes a City | Manager |
| CGL | Data Manager |
| Cambridge City Council | Data Manager |
| OHID | Data Analyst |
| OHID | Data Analyst |
| DHSC, OHID and DLUHC | RSDATG Programme Manager, South East England |
| Dual Diagnosis Street Project | Team Leader and Psychiatric Nurse |
| Jimmy's | CEO |
| CGL | HEaRT Project Manager |
| CGL | HEaRT Recovery Co-Ordinator |
| CGL | HEaRT Recovery Co-Ordinator (Women's Worker) |
| Ministry of Justice | Health and Justice Partnership Lead, East of England |
| Cambridgeshire Constabulary | Partnership Officer |
| Cambridge City Council | Street Outreach Team Leader |
| Wintercomfort | Service Manager |
| | Specialist Access Nurse Practitioner |
| Cambridge City Council | Housing Coordinator |
| Cambridge City Council | Housing Advice Partnership Manager |
| Make Every Adult Matter (MEAM) | Strategic Lead |
| CGL | Street Outreach Team and Hospital Discharge Project Manager |
| Sheffield Hallam University | Lead Researcher for National Review of RSDATG Services |
| | NHR Funded Healthcare Pathway Mapping Project Researcher |
| CGL | HEaRT Peer Mentor |
| CGL | HEaRT Peer Mentor |
| CGL | HEaRT Peer Mentor |
| CGL | HEaRT Peer Mentor |
| CGL | HEaRT Peer Mentor |
| CGL | Service Lead |
| Cambridge City Council | Public Health Commissioner |
| Cambridge City Council | Housing First Manager |
| The Sun Network | Service User Engagement Worker |

## APPENDIX 2 - DOCUMENTS REVIEWED

Cambridgeshire County Council (9th February 2023), Learning Event: RSDATG Partnerships [PowerPoint Slides]

Cambridge City. (20th January 2023) Rough Sleeping Meeting [Action Log]

Cambridge City (19th January 2023) PHE Rough Sleeping Drug and Alcohol Treatment Grant – Operational Meeting [Meeting notes and actions]

Cambridge City (30th March 2023) Rough Sleeping Drug and Alcohol Treatment Grant Operational Group meeting. [Agenda]

RSDATG: Year 1 Evaluation

RSDATG Quarterly Monitoring Returns, Q1-Q2 2022/23 [OHID Data Returns]

RSDATG Scheme 2020-2021 funding allocation to Cambridgeshire County Council and Peterborough City Council [Letter]

RSDATG Scheme 2021-2022 funding allocation to Cambridgeshire County Council and Peterborough City Council [Letter]

RSDATG Scheme 2022-24 funding allocation to Cambridgeshire County Council and Peterborough City Council [Letter]

Cambridge RSDATG finance report, Q1 2023/24, Version 2

Cambridge RSDATG – Budget Financial Reporting, Q4 2022/23, Final

CGL, HeaRT Approach in Cambridge [PowerPoint Slides]

Service Model – CGL HEaRT Team

Public Health Intelligence and Cambridge and Peterborough City Councils (March 2023), Drug and Alcohol Quantitative Data – Drug and Alcohol Needs Assessment [Data Pack]

Cambridgeshire and Peterborough Public Health Intelligence Team (March 2023), Drug and Alcohol Needs Assessment for Cambridgeshire and Peterborough: Summary Report

Cambridgeshire and Peterborough Public Health Intelligence Team (March 2023), Drug and Alcohol Needs Assessment for Cambridgeshire and Peterborough: Summary of Qualitative Engagement Work

Cambridgeshire and Peterborough Councils (December 2022), Drugs and Alcohol Priorities 2022-2027, implementation plan.

Cambridgeshire and Peterborough (April 2022) – Drugs and Alcohol Priorities 2022-2027 [PowerPoint Slides].

## APPENDIX 3 - THEORY OF CHANGE

### Theory of Change

The content below is highlighted in:
green = domains that can be checked for trends using data only;
orange = would require some self-assessment or qualitative input;
yellow = a mixture of the two (data and qualitative input).

| Domain | Inputs | Outputs/activities | Outcomes | KPIs/Measures | Baseline 2022-23 |
|---|---|---|---|---|---|
| **Client experience** | Psychologist support hostels and day centres, including to develop Trauma Informed Care (TIC).<br><br>Outreach staff and health outreach van.<br><br>Sufficient hours of outreach delivered to reach all potential service users who need it.<br><br>Drop-in sessions accessible to all. | Staff in all settings work in a trauma informed way<br><br>Outreach and drop-in sessions held at various times of day and evening in different locations. | **The development of a trusting relationship which leads to a sustained active contact with the service.** | The proportion of the cohort sustaining engagement with the service for at least 12 months.<br><br>The proportion of the cases that end in an unplanned exit. | 75% of the cohort sustained engagement with the services for at least 12 months.<br><br>NB 48 service users remained engaged with the service more than 2 years after starting.<br><br>66 people disengaged with the RSDATG service across 2022-23. This represents 35% of the cohort. |

| Domain | Inputs | Outputs/activities | Outcomes | KPIs/Measures | Baseline 2022-23 |
|---|---|---|---|---|---|
| | | | | Service users report trust and confidence in the staff.<br><br>The percentage of the users who would "recommend the service to others". | 65% of respondents either said "Agree" or "Strongly Agree" with this statement (survey).<br><br>79% of respondents either said "Agree" or "Strongly Agree" with this statement. |
| | | Provision of structured treatment, pharmacological interventions, psychosocial interventions and peer support.<br><br>A number of people successfully complete treatment. | **An increase in the number of people in the cohort gaining the benefit of treatment for their drug and alcohol use.** | Client reported benefit during service engagement.<br><br>The number of people within the cohort accessing treatment who have not previously done so as a proportion of those needing to access treatment at the start of the quarter. | A total of 48 individuals and represents on average 20% of those needing to start treatment per quarter.<br><br>The average is 65% engaged in structured treatment over 2022-23. |

| Domain | Inputs | Outputs/activities | Outcomes | KPIs/Measures | Baseline 2022-23 |
|---|---|---|---|---|---|
| | | | | Average quarterly proportion of the cohort in any form of structured treatment. | 75% of the cohort sustained engagement with the services for at least 12 months. |
| | | | | Total number of people successfully completing treatment as proportion of total cohort engaged with. | A total of 9 people successfully completed structured treatment in 2022-23. This is 5% of the total number of individuals engaged with the service over the year. |
| | | | | The percentage change in the proportion of the cohort in receipt of pharmacological interventions at their latest review in comparison to their first review. | This changed from 38% receiving a pharmacological intervention at the time of their first review to 55% at their latest review. This represents a positive rate of change of 45%. |

| Domain | Inputs | Outputs/activities | Outcomes | KPIs/Measures | Baseline 2022-23 |
|---|---|---|---|---|---|
| | | | | The percentage change in the proportion of the cohort in receipt of psychosocial interventions at their latest review in comparison to their first review. | 89% receiving a psychosocial intervention at the time of their first review increased to 90% at their latest review. This represents a positive rate of change of 1.5%. |
| | Access to planned primary and secondary healthcare including for co-morbid conditions is facilitated. | Service users who are said to need mental health treatment have been supported to access it.<br><br>Service users have better physical and mental health.<br><br>Number of referrals for Hep C treatment and for liver treatment. | **An increase in health and wellbeing among the cohort** | The proportion of those in need of mental health treatment, who were not already receiving treatment prior to the RSDATG service but who have successfully engaged with treatment since receiving the RSDATG service. | On average 37% if those not already engaged with mental health services but in need of so doing have engaged since being part of the RSDATG service. |

| Domain | Inputs | Outputs/activities | Outcomes | KPIs/Measures | Baseline 2022-23 |
|---|---|---|---|---|---|
| | | Number of people who are immunised or treated for Hep B, Hep C | | The proportion of those immunised for Hep B while in receipt of the service. | 49 people had been immunised at their first review, while this increased to 70 at their latest review. A rate of increase equal to 43% |
| | | | | The proportion of the cohort tested for Hep-C | 62% of the cohort were offered and accepted a test for Hep-C |
| | | | | The proportion of those who had tested positive for Hep C who had been referred for treatment while in receipt of the service. | All of the 10 people found to be positive when tested, were referred for treatment. This represents 100% |
| | | | | The proportion of the cohort who had tested positive who had been cleared of the virus by the time of their latest review. | 90% of those referred for treatment had been cleared of the virus by the |

| Domain | Inputs | Outputs/activities | Outcomes | KPIs/Measures | Baseline 2022-23 |
|---|---|---|---|---|---|
| | | | | | time of the latest review. |
| | Service users are supported to engage with physical and mental health services and to sustain their treatment | Number of people who report improved health and wellbeing and perceive an improved quality of life. | **An increase in health and wellbeing among the cohort.** | The proportion of cohort showing an improvement in relation to their perception of their physical health since they joined the service (as judged as at their latest review).<br><br>The proportion of the cohort showing an improvement in their perception of their psychological health since they joined the service – as judged at their last review.<br><br>The proportion of the cohort showing an improvement in their perception of their | 79 people reported improvement in their self-perception of their physical health between the first and latest review – which represents 44% of the total cohort.<br><br>77 people reported improvement in their self-perception of their psychological health between the first and latest review – which represents 43% of the total cohort.<br><br>87 people reported improvement in their self-perception of their |

| Domain | Inputs | Outputs/activities | Outcomes | KPIs/Measures | Baseline 2022-23 |
|---|---|---|---|---|---|
| | | | | overall quality of life since they joined the service – judged as at their last review or their exit from the service. | overall quality of life between the first and latest review – which represents 49% of the total cohort. |
| | | | | The percentage change in the average score in relation to self-perception of physical health between the first and latest reviews. | The average score for self-perception of physical health went from 10 out of 20 to 11 out of 20. This represents a positive rate of change of 9%. |
| | | | | The percentage change in the average score in relation to self-perception of psychological health between the first and latest reviews. | The average score for self-perception of psychological health went from 9.4 out of 20 to 10.3 out of 20. This represents a positive rate of change of 10%. |
| | | | | The percentage change in the average | The average score for self-perception |

| Domain | Inputs | Outputs/activities | Outcomes | KPIs/Measures | Baseline 2022-23 |
|---|---|---|---|---|---|
| | | | | score in relation to self-perception of overall quality of life between the first and latest reviews. | of overall quality of life went from 8.8 out of 20 to 10.8 out of 20. This represents a positive rate of change of 23% |
| | | | **An increase in health and wellbeing among the cohort.** | The percentage of service users reporting that engaging with the services has had a "positive impact on their life and view of the future".<br><br>The percentage of service users reporting that their general health "has improved since working with the service". | 93% of respondents either said "Agree" or "Strongly Agree" with this statement.<br><br>57% of respondents either said "Agree" or "Strongly Agree" with this statement. |
| | Rapid administration of emergency medication such as naloxone.<br><br>Residential detox and rehab available. | Number of people being issued with naloxone.<br><br>Number of people accessing detox and rehab. | **An increase in the proportion of the cohort that indulges in safer and more stable drug and alcohol use.** | Number of naloxone issues.<br><br>Number and % of people able to access detox/rehab when they are ready. | |

| Domain | Inputs | Outputs/activities | Outcomes | KPIs/Measures | Baseline 2022-23 |
|---|---|---|---|---|---|
| | Rapid re-access available for people who drop out of engagement. | Number of medical restarts. | | The average number of days injecting in the previous 28 days between their first and latest review. (ignoring alcohol only cases). | The average number of days across the injecting cohort went down from 5.5 out of 28 at the first review to 3.7 at the latest. This represents a reduction of 32% |
| | | | | The proportion of the cohort showing a reduction in the number of days injecting in the previous 28 days between their first and latest review. | 67% of those who had been injecting in the 28 days before their first review (46) had reduced the amount of injecting they were doing by the latest review |
| | | | | The proportion of the cohort showing a reduction in the number of days using their primary drug in the previous 28 days | 80% of the cohort had shown a reduction in primary drug used in the 28 days prior to latest review in |

| Domain | Inputs | Outputs/activities | Outcomes | KPIs/Measures | Baseline 2022-23 |
|---|---|---|---|---|---|
| | | | | between their first and latest review.<br><br>The change in the average consumption of the primary drug over the previous 28 days between their first and latest review | comparison to the first review<br><br>The average consumption of opiates in the previous 28 days went down by 19% between the first and latest review<br><br>The figure for alcohol was 22%, and for Crack Cocaine was 28% |
| | Demographic data demonstrates the service is available to underserved groups including BMER, EU Citizens, LGBTQ+ and others. | The service is welcoming to different groups and tailored to meet the needs of different demographics. | **An increase in the number of people in the cohort gaining the benefit of treatment for their drug and alcohol use.** | | 4% for BMER and LGBTQ<br><br>19% female/80% male |
| | Specialised staff for underserved groups are employed. | Staff in place | | Qualitative from stakeholder interviews and staff focus groups. | |
| | Rough sleepers and those in | Proportion of caseload in need of housing needs | **An increase in those living in** | | 62% of the people needing a housing |

| Domain | Inputs | Outputs/activities | Outcomes | KPIs/Measures | Baseline 2022-23 |
|---|---|---|---|---|---|
| | unstable/temporary housing are supported to access treatment.<br><br>Service users with housing issues are supported to be assessed for and to access and sustain suitable housing. | assessment who received it.<br><br>Number of rough sleepers who are assessed as relief duty cases.<br><br>Number of service users with housing problems reduces. | **accommodation that they feel is safe and secure.** | Average quarterly proportion of rough sleeper caseload working with local authority as a relief duty case.<br><br>The percentage change in the proportion of cohort with an acute housing problem at latest review in comparison to the first review.<br><br>The percentage change in the | needs assessment when they entered the service had received it by Quarter 4 of 2022-23.<br><br>Over the last 2 quarters of 2022-23 this was 14-15% of the total cohort.<br><br>The number of people categorised as having an acute housing problem reduced from 84 to 62 between the first and latest reviews. This is a decrease of 26% in the number of people with acute housing problems |

**Commented [CR1]:** Should this be added into the main body of the report? I can't see a specific discussion around this outcome but I may be missing it.

**Commented [LZ2R1]:** done

| Domain | Inputs | Outputs/activities | Outcomes | KPIs/Measures | Baseline 2022-23 |
|---|---|---|---|---|---|
| | | | | proportion of cohort either in unsuitable housing or at risk of eviction at latest review in comparison to the first review<br><br>The percentage change in the proportion of the cohort that are in a "home of their own" at their latest review in comparison to the situation at the first review<br><br>The percentage change in the proportion of service users who were at risk of eviction from their own home at the latest review in comparison to the situation at the first review. | The number of people either in unsuitable housing or at risk of eviction reduced from 39 to 26 between the first and last reviews. This is a decrease in the number of people in unsuitable housing or at risk of eviction of 33%.<br><br>8 people were in a home of their own at the first review, but this had increased to 33 at the latest review. This represents a positive rate of change of 73%.<br><br>8 people were at risk of homelessness at |

| Domain | Inputs | Outputs/activities | Outcomes | KPIs/Measures | Baseline 2022-23 |
|---|---|---|---|---|---|
| | | | | | their first review, while this had increased to 13 by the time of latest review. This represented a negative rate of change of 58%. On the other hand this is a partial reflection of the fact that a significantly greater number of people then had their own home. |
| **Systems, service, workforce, partnerships and collaboration** | Integrated data collection system across organisations (clients tell their stories once). | All agencies inputting service user information into one database accessible to all; data sharing arrangements in place. | Service users feel that services are working together effectively. | Client reported; qualitative inputs from stakeholder interviews. | |
| | Appropriate staff training (inc trauma informed care) available. | Staff receiving training on trauma informed care. | Service users feel that staff treat them with respect and dignity. | Client reported during service engagement. | |

| Domain | Inputs | Outputs/activities | Outcomes | KPIs/Measures | Baseline 2022-23 |
|---|---|---|---|---|---|
| | Effective workforce recruitment and retention. | Sufficient well qualified staff in post and consistency of service provision. | Caseload levels which enable staff to spend sufficient time with clients. | Qualitative information from stakeholder interviews. | |
| | Staff receive suitable support from managers/clinical supervision. | Sufficient well qualified staff in post and consistency of service provision. | Increased staff wellbeing and confidence to provide an effective service. | Qualitative information from stakeholder interviews. | |
| | Manageable caseloads/capacity. | Staff feel that caseloads are manageable.<br><br>Sufficient well qualified staff in post and consistency of service provision. | Increased staff wellbeing and confidence to provide an effective service. | Qualitative information from staff focus groups. | |
| | Regular and well-attended multi-agency meetings which focus on progressing service user's cases. | Effective partnership working to resolve service user issues which cross organisational boundaries: meetings take place regularly and attended by key participants.<br><br>Service users experience a seamless service and do not have to repeat | System works together effectively to deliver a seamless service. | Client reported during service engagement.<br><br>Qualitative information from stakeholder interviews. | |

| Domain | Inputs | Outputs/activities | Outcomes | KPIs/Measures | Baseline 2022-23 |
|---|---|---|---|---|---|
| | | themselves to different agencies. | | | |
| | Peer support available. | Number of peer mentors employed. | Service users are inspired by people further along in their journey. | Client reported. | |
| **Long term change** | Access to a community support network focused away from substance use. | Support to engage with activities and organisations that support recovery. | An increase in the number of people engaged in community organisations and activities. | Client reported during service engagement. | |
| | Mechanisms exist to ensure that learning from RSDATG pilots are embedded in local treatment systems. | Services share learning through effective multi-agency partnership work; services continue to change in response to learning. | Continuous service improvement. | Qualitative information from stakeholder interviews. | |

## APPENDIX 4 - DATA TABLES FOR ANALYSIS OF CGL DATA

| Cohort demographic profile | | 178 | % |
|---|---|---|---|
| Gender | Male | 143 | 80% |
| | Female | 34 | 19% |
| | Not specified | - | -% |
| Ethnicity | White - White British | 152 | 85% |
| | White - Other White | 15 | 8% |
| | Asian/ Asian British - Other Asian | - | - |
| | Mixed - Other Mixed | - | - |
| | Mixed - White and Black Caribbean | - | - |
| | White - White Irish | - | - |
| | Black/ Black British - Caribbean | - | - |
| | White - Gypsy, Roma or Traveller | - | - |
| Sexuality | Heterosexual | 157 | 88% |
| | Not known | 7 | 4% |
| | Gay or Lesbian | 5 | 3% |
| | Not stated | - | - |
| | Bisexual | - | - |

| Cohort drug-use pro | | 178 | % |
|---|---|---|---|
| Primary drug used | Heroin illicit | 113 | 63% |
| | Alcohol unspecified | 39 | 22% |
| | Cocaine Freebase (crack) | 11 | 6% |
| | Cannabis herbal | - | - |
| | Cocaine unspecified | - | - |
| | Methadone unspecified | - | - |
| | Opiates unspecified | - | - |
| | Cocaine Hydrochloride | - | - |
| | Buprenorphine | - | - |
| | GHB/GBL | - | - |
| | Tramadol Hydrochloride | - | - |
| | Codeine Tablets | - | - |
| | Ketamine | - | - |
| | Other prescribed drug | - | - |
| Secondary drug used | Cocaine Freebase (crack) | 98 | 55% |
| | Heroin illicit | 14 | 8% |
| | Alcohol Unspecified | 5 | 3% |

| | | | |
|---|---|---|---|
| | Cocaine Unspecified | - | - |
| | Cannabis Herbal | - | - |
| | Methadone Unspecified | - | - |
| | Amphetamines Unspecified | - | - |
| | Buprenorphine | - | - |
| | Methamphetamine | - | - |
| | Beer or cider | - | - |
| Tertiary drug used | Alcohol unspecified | 19 | 11% |
| | Cocaine Freebase (crack) | 10 | 6% |
| | Cannabis Unspecified | 7 | 4% |
| | Cannabis herbal | 6 | 3% |
| | Cannabis herbal (skunk) | 5 | 3% |
| | Benzodiazepines Unspecified | - | - |
| | Cocaine Hydrochloride | - | - |
| | Cocaine unspecified | - | - |
| | Cannabis resin | - | - |
| | Diazepam | - | - |
| | Pregabalin | - | - |
| | Heroin illicit | - | - |
| | Buprenorphine | - | - |
| | Methamphetamine | - | - |
| | Amphetamine Sulphate | - | - |
| | Methadone unspecified | - | - |
| | Alprazolam | - | - |
| | Methadone linctus | - | - |
| Number of drugs used | No second drug | 42 | 24% |
| | No third drug | 69 | 39% |
| | Three drugs used | 67 | 38% |

| Service Duration | | | | |
|---|---|---|---|---|
| **Duration** | **Ended** | | **Ongoing** | |
| <6 months | 20 | 34% | 12 | 10% |
| 6-12 months | 15 | 25% | 24 | 20% |
| 12-18 months | 10 | 17% | 18 | 15% |
| 18-24 months | 5 | 8% | 16 | 14% |
| >2 years | 9 | 15% | 48 | 41% |
| **Total** | **59** | **100%** | **118** | **100%** |

| | Average time in service (months) |
|---|---|
| **Ended** | 11.9 |
| **Ongoing** | 21.8 |
| **Overall** | 18.5 |

| CIR Interventions | First | | Last | | % change |
|---|---|---|---|---|---|
| | Num | % | Num | % | |
| Hep-B Immunised | 49 | 28% | 70 | 39% | 43% |
| Hep-B Immunisation Offered | 74 | 42% | 61 | 39% | -5% |
| Hep-B Immunisation Not Offered | 9 | 5% | 10 | 6% | 11% |
| Hep-C offered and accepted test at Last Intervention | N/A | N/A | 110 | 62% | N/A |
| Hep-C positive | N/A | N/A | 10 | 6% | N/A |
| Offered treatment (of positive) | N/A | N/A | 10 | 100% | N/A |
| Cleared by treatment via referral pathway | N/A | N/A | 9 | 35% | N/A |
| Liver | 16 | 9% | 20 | 11% | 25% |
| Receiving mental health treatment of those with need | 79 | 65% | 80 | 65% | 0% |
| No home of their own | 41 | 76% | 73 | 57% | -25% |
| Either in rented home or other accommodation | 13 | 24% | 56 | 43% | 80% |
| CIR Client homeless in the next 56 days | 8 | 15% | 13 | 6% | -58% |
| CIR Issued with Naloxone | N/A | N/A | 32 | 23% | N/A |

| | SIR Interventions | Num | % | - | % change | % of… |
|---|---|---|---|---|---|---|
| First | Total receiving any pharmacological intervention | 61 | 38 % | N/A | 45.9% | *Proportion of SIR entries (162)* |
| Last/most recent | | 89 | 55 % | N/A | | |
| First | Total receiving any psychosocial intervention | 147 | 89 % | N/A | 1.4% | |
| Last/most recent | | 149 | 90 % | N/A | | |

| | | Y | N | % Y | % change | |
|---|---|---|---|---|---|---|
| First | Opioid assessment and stabilisation | 35 | 126 | 22% | 37.1% | **57%** |
| Last/most recent | | 48 | 113 | 30% | | **54%** |
| First | Opioid withdrawal | - | 159 | -% | 66.7% | **5%** |
| Last/most recent | | 5 | 157 | 3% | | **6%** |
| First | Opioid maintenance | 50 | 108 | 32% | 14.7% | **82%** |
| Last/most recent | | 57 | 100 | 36% | | **64%** |
| First | Opioid assess & stabl/withdr/maint | 0 | 162 | 0% | 0.0% | **0%** |
| Last/most recent | | 0 | 162 | 0% | | **0%** |
| First | Benzodiazepine maintenance | 0 | 162 | 0% | 0.0% | **0%** |
| Last/most recent | | 0 | 162 | 0% | | **0%** |
| First | Stimulant Withdrawal | 0 | 162 | 0% | 0.0% | **0%** |
| Last/most recent | | 0 | 162 | 0% | | **0%** |
| First | GHB/GBL withdrawal | 0 | 162 | 0% | 0.0% | **0%** |
| Last/most recent | | 0 | 162 | 0% | | **0%** |
| First | Gabapentinoid withdrawal | 0 | 162 | 0% | 0.0% | **0%** |
| Last/most recent | | 0 | 162 | 0% | | **0%** |
| First | Opioid relapse prevetion | 0 | 162 | 0% | 0.0% | **0%** |
| Last/most recent | | 0 | 162 | 0% | | **0%** |
| First | Alcohol relapse preve/cosump reduction | 0 | 162 | 0% | 0.0% | **0%** |
| Last/most recent | | 0 | 162 | 0% | | **0%** |
| First | Alcohol withdrawal | 0 | 162 | 0% | 0.0% | **0%** |

| | | | | | | |
|---|---|---|---|---|---|---|
| Last/most recent | | 0 | 162 | 0% | | 0% |
| First | Alcohol relapse prevention | 0 | 162 | 0% | 0.0% | 0% |
| Last/most recent | | - | 161 | -% | | -% |
| First | Motivational Interventions | 119 | 43 | 73% | -2.5% | 81% |
| Last/most recent | | 116 | 46 | 72% | | 78% |
| First | Contingency Management | 11 | 151 | 7% | -100.0% | 7% |
| Last/most recent | | 0 | 162 | 0% | | 0% |
| First | Family and Social Network Interventions | 0 | 162 | 0% | 0.0% | 0% |
| Last/most recent | | - | 160 | -% | | -% |
| First | C&B relapse prev. ints. (sub. mis. specific) | 0 | 162 | 0% | 0.0% | 0% |
| Last/most recent | | 0 | 162 | 0% | | 0% |
| First | Evidence-based psych. int. for mental health problems | 0 | 162 | 0% | 0.0% | 0% |
| Last/most recent | | - | 161 | -% | | -% |
| First | Psychodynamic Therapy (substance use focus) | 0 | 162 | 0% | 0.0% | 0% |
| Last/most recent | | 0 | 162 | 0% | | 0% |
| First | 12-Step work | 0 | 162 | 0% | 0.0% | 0% |
| Last/most recent | | 0 | 162 | 0% | | 0% |
| First | Counselling - BACP Accredited | 0 | 162 | 0% | 0.0% | 0% |
| Last/most recent | | 0 | 162 | 0% | | 0% |
| First | Peer Support Involvement | 6 | 156 | 4% | -66.7% | 4% |
| Last/most recent | | - | 160 | -% | | -% |
| First | Facilitated Access to Mutual Aid | 16 | 146 | 10% | 18.8% | 11% |
| Last/most recent | | 19 | 143 | 12% | | 13% |
| First | Family Support | 0 | 162 | 0% | 0.0% | 0% |
| Last/most recent | | - | 160 | -% | | -% |
| First | Parenting Support | | 161 | 1% | -100.0% | -% |
| Last/most recent | | 0 | 162 | 0% | | 0% |
| First | Housing Support | 53 | 109 | 33% | -83.0% | 36% |
| Last/most recent | | 9 | 153 | 6% | | 6% |

| | | | | | | |
|---|---|---|---|---|---|---|
| **First** | **Employment Support** | - | 161 | -% | -100.0% | **-%** |
| **Last/most recent** | | 0 | 162 | 0% | | **0%** |
| **First** | **Education and Training support** | 0 | 162 | 0% | 0.0% | **0%** |
| **Last/most recent** | | 0 | 162 | 0% | | **0%** |
| **First** | **Supported Work or Volunteer Placements** | - | 161 | -% | -100.0% | **-%** |
| **Last/most recent** | | 0 | 162 | 0% | | **0%** |
| **First** | **Recovery Check Ups** | 124 | 38 | 77% | -21.0% | **84%** |
| **Last/most recent** | | 98 | 64 | 60% | | **66%** |
| **First** | **Evidence-based psych int. to support relapse prevention** | - | 161 | -% | -100.0% | **-%** |
| **Last/most recent** | | 0 | 162 | 0% | | **0%** |
| **First** | **Client provided with complementary therapies** | | 161 | -% | -100.0% | **-%** |
| **Last/most recent** | | 0 | 162 | 0% | | **0%** |
| **First** | **Mental Health Interventions** | - | 161 | -% | 0.0% | **-%** |
| **Last/most recent** | | - | 161 | -% | | **-%** |
| **First** | **Client provided with smoking cessation interventions** | 0 | 162 | 0% | 0.0% | **0%** |
| **Last/most recent** | | 0 | 162 | 0% | | **0%** |
| **First** | **Client prescribed medication for relapse prevention?** | 0 | 162 | 0% | 0.0% | **0%** |
| **Last/most recent** | | 0 | 162 | 0% | | **0%** |
| **First** | **Provided with domestic abuse support for victim/survivor?** | - | 161 | -% | -100.0% | **-** |
| **Last/most recent** | | 0 | 162 | 0% | | **0%** |
| **First** | **Client provided with domestic abuse support for perpetrator?** | 0 | 162 | 0% | 0.0% | **0%** |
| **Last/most recent** | | 0 | 162 | 0% | | **0%** |

| Net change in all drug use (28 days) | | Average days used | % change |
|---|---|---|---|
| First | ALCOHOL | 11.7 | -14% |
| Last/most recent | | 10.1 | |
| First | OPIAITE | 11.1 | -18% |
| Last/most recent | | 9.1 | |
| First | CRACK | 9.6 | 0% |
| Last/most recent | | 9.7 | |
| First | COCAINE | 0.6 | -22% |
| Last/most recent | | 0.5 | |
| First | AMPHETAMINE | 0.1 | -76% |
| Last/most recent | | 0.0 | |
| First | CANNABIS | 5.7 | 15% |
| Last/most recent | | 6.5 | |
| First | OTHER | 1.2 | -9% |
| Last/most recent | | 1.1 | |

| Net change in primary drug use (28 days) | | Average days used | % change |
|---|---|---|---|
| First | ALCOHOL | 24.1 | -26% |
| Last/most recent | | 17.9 | |
| First | OPIAITE | 14.1 | -19% |
| Last/most recent | | 11.4 | |
| First | CRACK | 16.1 | -28% |
| Last/most recent | | 11.5 | |
| First | COCAINE | 4.5 | -78% |
| Last/most recent | | 1.0 | |
| First | AMPHETAMINE | N/A | N/A |
| Last/most recent | | N/A | |
| First | CANNABIS | 3.5 | -100% |
| Last/most recent | | 0.0 | |
| First | OTHER | 9.3 | -100% |
| Last/most recent | | 0.0 | |

| Numbers decreasing their primary drug consumption | | | |
|---|---|---|---|
| Primary drug | INCREASE | DECREASE | % of Total |
| ALCOHOL | 6 | 33 | 85% |
| OPIATES | 25 | 94 | 79% |
| CRACK | - | 8 | 67% |
| COCAINE | 0 | - | 100% |
| AMPHETAMINE | 0 | 0 | 0% |
| CANNABIS | 0 | - | 100% |
| OTHER | 0 | - | 100% |

| Net change in client reported health and quality of life | | Average score | % change |
|---|---|---|---|
| First | PSYCHSTAT | 9.4 | 10% |
| Last/most recent | | 10.3 | |
| First | PHYSTAT | 10.0 | 9% |
| Last/most recent | | 11.0 | |
| First | QUALIFE | 8.8 | 23% |
| Last/most recent | | 10.8 | |

| Numbers reporting improvements | N | % of total |
|---|---|---|
| PSYCHSTAT | 77 | 43% |
| PHYSTAT | 79 | 44% |
| QUALIFE | 87 | 49% |
| ALL ^ | 55 | 31% |

| Net change in housing problems | | N | % change |
|---|---|---|---|
| First | Acute housing problem | 84 | 26% |
| Last/most recent | | 62 | |
| First | Unsuitable housing or at risk of eviction | 39 | 33% |
| Last/most recent | | 26 | |

## APPENDIX 5 - SERVICE USER QUESTIONNAIRE

Change Grow Live

**Service user survey for evaluation of HEaRT**

**Cambridgeshire Country Council have recently commissioned Campbell Tickell to carry out an assessment of how well the Rough Sleeper Drug and Alcohol Treatment Grant (RSDATG) funded programmes are working in Cambridge and Peterborough. This means we are looking at the HEaRT and Aspire services in the two cities to see what is working well and therefore should continue, and what, if anything, needs to change.**

**As part of this assessment, it is really important to us that we hear from people who have direct experience of using the services. This survey is designed to enable you to have your say on how the HEaRT or Aspire services are doing.**

**This survey contains a series of statements. You will be asked to indicate your level of agreement for each. You will then be given an opportunity to add any comments.**

**If we have missed anything that you think is important, you can tell us this at the end of the survey.**

**We may wish to use direct quotes from your responses in our report, but please be assured that the suvey is anonymous so anything you say won't be attributable to you.**

**Depending on how much you would like to tell us, this short survey should take no more than 20 minutes to complete.**

**Please complete this survey by Friday 28th July 2023.**

***1. Before you continue, please indicate whether you use the services in Peterborough or Cambridge. ****

- ☐ Cambridge
- ☐ Peterborough

### Service User Survey

***2. I feel that I have an input into my treatment plan.***
***For example, I feel listened to in the design and implementation of my treatment plan.***

- ☐ Strongly Agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

Please add comments to explain why you have given this response.

***3. I have trust and confidence in the staff I work with at HEaRT.***

- ☐ Strongly Agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly Disagree

Please add comments to explain why you have given this response.

***4. Engaging with the HEaRT team has had a positive impact on my life and view of the future.***

- ☐ Strongly Agree
- ☐ Agree
- ☐ Disagree

- [ ] Strongly Disagree

Please add comments to explain why you have given this response.

***5. I feel that my general health has improved since working with HEaRT.***

- [ ] Strongly Agree
- [ ] Agree
- [ ] Disagree
- [ ] Strongly Disagree

Please add comments to explain why you have given this response.

***6. Have you engaged with a peer mentor at HEaRT?***

- [ ] Yes
- [ ] No

If you have not engaged with a peer mentor at HEaRT, please add a comment to explain why.

***7. Please only answer this question if you have engaged with a peer mentor at HEaRT.***

***Engaging with a peer mentor has been a positive experience for me.***

- [ ] Strongly Agree
- [ ] Agree
- [ ] Disagree
- [ ] Strongly Disagree

Please add comments to explain why you have given this response.

***8. I would recommend HEaRT to a friend.***

- [ ] Strongly Agree
- [ ] Agree
- [ ] Disagree
- [ ] Strongly Disagree

Please add comments to explain why you have given this response.

***9. Do you think we have asked you the right questions?***

- [ ] Yes
- [ ] No

If you have answered 'No', please tell us what you think we have missed.

***10. Please tell us anything else you think is important for us to consider in our assessment of the HEaRT service.***

***11. Please confirm whether you would be willing for us to use your story as a case study in our assessment report.***

- ☐ Yes, please use me as an anonymous case study.
- ☐ No, please do not include details of my story.

## APPENDIX 6 - EVALUATION FRAMEWORK

**Introduction**

This short paper sets out key issues and options for a future evaluation and monitoring framework, which will support of interventions supported with RSDATG programme funding. The reviews will be led by reviews led by Cambridge and Peterborough City Councils.

**Evaluation framework elements and issues for consideration**

These are set out in the table below.

| Evaluation framework element | Detail | Issues for consideration |
|---|---|---|
| **Who will be involved in evaluation process** | We are assuming a peer review approach, as this will enable the evaluation to be carried out within existing staffing/resources.<br><br>Peer review also supports a collaborative approach and shared learning.<br><br>. | Will evaluators include:<br><br>• Managers and frontline staff?<br>• Commissioned providers and/or local authority representatives?<br>• People with lived experience?<br><br>Each of these groups bring their own perspectives and increase resources for the evaluation. Staff and managers are likely to have good insights into the practical issues involved in service delivery and to develop good recommendations.<br><br>How would involving LA representatives be viewed by service providers (promoting or inhibiting joint learning opportunities?) |

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| | | Will experts by experience be fully involved in the evaluation, eg: developing topic guides, interviewing stakeholders, as well as service users?<br><br>There are possible capacity issues – staff will need to carry out their evaluation tasks alongside other duties.<br><br>There are possible skills/confidence issues, eg: analysing survey results, findings from qualitative interviews. |
| **Evaluation scope** | Evaluation and data collection could be organised within themes, eg:<br><br>• Service user experience<br>• Service and workforce development<br>• System development. | Thematic arrangement increases clarity around what is being evaluated and can be used to explore all relevant issues, eg:<br><br>• Planning, delivery and uptake of interventions<br>• Strength of partnerships/collaborative working<br>• Quality of deliver wraparound support<br>• Equality, diversity and inclusion<br>• Operational improvements achieved and required<br>• Impact of local context and system on service models (eg: availability of affordable/suitable housing, staff with appropriate skills).<br><br>Are these themes suitable?<br><br>Should annual evaluation seek to evaluate all aspects of service delivery, or only some (eg: where outcomes indicate weaker performance)? |

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|---|---|---|
| **Performance criteria and indicators** | These will be drawn from outputs and outcomes contained within the finalised Logic Model. | |
| **Type of data to be collected**<br><br>**How data will be collected** | We assume a mix of qualitative and quantitative information will be included.<br><br><u>Quantitative evaluation</u> will consist of review of available data over an agreed period, as contained in monitoring reports, surveys etc.<br><br><u>Qualitative evaluation</u> can include a number of approaches:<br><br>• Semi-structured one to one interviews with key stakeholders and/or service users<br>• Focus groups with key stakeholders and/or service users<br>• Site visits<br>• Online/in person surveys<br>• Desktop review of available documents (eg: aims & objectives, local strategies, SLAs, meeting minutes) and/or good practice review (comparison with similar services/geographical areas)<br>• Case file review. | Mix of qualitative and quantitative gives richer data.<br><br>Choice of qualitative approaches and sample size (interviews, case files reviewed etc) will be impacted by:<br><br>• Capacity of staff and experts by experience<br>• Skills and confidence of staff and experts by experience<br>• If the evaluation focus is more strategic or granular-level.<br><br>In general terms, semi-structured interviews and focus groups offer the opportunity to discuss key issues and a more exploratory approach, eg: if the service is meeting its objectives, where and why it has had most success in meeting targets, collaboration and joint working, innovation and continuous service improvement. On the other hand, case file review generates insight into day to day working practice and how this contributes to service outcomes.<br><br>Semi-structured interviews and focus groups potentially give richer data but are more time consuming/resource intensive to carry out; staff may not feel confident to carry out analysis. Surveys, using a mix of open and closed questions, are a less resource-intensive possible alternative. |

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|---|---|---|
| **Who is responsible for analysing and interpreting findings** | Qualitative and quantitative data will need to be triangulated, drawing out key findings, learning and recommendations. | • Will there be a formal written report and/or presentation and who will be responsible for leading on producing this?<br>• What will be the focus of report, eg: good practice, highlighting and addressing areas of concern? [I think they have indicated an 'appreciative enquiry' approach – what has worked and why, lessons learned and impact on future service delivery]<br>• How will findings and feedback be shared with all relevant stakeholders?<br>• How will recommendations/actions be prioritised and followed up? One approach<br>• What mechanism will be in place to deal with any disagreements about findings? |

## APPENDIX 7 - TABLE COMPARING PERFORMANCE ON INTENDED OUTCOMES

| Intended Outcome | KPI | Cambridge | Peterborough |
|---|---|---|---|
| **An increase in the proportion of the cohort that indulges in safer and more stable drug and alcohol use.** | The average number of days injecting in the previous 28 days between their first and latest review (ignoring alcohol only cases). | A reduction of 32% across the 46 individuals using drugs intravenously. | A reduction of 26% across the 55 individuals using drugs intravenously. |
| | The proportion of those within the cohort using drugs intravenously showing a reduction in the number of days injecting in the previous 28 days between their first and latest review. | 67% of the cohort of 46 who use drugs intravenously | 38% of the cohort of 55 who use drugs intravenously |
| | The proportion of the cohort showing a reduction in the number of days using their primary drug in the previous 28 days between their first and latest review. | 80% of the cohort had shown a reduction in primary drug used | 85% of the cohort had shown a reduction in primary drug used |
| | The change in the average consumption of the primary drug over the previous 28 days between their first and latest review | The average consumption of opiates went down by 19% The figure for alcohol was 22%, and 28%for Crack Cocaine | The average consumption of opiates went down by 12% The figure for alcohol was 13%, but no reduction for Crack Cocaine |
| **An increase in the number of people in the cohort gaining the benefit of treatment for their drug and alcohol use** | Average quarterly proportion of the cohort in any form of structured treatment | The average is 65%. | The average is 70%. |
| | Total number of people successfully completing treatment as proportion of total cohort engaged with over 2022-23 | 5% of the total number of individuals engaged with the service over the year | 3.5% of the total number of individuals engaged with the service over the year |
| | The number of people within the cohort accessing treatment who have not previously done so as a | 20% of those needing to start treatment per quarter | 38% of those needing to start treatment per quarter |

| Intended Outcome | KPI | Cambridge | Peterborough |
|---|---|---|---|
| | proportion of those needing to access treatment at the start of the quarter | | |
| | The percentage change in the proportion of the cohort in receipt of pharmacological interventions at their latest review in comparison to their first review | This represents a positive rate of change of 45% | This represents a negative rate of change of 36% |
| | The percentage change in the proportion of the cohort in receipt of psychosocial interventions at their latest review in comparison to their first review | A positive rate of change of 1.5% | A negative rate of change of 40.5% |
| **An increase in health and wellbeing among the cohort** | The proportion of those in need of mental health treatment, who were not already receiving treatment prior to the RSDATG service but who have successfully engaged with treatment since receiving the RSDATG service | On average 37% | On average 37% |
| | The proportion of those immunised for Hep B while in receipt of the service | A rate of increase equal to 43% | A rate of increase equal to 11% |
| | The proportion of the cohort who were tested for Hep-C | 110 individuals were offered and accepted a test. This represents 62% | 218 individuals were offered and accepted a test. This represents 72%. |
| | The proportion of those who had tested positive for Hep C who had accepted treatment while in receipt of the service | Of the 10 people found to be positive while tested, 9 accepted treatment. This represents 90% | Of the 14 people found to be positive while tested , 7 accepted treatment. This represents 50% |

| Intended Outcome | KPI | Cambridge | Peterborough |
|---|---|---|---|
| | The proportion of cohort showing an improvement in relation to their perception of their physical health since they joined the service (as judged as at their latest review) | 44% of the total cohort | 43% of the total cohort |
| | The proportion of the cohort showing an improvement in their perception of their psychological health since they joined the service – as judged at their last review | 43% of the total cohort | 53% of the total cohort |
| | The proportion of the cohort showing an improvement in their perception of their overall quality of life since they joined the service – judged as at their last review or their exit from the service | 49% of the total cohort | 55% of the total cohort |
| | The percentage change in the average score in relation to self-perception of physical health between the first and latest reviews | This represents a positive rate of change of 9% | This represents a negative rate of change of 2% |
| | The percentage change in the average score in relation to self-perception of psychological health between the first and latest reviews | This represents a positive rate of change of 10% | This represents a positive rate of change of 5% |
| | The percentage change in the average score in relation to self-perception of overall quality of life between the first and latest reviews | This represents a positive rate of change of 23% | This represents a positive rate of change of 9% |

| Intended Outcome | KPI | Cambridge | Peterborough |
|---|---|---|---|
| | The percentage of service users reporting that engaging with the services has had a "positive impact on their life and view of the future" | 93% of respondents either said "Agree" or "Strongly Agree" | 85% of respondents either said "Agree" or "Strongly Agree" |
| | The percentage of service users reporting that their general health "has improved since working with the service". | 57% of respondents either said "Agree" or "Strongly Agree" | 57% of respondents either said "Agree" or "Strongly Agree" |
| **An increase in those living in accommodation that they feel is safe and secure** | The percentage change in the proportion of cohort with an acute housing problem at latest review in comparison to the first review | This is a positive rate of change of 26% | This is a positive rate of change of 19% |
| | The percentage change in the proportion of cohort either in unsuitable housing or at risk of eviction at latest review in comparison to the first review. | This is a positive rate of change of 33% | This is a positive rate of change of 19% |
| | The percentage change in the proportion of the cohort that are either in a rented home or other type of accommodation at their latest review in comparison to the situation at the first review | This represents a positive rate of change of 80%. | This represents a positive rate of change of 68%. |
| | The percentage change in the proportion of service users who were at risk of eviction from their own home at the latest review in comparison to the situation at the first review. | This represented a negative rate of change of 58%. | This represented a negative rate of change of 41%. |
| **Development of trusting relationship which leads to a** | The proportion of the cohort sustaining engagement with the service for at least 12 months | 75% of the cohort sustained engagement with the | 69% of the cohort sustained engagement with the services for at least 12 months |

| Intended Outcome | KPI | Cambridge | Peterborough |
|---|---|---|---|
| **sustained active contact with the service** | | services for at least 12 months | |
| | The proportion of the cases that end in an unplanned exit | This represents 35% of the cohort | This represents 35% of the cohort |
| | The percentage of service users reporting “trust and confidence in the staff” | 65% of respondents either said “Agree” or “Strongly Agree” | 100% of respondents either said “Agree” or “Strongly Agree” |
| | The percentage of the users who would “recommend the service to others” | 79% of respondents either said “Agree” or “Strongly Agree” | 86% of respondents either said “Agree” or “Strongly Agree” |

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