Changing Futures Programme: Delivery Plan Template

1.1 Area	Nottingham City	
1.2 Named contact (a) name (b) main role	(a) Rich Brady	(b) Programme Director
1.3 Address	1 Standard Court, Park Row, Nottingham NG1 6GN	
1.4 Telephone number (a) organisation (b) contact	(a) Nottingham City Integrated Care Partnership	(b) 07920 751 309
1.5 Email address of named contact	rich.brady@nhs.net	

Guidance notes

- The purpose of this delivery plan is to build on your initial expression of interest, and to set out a theory of change and costed proposals for how you intend to improve outcomes for adults experiencing multiple disadvantage in your area through the Changing Futures programme.

- This delivery plan will be a live document, with flexibility to develop over the course of the three-year delivery period and designated review points. However, we want to have a clear sense of your proposals for involvement in the programme at this stage to inform a robust assurance and final selection process, while acknowledging that implementation and delivery will be an iterative and evolving process.

- Please refer to the Changing Futures prospectus when completing this delivery plan form, including section 2.1 on the aims of the programme; 2.2 on defining the cohort; 2.3. on core delivery principles; and 2.4 on core partnership requirements. Further guidance on each section is also available in the attached guidance document.

- We may share information in your delivery plan, including contact details, with other government colleagues and The National Lottery Community Fund for assessment and for the purpose of developing our understanding and informing wider policy development and best practice.

- Please use black type, Arial font 11. Where additional supporting materials such as the theory of change template are requested, further information is provided in the questions and guidance below.
  The deadline for submission is 23:55, **Thursday 6 May.**

1. Cohort identification: Who will the programme support?

Please provide information on the cohort you intend to work with over the course of the programme. **Max: 600 words**

The Nottingham City Joint Strategic Needs Assessment (JSNA) chapter: Severe and Multiple Disadvantage brings together a range of insight to provide a foundation for our understanding of local need of SMD.

Nottingham has the 8th highest prevalence of SMD in England, with estimates in 2019 suggesting over 5,300 people experience SMD. JSNA analysis categorises the number of people experiencing SMD according to experience of homelessness, mental ill-health, substance misuse and offending:

- 4 disadvantages: 294
- 3 disadvantages: 1,620
- 2 disadvantages: 3,428

This does not include the fifth source of disadvantage identified in the CF criteria (domestic abuse). Using the criteria for CF, we estimate in excess of 6,600 people face at least three sources of disadvantage – approximately 50% are female.[1] Women and BAME communities are known to be underrepresented in access to services, we therefore used the development grant to engage local experts to undertake research to better understand prevalence and issues impacting on women and BAME communities experiencing SMD. Not only has this provided additional insight into the nature and occurrence of disadvantage faced by women and BAME communities, it has helped to reappraise the overall population experiencing SMD, as well as aiding our understanding of the additional barriers (e.g. fear or lack of trust of services, stigma, and failure to recognise different forms of disadvantage) that we need to overcome to ensure more equitable access.

We have reviewed our referral and assessment processes with representation from across our partnership (including people with lived experience and organisations working with women and BAME communities), to support appropriate access to the programme.

In our experience from Opportunity Nottingham (ON), some organisations can be discouraged from referring into the programme when extensive details are required for an initial referral. The partnership has redesigned the processes and forms to simplify information required to make referrals and establish eligibility for the programme[2]. This will improve access for those not currently connected with support services.

The group has developed and amended the New Directions Team tool (NDT)[3] used to complete assessments. Adaptations to the NDT take better account of the ways in which multiple disadvantage might be expressed in populations we understand are currently

[1] Bramley, G, Johnsen, S, Sosenko, F. (2020) Gender Matters: Gendered patterns of severe and multiple disadvantage in England. London: Lankelly Chase Foundation
[2] See *Nottingham City SD Q1 DRAFT CF Referral Form*
[3] See *Nottingham City SD Q1 DRAFT Amended NDT Assessment Tool*

underserved, including women, BAME communities and other groups with protected characteristics. Additional questions and adjusted weightings will help properly factor in, for example, areas of risk related to:

- Cultural / gender related reluctance to engage with services
- Non-aggressive difficulties in social effectiveness
- DA/DV as a specific aspect of “risk from others”
- Absence of social, family and other networks

We will evaluate the impact of changes to referral and assessment to revisit and refine arrangements based on evidence and feedback to inform further delivery.

We expect to provide direct support to a total of 388 beneficiaries over the course of the programme (64 in year 1 (in addition to ON), 144 in year 2, and 180 in year 3). This accords with learning from ON demonstrating that successful outcomes often take two years and are achieved through caseloads that allow for intensive support.

Table 1: Caseload Predictions

	-	Year 1	Year 2	Year 3
Navigator Caseload per FTE	**8**			
Navigator FTE number *		7	17	17
Navigator Cases		56	132	132
Peer Mentor Hrs Per Case	**3**			
Peer Mentor Hours		75	146	146
Peer Mentor Cases		25	49	49
Case Capacity		**81**	**181**	**181**
Average days on service **		*455*	*455*	*365*
Beneficiaries per year		**64**	**144**	**180**
Total Beneficiaries				**388**

** Includes 1 FTE social worker in Yr 1*

*** Assumes cases closed before end of programme in Yr 3*

We anticipate achieving shorter successful engagements through CF due to improved coordination between wider services. A larger number of people are expected to be supported through affiliated programmes and services (e.g. RSI navigators) benefiting from some coordination with CF. We do not anticipate using a waiting list for the programme as our delivery approach will enable greater access to wider support services. In addition to the 388 beneficiaries, we estimate that a further 310 to benefit from capacity improvements within mainstream services through embedded posts and access to operational support from CF (e.g. via the MDT – see delivery plan).

(599 – not including footnotes)

2. Outline theory of change: How will the programme achieve improved outcomes at individual, service and system level?

Please set out your outline theory of change at system, service and individual level using the templates provided (annex A). Use the section below to provide a brief overall narrative explaining how you developed the theory of change and how the different levels connect.

Max 2,500 words (templates & summary)

Developing the Theories of Change

Our Theories of Change (TOCs) will help us ensure people experiencing SMD live longer, healthier lives. For this we need system change, more integrated working, with services having a better understanding of SMD and their role in helping people to achieve positive, sustained change.

Our TOCs have been co-produced with beneficiaries and system partners.[4] Building on work of the ICP SMD programme, we initially developed draft TOC. These were informed by workshops with beneficiaries and services, focussing on what works well and where there is more to be done. We used the development grant to fund specific work to improve our understanding, led by partners with specialist knowledge of women and BAME communities.[5] Peer-researchers led on beneficiary engagement, interviewing 26 people, supported by a range of services in Nottingham.

We ran externally facilitated workshops to test our TOCs. A similar approach was taken with beneficiaries from a range of organisations, led by ON's lived experience team and Service for Empowerment and Advocacy. We also held one-to-one discussion sessions with beneficiaries and services.

Finally, we asked for feedback from MEAM around our approach to co-production and to critically challenge our TOCs.

How the levels interact:

Our TOCs clearly align from system to individual level. Guided by people with lived experience, frontline workers and services, we developed an over-arching 'problem statement' that cuts across all three levels:

In Nottingham City, people experiencing SMD experience barriers to receiving joined up, flexible, person-centred care from the right services, at the right time and in the right place.

Therefore our objective is:

To ensure that people living in Nottingham City who experience SMD receive joined up, flexible, person-centred care from the right services, at the right time and in the right place.

[4] See *Nottingham City SD Q2 Summary of engagement and co-production activity*
[5] See *Nottingham City SD Q2 CF SMD Womens report* and *Nottingham City SD Q1 CF BAME report*

This means that at ***system level*** we need:

- To maintain momentum, with Nottingham City ICP as the lever for sustained system change.
- A system that supports joint working (underpinned by shared governance / decision making and budgets) to plan/deliver the right support.
- Strategic decision making guided by lived experience, with explicit governance structures.
- An ambitious approach to commissioning, developing/trialling integrated and personalised approaches.
- Workforce development, supporting services/organisations to participate in opportunities and plan for future need.
- The right evidence to secure long-term, sustainable resource.

This means at ***service level*** we need:

- Beneficiaries co-producing services and guiding improvement.
- Flexible services that are actively inclusive, engaging and not excluding people by rigidly adhering to thresholds/eligibility criteria.
- Services where staff understand experiences of all people that experience SMD, responding to needs in a positive way, with SMD clearly included in strategic priorities.
- Services where staff know what to do if they are worried about someone or need additional support.
- Person-centred services that are culturally and gender responsive.
- Services working well together, learning supporting continual improvement.

Therefore, at ***individual level*** we need:

- An ambitious offer that is strengths-based and developed through lived experience.
- An offer that is not stigmatising or complex to navigate.
- Services that are accessible, trauma informed, not asking beneficiaries to tell their story repeatedly. This is frustrating at best and re-traumatising for many.
- More choice, an offer that understands and is responsive to the needs of **all** people that experience SMD, including women and beneficiaries from BAME communities.
- Services that are here to stay, valued by the system and sustainably funded.

(2,491 – not including footnotes)

3. Delivery plan: What will you deliver as part of the programme?

Please set out your plan to deliver the activity in your outline theory of change over the three-year delivery phase.

Max 1,250 words

Our delivery approach is rooted in the outcomes that people who experience SMD have told us they want to see achieved in our **individual** TOC. Our model responds to the need in our **service** TOC for a more closely integrated system of support with collective 'ownership' of the needs of beneficiaries in place of restrictive outcomes defined by individual services. Crucially, the model sets out not just to meet the needs of beneficiaries over the course of the programme but also to achieve the **system** change needed.

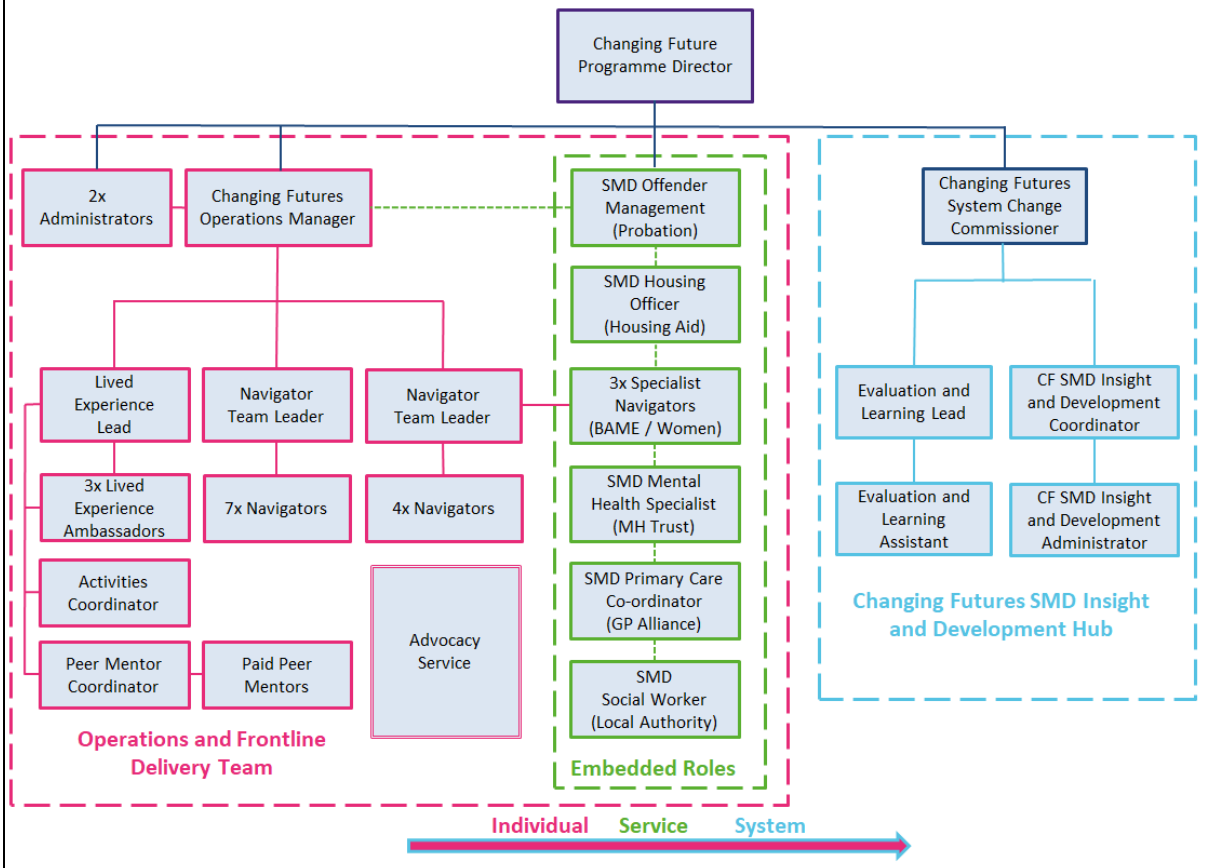


Figure 1: Proposed Changing Futures Delivery Approach

Our proposed delivery approach sees three significant strands:

1. An operations and frontline delivery team will provide the key functions for beneficiaries based around the **individual** TOC.
2. Posts embedded within statutory partners will deliver the activities in the **service** level TOC and ensure a genuine partnership response to SMD.
3. An SMD Insight and Development Hub will influence local commissioning and embed learning and best practice across statutory partners to meet the objectives of the **system** TOC.

Operations and frontline delivery team

The frontline team will be responsible for assessing referrals for suitability against the

eligibility criteria and providing support and coordination.

Navigators will guide beneficiaries to access and engage with assistance they need, as well as helping agencies to meet their needs. Navigators will collectively work as a network / virtual team (including those funded through related programmes e.g. RSI) to coordinate support across the system. Navigators will work in a trauma and psychologically informed way to build trusting relationships with beneficiaries, listening to their needs and supporting engagement at a pace that suits them. Specialist navigators will offer appropriate support to people with cultural/gender specific needs, as well as meeting preferences to be supported by someone with lived experience.

A **Multi-Disciplinary Team (MDT)** will bring agencies together to develop joint plans to meet holistic needs of beneficiaries. The MDT will create flexibility in how local services respond, providing a route for escalation by Navigators, enabling agencies to share ideas, solutions and plan delivery of coordinated treatment/support. Beneficiaries can also request an MDT is called on their behalf.

Independent advocacy will support beneficiaries where they wish to challenge or complain about the way they are being supported, within the wider system or by CF itself. This will ensure their voice is heard, views are taken into account and concerns dealt with properly.

A **Lived Experience Team** will ensure lived experience is at the heart of frontline delivery. CF will employ **paid ambassadors** (including women and BAME specialists) to ensure the "voice of lived experience" is in all aspects of project design and delivery, including at the Changing Futures Development Board.

We know that people with SMD often prefer to be supported by someone with direct experience who they believe will understand how they are feeling and be less judgemental. **Peer mentors** will also provide opportunities for beneficiaries, improving life chances through access to ETE, meaningful occupation and paid work. It will also ensure that the system is constantly shaped by those that have used services and who know what works.

People experiencing SMD told us they wanted to see services that deliver a range of diverse treatments and therapeutic interventions, including access to meaningful occupations and support towards employment. The **Activities Coordinator** will have a budget to facilitate this.

Personalised approaches to commissioning will create flexibility in the system to respond to individual needs. This will enable beneficiaries to choose support from a provider they feel will best serve their needs (e.g. specialist support, including BAME led).

Embedded posts in partner organisations (**see figure 1**) will ensure delivery of dedicated and specialised support to CF, including membership of the MDT. These posts are critical to our system change plans to establish stronger links with key agencies, resolve barriers and jointly plan support. They will champion SMD within mainstream services, improving responsiveness and contributing to improving data sharing / systems, to improve service delivery, inform policy and commissioning.

The **SMD Insight and Development Hub (IDH)** will coordinate learning across the partnership. It will have responsibility for improving capture and use of data across **services**, to understand the outcomes achieved for **individuals** and impact on the **system**. The IDH

will support the MDT, capturing insights from operational delivery, informing commissioning and system change. The IDH will be responsible for improving practices (e.g. facilitating training and development) within core CF services, as well as across the system (including non-specialist services).

Driving lasting system change

Strategic posts will secure the legacy of the partnership beyond the end of CF. This is crucial to prospects for the development of an effective and sustainable system.

A Programme Director will oversee the delivery of CF, driving system change, securing the sustained strategic and financial commitment from partners, establishing the governance, structures and forums needed to jointly resource, plan and deliver an effective system for people experiencing SMD.

People experiencing SMD tell us our current arrangements do not always provide a joined-up, flexible, whole person approach. Individual service-led outcomes do not incentivise services to collectively 'own' a person's overall outcomes. A specialist commissioning role will provide commissioning stewardship to the technical activities needed to enable joint planning and use of resources currently held across the system, and to create more opportunity for partners to work together to develop effective solutions and support beneficiary choice. Oversight of the IDH will ensure learning from local delivery will feed into commissioning practices.

Key milestones

Year	Key milestones for delivering activity
2021/22	• Alignment of ON activity to CF delivery approach • Existing infrastructure of ON used to support establishment and development of CF team • Appoint key CF posts: Programme Director, Commissioner, Operations Manager and embedded roles • Establish CF governance (section 5) incl. CFDB, ECF and WF to embed within system governance and accountability structures • Develop system change plan, building on existing transformation work (incl. ICP/ICS) • Information sharing agreements across partners, exploring potential for shared data systems • Intensive support to a minimum of 64 beneficiaries (in addition to ON)
2022/23	• Conclusion of ON, ensuring continuity for beneficiaries receiving support • Review of year 1 delivery activity (incl. specialist posts) to inform years 2, 3 and system change plan • Test integrated delivery model with providers and commissioners for beyond 2024 • Commitment to match funding from statutory partners • Intensive support to a minimum of 144 beneficiaries
2023/24	• Transition plan agreed by statutory partners to ensure continuity of support to SMD beyond 2024

	• Establish integrated delivery model for beyond 2024, agreed by partners • Secure match funding agreements from partners for beyond 2024 through illustrating impact and efficiency of CF delivery model • Intensive support to a minimum of 180 beneficiaries
2024/25	• Provision to support people experiencing SMD embedded within the system

Key risks / mitigations

Risk	Mitigation
Delay in appointing Programme Director (PD) and System Change Commissioner	ICP Programme Director to maintain oversight until recruitment is complete
Insufficient capacity in community and voluntary organisations to receive referrals	Personalisation of commissioning creates capacity
Unequal access to support for people with protected characterises	Specialist support recruited and evaluated as part of programme
Embedded roles not responsive to programme	Accountability assured by PD and MoU
PD unable to access system discussions with key partners	SMD is ICP priority; ICP PD to ensure access
Embedded roles assumed by partners to be sole SMD requirement	Clarification through MoU and accountability to CFDB / ICP
Partners unwilling to fund provision beyond conclusion of CFP	PD influence with system leaders Learning and evaluation programme designed to evidence impact and efficiency

(1243)

4. Funding requirement

Please set out costed proposals for how you intend to use Changing Futures grant funding to support the activity set out in your theory of change and delivery plan, using the spreadsheet attached at annex B.
Total grant request: £4,044,873

5. Partnership and governance arrangements

Please set out your partnership and governance arrangements for the programme.

Max: 750 words, not including table and any supporting diagrams

Role	Named Lead	Organisation	Email address
Political lead	Councillor David Mellen, Leader	Nottingham City Council	david.mellen@nottinghamcity.gov.uk
Senior Responsible Officer	Mel Barrett, Chief Executive	Nottingham City Council	mel.barrett@nottinghamcity.gov.uk
Partnership lead	Rich Brady, Programme Director	Nottingham City Integrated Care Partnership	rich.brady@nhs.net
System change lead	Jane Bethea, Consultant in Public Health and ICP SMD Programme Lead	Nottinghamshire Healthcare NHS Foundation Trust and Nottingham City Council	jane.bethea@nottshc.nhs.uk jane.bethea@nottinghamcity.gov.uk
Data and digital lead	Grant Everett, Evaluation and Learning Lead	Opportunity Nottingham	grant.everitt@FrameworkHA.org
Lived experience lead	Mark Garner, Project Manager	Opportunity Nottingham	mark.garner@FrameworkHA.org

The ambition of the CFP is to ensure that by the end of the programme, evidence-based approaches to supporting people who experience SMD are embedded into service provision and commissioning. To achieve this, CF must be knitted into the fabric of governance structures in Nottingham, with a clear line of sight to the leaders of statutory and non-statutory organisations through the Nottingham City Integrated Care Partnership (ICP).

Relevant strategic priorities

The ICP already has an established partnership programme with a shared strategic priority to, "*support people who face SMD to live longer, healthier lives*" representing a clear commitment from senior leaders to work in partnership to improve outcomes for adults experiencing SMD. The ICP SMD programme was established in July 2020 and has six workstreams led by different partners, representing organisations required in the prospectus. Through the SMD IDH, we will ensure that the learning from the CF programme is embedded across the ICP to establish lasting system change.

Strategic arrangements for governance and oversight of delivery

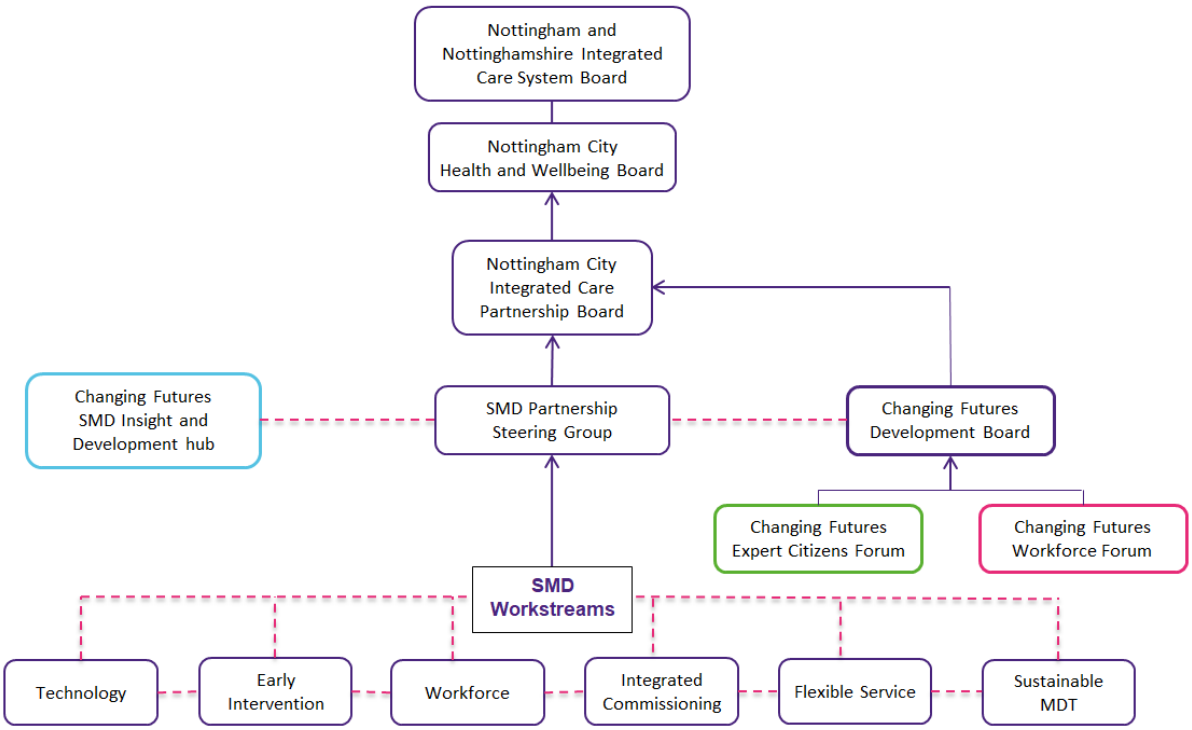


Figure 2. Proposed Changing Futures Governance

The CFP will run in parallel to the ICP SMD programme, but with its own established governance to ensure clear lines of accountability for delivery in its own right. The CF Team will work alongside the operational delivery partners of the ICP SMD group (and wider partnership) but also report into the ICP Board that brings together chief executives and executive directors from across the partnership. This will ensure that the work regularly reports into the City's Health and Wellbeing Board and the Integrated Care System, which from April 2022 will be established as statutory NHS body with responsibilities for commissioning services that impact on people experiencing SMD.

The Changing Futures Delivery Board (CFDB) will be responsible for operational management, performance and service development, consistent with the MEAM approach and current practice. CFDB will be run by the Programme Director and have an independent Chair with a broad membership from across the partnership (**see figure 3**). Membership includes senior representation from statutory and voluntary sector partners across the key areas of health (both mental and physical), policing, housing and homelessness, offending, substance misuse treatment, and domestic abuse. Local commissioning leads will also be represented on the Board.

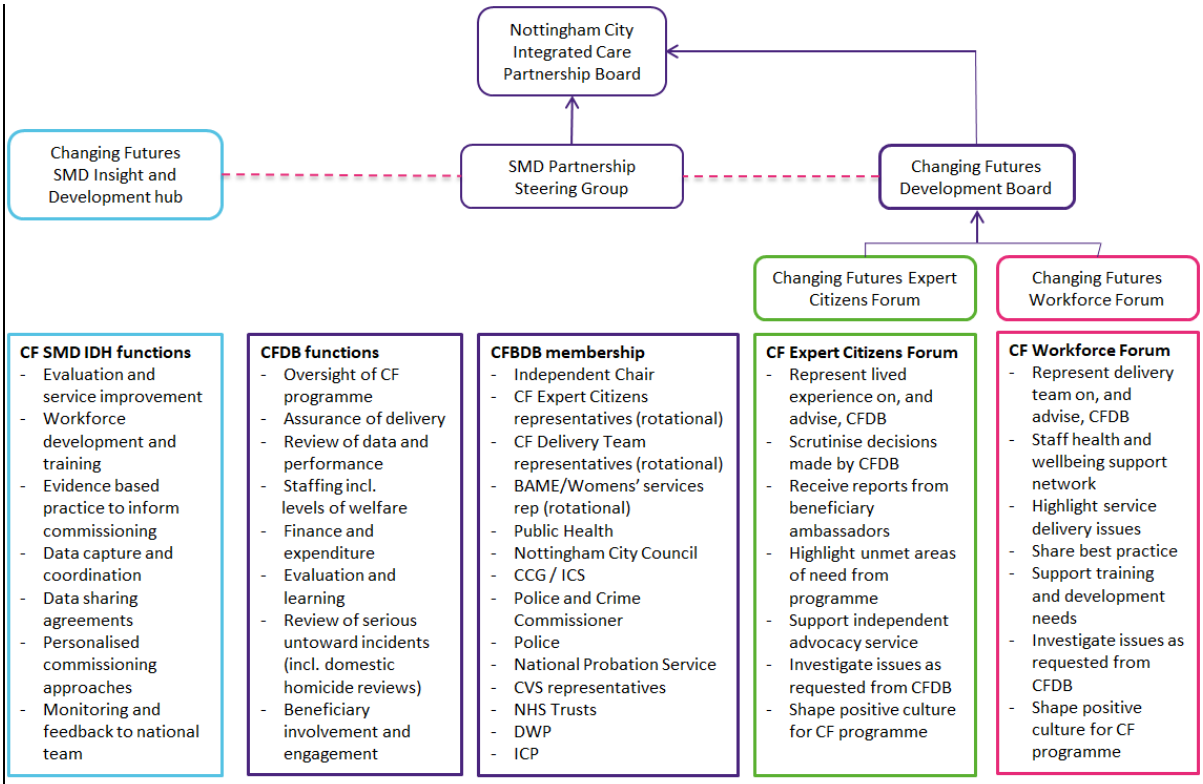


Figure 3. Proposed Changing Futures Governance Functions

Crucially, the CFDB will be advised by an Expert Citizen Forum (ECF) led by people with lived experience, with members of this group also sitting on the CFDB. In our experience, a separate citizen engagement forum is not enough; people with lived experience must have an equal seat at the table, and those represented on the CFDB will.

Equally, as a partnership, we know that the people working directly with beneficiaries are our biggest assets and operationally they have the greatest understanding of what works and what doesn't. We will establish a Changing Futures Workforce Forum (WF) to bring together the CF Operations and Frontline Delivery Team. As with the ECF, members of the WF will attend the CFDB on a rotational basis so that the voices of the frontline team are always represented in strategic discussions.

Operational partnership arrangements that will support delivery of the programme

The team will work alongside statutory and non-statutory services in Nottingham including the Homeless Health Team, Police, substance misuse treatment, general practice, Probation, homeless and housing support and wider partners. The CF team will be embedded within wider operational partnership arrangements, with the aim of increasing overall effectiveness and efficiency across related programmes through integration in the delivery model for CF.

Members of the CF Operations and Frontline Delivery Team will play a crucial role in the already established ICP SMD MDT which provides wraparound support to people experiencing SMD. Posts embedded within statutory organisations will ensure that decisions taken about **individuals** in MDT meetings are fed back into **services** collectively strengthening the **system** response to SMD.

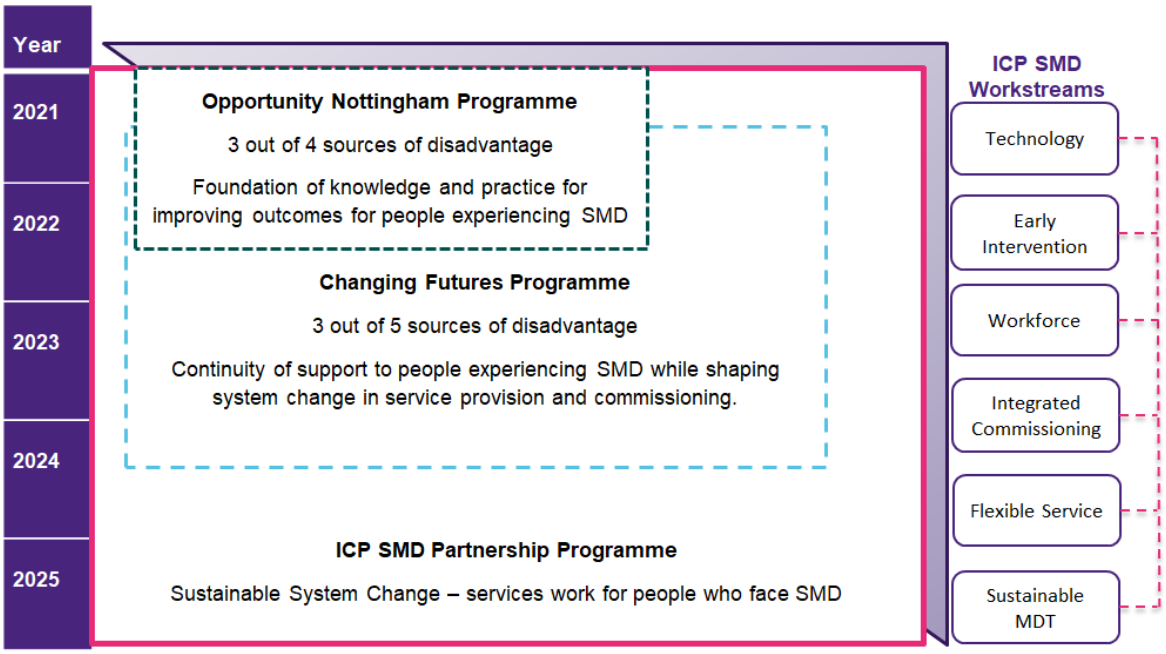
At an operational level, the CFP represents a clear opportunity to:

- Better co-ordinate activities and prevent duplication
- Strengthen joint decision making
- Integrate data and information sharing across partners
- Maximise the benefit from collective resource in the City
- Share good practice and learn from one another
- Embed ways of monitoring how partners collectively meet the needs of people who face SMD

The opportunities presented will enable partners to transform care coordination and planning so that services work around people who face SMD, not the other way around.

(714)

6. Interaction with other projects and programmes

Please set out how the planned activity in your delivery plan will complement and enhance other programmes and interventions underway or planned that impact on adults experiencing multiple disadvantage, while avoiding duplication. **Max: 750 words, not including any supporting diagrams**
Opportunity Nottingham has successfully supported hundreds of people experiencing SMD in Nottingham, proving that navigators working alongside beneficiaries can unlock support and treatment pathways the general public take for granted. It has also evidenced that through this approach, people who may have experienced SMD for decades can begin realising their full potential. Alongside demonstrating a support model that works, ON has advanced the local system's understanding of SMD. While there is commitment through the ICP, further support from CF is needed to root the partnership response to SMD within core structures. **Figure 4** demonstrates how the CFP is part of a wider local strategy on SMD. CF will create stability in the short-term, by ensuring beneficiaries receive continuity of support beyond the conclusion of the ON programme, while ensuring SMD is cemented into joint planning, coordination and use of resources for the benefit of all people experiencing SMD through the ICP.      **Figure 4: Legacy for System Change in Nottingham City** The ICP SMD programme has already had significant influence on operational delivery, establishing an MDT approach to those at risk of rough sleeping and supporting in the development of a Primary Care SMD Local Enhanced Service. The ICP provides a strong platform for development of CF, maximising the legacy of learning from ON and the opportunity to establish a sustainable partnership supporting people experiencing SMD. Our ambition is that through CF, we will accelerate system change in Nottingham,

evidencing how resources held across the system can be maximised to get better outcomes for **individuals** experiencing SMD, as well as reducing pressures on **services** across the **system**. This will be realised through sustainable structures and a commitment to contributions from core budgets to continue activity beyond the end of the CF programme. If accepted onto the CF programme, we have a starting commitment from our partners to match fund 5WTE peer mentors and 1WTE administrator to support the MDT.

The ICP brings together partners delivering a number of funding strands being used to respond the needs and challenges of our SMD population. These programmes exist both within 'core' budgets and through targeted government programmes. These funds are aligned to serve related but separate agendas (e.g. health or housing) in a way that creates gaps and tensions between services, meaning partners are not incentivised to collectively 'own' outcomes of people experiencing SMD. CF will support partners to bridge these gaps and enable joined up delivery and wraparound support. For example:

- To ensure coordinated responses to reduce rough sleeping, the CF team will be integrated with roles funded through the **RSI** and the **Rough Sleeping Accommodation Programme** with regular interface at, and outside, the MDT. To reduce pressures on A&E and facilitate hospital discharge, the CF team will work with specialist rough sleeper health roles including the Homeless Health Team, **NHSE/I funded Rough Sleeper Mental Health Practitioners**, and the roles anticipated through the **DHSC Shared Outcomes Out of Hospital Care Fund**.

- **Figure 5** illustrates how the CF funded roles will bridge the gaps between statutory and other funded programmes. For example, we have a number of services for women who experience DSVA. We will use learning from the **MHCLG R2C** programme to interface and complement these services to meet the needs of women who experience SMD.

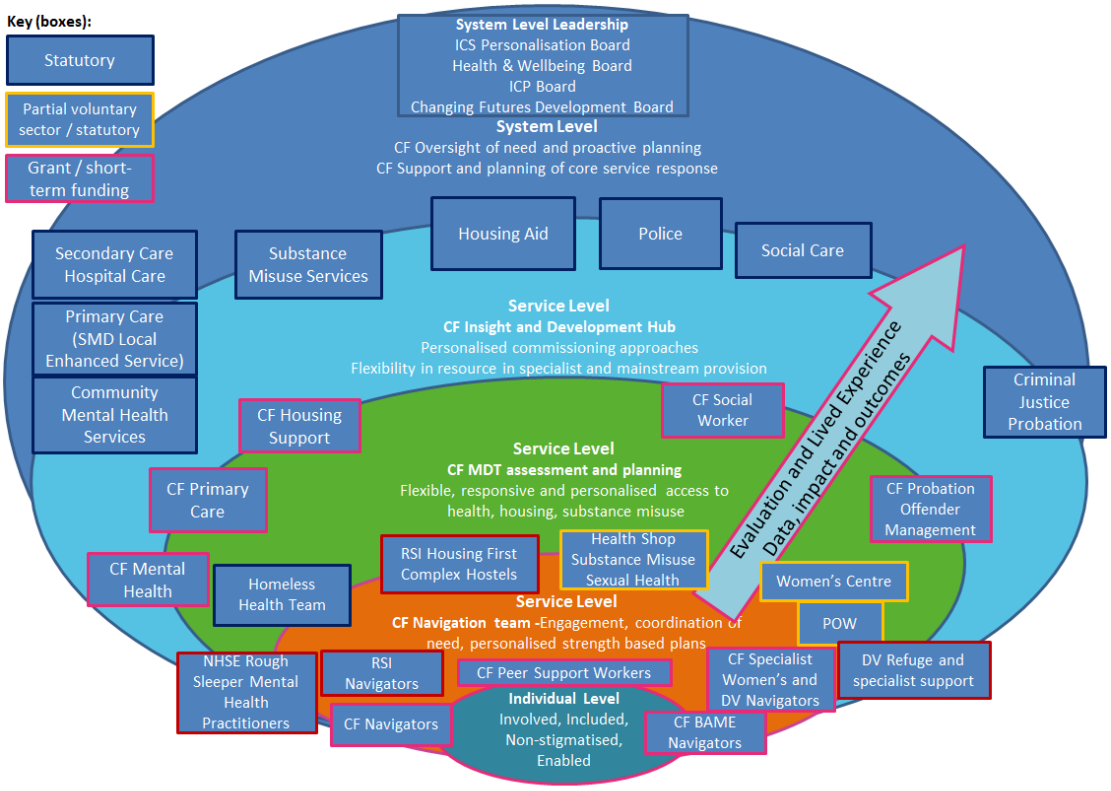


Figure 5: CF complementing wider system activity

In addition to improving operational coordination for people experiencing SMD, partnership delivery coordinated under CF will inform opportunities to strengthen the system (underpinned by learning from our IDH). Examples include identification of opportunities for improving pathways, information sharing / shared assessments, service gaps to be addressed through 'system' investments, and opportunities for progressive integration through commissioning.

While ON has opened the eyes of leaders across the city and ICP partners are keen to realise meaningful change across the systems they represent, the structures required to allow the system "to work as one" are not yet mature enough to provide a system response for people experiencing SMD.

Nottingham City has the right ingredients to maximise the opportunity presented through CF. Strong operational partnerships formed through the life of ON have significant potential to grow to include more elements of the system encountered by people experiencing SMD. Citizens experiencing SMD are working alongside services and systems to ensure that they are understood, and approaches wrap around to support them as a whole. Most significantly; at every level, **individual, service** and **system**, partners want to embrace change and learn how to make that change count.

The ICP's commitment to the SMD programme is not dependent on CF, its capacity to realise transformational sustained change to the whole system is.
(750)

7. Data

Please set out how you intend to develop the collection, sharing, analysis and use of data to drive service improvement and measure outcomes set out in your theory of change. **Max: 600 words**
Current monitoring and evaluation through ON provides us with an approach to build on, with existing data sharing agreements we can adapt and expand. We will collect data as required by the national team and will build in reporting metrics and processes to allow continual monitoring of progress. ***Data available:*** • A total of 113 measures are reported quarterly as part of Fulfilling Lives reporting requirements. Data on beneficiary outcomes are collected through a range of tools and includes demographics, services use and economic impact (visits to ED, arrests, etc). • Data collected through the MDT on beneficiary needs, engagement with services and outcomes. • Data on beneficiary experience through on-going ON evaluation and through ICP SMD programme development. ***Data accessible through ICP partners and developing work:*** • *Physical and mental health:* Primary care data facilitated by the CCG and proposed embedded posts, mental health data facilitated by Nottinghamshire Healthcare NHS Foundation Trust and proposed embedded post, ED and secondary care data through partnership with Nottingham University Hospitals NHS Trust. • *Housing:* Data on housing related outcomes facilitated by Housing Aid and proposed embedded post. • *Probation and criminal justice:* Data on outcomes for offenders facilitated by probation and by proposed embedded post, outcomes associated with engagement with criminal justice substance misuse pathway. • *Substance misuse:* National Drug Treatment Monitoring System data can identify uptake of treatment in people with SMD and report on treatment outcomes for individuals. ***Data gaps we need to address:*** *Work and employment:* We have links with DWP and need to identify data needs, and how data can be accessed and used to demonstrate change. *Data on need*: Our research into the needs of women and BAME communities identified a need to improve data recording across the system. We need to better understand the impact/demand on specialist services (e.g. BAME communities, women) to inform future commissioning approaches. ***Data sharing:*** Data Sharing Agreements exist between all organisations engaged in the MDT, including ON, health, social care, substance misuse treatment, housing and probation. Data sharing will be a requirement of partners' engagement in the programme. Data will be required on outcomes from all navigators and staff embedded in organisations. Qualitative

data on experience of beneficiaries and frontline staff will also be collected.

We have access to Information Governance expertise across the system and have benefitted from that in the development of the MDT. We will use the ICP to address known gaps including frequent attendees at A&E and other high volume service users.

Our longer-term goal is to have shared care plans/records. Through the ICP, we are being supported by NHS partners to pilot the use of the platform technology 'Patients Know Best'. This is beneficiary-led and allows information to be shared with the beneficiary and with the people supporting them. The trial starts in 2021 and if successful will be rolled out more widely in 2022/2023.

Data provided by partners and beneficiaries will be stored and analysed securely by the SMD IDH. Reporting on outcomes will be a standing item on the CFDB agenda and shared at system level through the ICP.

Other work needed:

Through the amended NDT and Outcomes Star, we will better capture and monitor beneficiary progress and outcomes. We will review and develop our approach throughout the delivery of the programme, committing time and resource coproducing with people with lived experience.

We will bring together data held by partners at a **service** level in order to demonstrate total use of the **system** by individuals experiencing SMD. This information will be used to inform support for individuals, as well as the whole system response (and our collective use of resources).

(599)

Table 1: short-term outcomes

Level	**Short-term Outcomes**	**Proposed measurement metric**	**Current availability (data held/data collected but not held/new data required)**
System	*Increased uptake of SMD focussed training and support offer across the system starts to upskill the system around trauma informed approaches and responsive person-centred care*	Uptake by organisations and services Number and % of workforce attending (by service / organisation and by job role)	New data required. To be collected and managed by the proposed SMD Insight and Development Hub.
	ICP and partners have clear inclusion of SMD in organisational plans and strategies	Number / % of partners with clear strategic plan for responding to and preventing SMD.	New data required. To be collected and managed by the proposed SMD Insight and Development Hub.
	Lived experience has greater influence on	*TBC through co-production. Likely to include:*	New data required. To be collected and managed

	system decision making at all levels	Number of Lived Experience Forums organised Number of requests for support from forum by partner organisations Number of ICP Board and other strategic decisions co-produced or guided by forum Any change in perception of the benefit of co-production in partner organisations	by the proposed SMD Insight and Development Hub.
Service	*Increase in joint working through enhanced role of the MDT, the integrated SMD function and embedded roles in key services*	Number of beneficiaries provided with MDT support Number/% of successful MDT outcomes Number/% of beneficiaries that are survivors, from BAME groups, have protected characteristics Change in joint working as reported by services and beneficiaries	MDT monitoring data (held) Measure through regular engagement work with services and beneficiaries (New data required) Above to be collected and managed by the proposed SMD Insight and Development Hub
	Flexible approaches to commissioning are developed, including integrated and personalised approaches	Number/% of beneficiaries receiving a personal budget Number/% of beneficiaries offered choice through a personalised commissioning approach Outcomes for beneficiaries taking up personal budget, personalised approach and supported by integrated function	Collected as part of routine data collection to inform outcome monitoring (new data required) Routine beneficiary outcome monitoring data (to include Outcomes Star, NDT) Data to be collected and managed by the proposed SMD Insight and Development Hub
	More effective recording, sharing and use of data and learning	Number of services participating in data and information sharing Number of data sharing agreements in place	Collected as part of routine service level data collection to monitor on-going strength of partnership working (new data required)

		Change in quality / consistency of routine recording of protected characteristics and use of flags to identify people at risk of or experiencing SMD Impact of data sharing on joint working	Collected as part of routine service level data collection (new data required) Collected as part of regular engagement work with beneficiaries and services (new data required)
Individual	*Improvement in experience of care and support leads to stabilisation*	Beneficiary outcomes: • Outcomes Star • Revised NDT • Experiential data and information	Part of routine beneficiary outcomes monitoring (new data required)
	People with lived experience/beneficiaries know that their experiences are important and have an impact on services and planning.	Change in positive testimony by beneficiaries against baseline, collected by survey/interviews led by peer researchers	Collected through regular and on-going service user led beneficiary engagement (new data required)
	Beneficiaries have greater choice and control in their care, can get specialist support if they want it and can use a personal budget to help them meet their goals and are offered access to technology to aid person centred joint care planning	Number/% of beneficiaries receiving support from navigator Number/% of beneficiaries receiving support from specialist navigator Outcomes for beneficiaries supported by navigator/specialist navigator Number/% of beneficiaries receiving a personal budget Number/% of beneficiaries offered choice through a personalised commissioning approach Outcomes for beneficiaries taking up personal budget, personalised approach and supported by integrated function Number of beneficiaries using IT platform to facilitate person-centred joint care	Collected through routine beneficiary outcomes monitoring, including: Outcomes Star Revised NDT Experiential data and information Collected as part of evaluation of IT programme development

		planning Experiential data and information	and implementation Collected as part of regular engagement work with beneficiaries and services Above: New data required

Table 2: long-term outcomes

Level	**Longer-term Outcomes**	**Proposed measurement metric**	**Current availability (data held/data collected not held/new data require**
System	*SMD is well understood by the system, trauma informed approaches are part of usual business.*	Number/% of system partners adopting trauma informed approaches	"Annual stocktake" – using MEAM toolkit and TIC measurement such as the PIZAZZ (psychologically informed environments measuring tool) Above: New data required
	Benefits of the programme are well understood and tangible	Number/% of/change in number of system partners demonstrating positive understanding of reflecting this in delivery	Annual stocktake" – using MEAM toolkit Above: New data required
	Partners commit to long term sustainable resource to develop and expand the work of the programme to the wider ICS footprint	Resources (money or in kind to add value) provided to sustain the work of the programme Number/% of partners with clear strategic plan for responding to and preventing SMD.	Measured financially and re or organisations relevant reports/literature Above: New data required
Service	*Services can share information easily and lawfully, supported by technology and robust information sharing agreements*	Number of services participating in data and information sharing Number of data sharing agreements in place Number of	Collected as part of routine service level data collectior (new data required)

		beneficiaries using IT platform approach to support joined up care planning Sustained change in quality/consistency of routine recording on protected characteristics and use of flags to identify people at risk of or experiencing SMD		
	Staff across the services are more knowledgeable and understand how to refer clients to the MDT and how to get specialist advice and support	Increase in staff knowledge Number, source and appropriateness of referrals to the MDT Number source and appropriateness of referrals to SMD function	Collected via evaluation survey (new data required) Collected as part of routine service level data collection (new data required)	
	Services can be flexible to meet the needs of people experiencing SMD, not sticking rigidly to thresholds or eligibility criteria	Number and nature of services adopting a flexible approach Beneficiary experience and outcomes associated with change	Collected as part of routine service level data collection Surveys interviews with peer researchers Above: New data required	
Individual	*People experiencing SMD report receiving joined-up care that works around them and doesn't require them to tell their story repeatedly*	Increase in positive testimony against base line Beneficiary outcomes	Surveys interviews with peer researchers Collected through routine beneficiary outcomes monitoring, including: Outcomes Star Revised NDT Above: New data required	
	Beneficiaries meet their goals and aspirations	Increase in positive testimony against base line	Surveys interviews with peer researchers	

		Beneficiary outcomes	Collected through routine beneficiary outcomes monitoring, including: Outcomes Star Revised NDT Above: New data required	
	Beneficiaries have less need to use emergency or crisis services to meet their needs as care plans and support is well planned and co-produced	N/% beneficiaries that use emergency hospital care N/% beneficiaries in contact with criminal justice system N/% beneficiaries in planned health service- long term condition management N/% beneficiaries experiencing rough sleeping or eviction	Collected through routine beneficiary data and through partners in secondary care, housing and criminal justice. Above: New data required	

Annex A: Theory of Change Templates

To aid the read across between our Theories of Change we have colour coded areas of development and intervention:

	Lived experience and co-production
	Innovation in joint commissioning and provision of care and support
	ICP support and governance
	Workforce development (including training, navigator support and peer-mentors)
	Research, evaluation and service improvement
	Information sharing to improve care and outcomes

	System level
Context/problem	• *We do not collectively 'own' a person's overall outcomes. Resources are managed in a siloed way, and decisions are not made as a system.* • *Building on work of ON and Nottingham City ICP, now is the right time for sustained change to happen at pace*
Inputs	• Leadership of CF programme working with Nottingham City ICP
	• Permission to trial innovative commissioning approaches
	• CF and system commitment to co-production, recognising beneficiaries/ VCS partners as integral
	• Support from ICP to allow CF to develop system wide workforce development, including VCS organisations (incl. those that are BAME led and working with survivors)
	• CF resources support research/evaluation/service improvement
	• Leadership and resource so information sharing drives improvement
Activities	• Strategic support from Nottingham City ICP; SMD continues as a priority • Changing Futures Development Board (CFDB) oversees work of CF programme, reporting to ICP Board and Health and Wellbeing Board (HWB) • CFDB advised by Expert Citizen Forum (ECF), led by people with lived experience, with members sitting on CFDB • CFDB uses ICP/HWB structures to raise issues/barriers, requiring partners to give clear commitment to solutions • CFDB works with ICP/HWB partners, preventing/responding to SMD is part of strategic plans, including workforce planning
	• Innovative commissioning – including integrated/personalised approaches • Commissioning role within CF programme leads implementation • Insights from beneficiaries and frontline workers ensure models have right focus • Build on existing work, integrating services for wider SMD population

	• Commitment to co-production, lived experience at the heart of everything we do • Build on existing models to develop ECF, reporting into CFDB • People with lived experience employed as peer-mentors/peer-researchers
	• System workforce development offer: training, support, communities of practice, workplace champions • Workforce Forum (WF) developed • Develop workforce knowledge around needs of BAME communities and women, support from specialist roles • ICP/HWB supports implementation of training/support • Co-produced training package, including gender and cultural responsiveness
	• Peer-researchers guide/deliver evaluation • Evidence guides service/system improvement, developing robust business cases for investment • Build on work by partners around needs of women/BAME communities, specific work done to understand individual/service/system needs
	• Build on the work of the ICP around information sharing, develop shared approach to co-produced care plans • Trial feasibility of using platform technology to develop a single care record
Outputs	• Terms of Reference (ToR) for CFDB/ECF/WF • Outcomes agreed/co-produced with partners/beneficiaries • Reporting and governance structure agreed to influence at strategic level, addressing service issues • CFDB membership reflects the partnership and Nottingham's diverse population • Evidence of collective decision making re use of resources
	• Commissioning strategy • Integrated function supports beneficiaries and upskills staff/system • Personalised commissioning approaches
	• ECF functioning, ToR and formal link to CFDB • Peer researchers trained/embedded in the Insight and Development Hub (IDH)
	• Workforce development strategy • Development of WF • Communities of Practice and network of workplace champions • Work to understand needs of BAME communities and women, specialist roles implemented • Co-produced/co-delivered training package including gender and cultural responsiveness

	• Peer researchers support the function, developing skills to lead/design/deliver evaluation • Evidence based business cases sustain progress/funding
	• Trial project of IT solution supports joint care planning
Short-term outcomes	• Increased uptake of SMD focussed training/support offer upskills system around trauma informed approaches and responsive person-centred care • ICP and partners include SMD in organisational plans/strategies • Lived experience has greater influence on system decision making
Longer-term outcomes	• SMD and TIC/PIE are well understood by the system • Benefits of the programme are understood and tangible • Partners commit to long term sustainable resource to develop/expand the work of the programme to wider ICS footprint
Impacts	• *System understands SMD as 'everyone's business', recognises that support is needed to improve outcomes, including culturally/gender specific support* • *System understands/values lived experience* • *System sees the value of work done through the programme, continuing to provide support* • *Flexible approaches to commissioning support, integrated services that wrap around the individual* • *Resources used more effectively, unified approach to the outcomes we want/need to achieve* • *Improved access to data/information*
Key assumptions	• We can sustain and develop the partnership, relationships continue to develop and support a joint approach • We can evidence change and progress to secure long-term investment from system partners
External factors	• Anticipated structural changes as the ICS takes on greater responsibility • Funding for partner agencies supporting this work outside of CF funding • Service pressures linked to Covid-19 response/recovery
Unintended consequences	• We rely upon the CF programme as the specialist programme supporting people experiencing SMD, leading to lack of accountability as a system

	Service level
Context/problem	• *Services aren't always 'joined up', beneficiaries need to navigate services and have to re-tell their story* • *Lack of flexibility excludes people* • *Services don't always focus on beneficiary strengths/goals* • *Services/staff/beneficiaries don't always have a clear understanding of support available* • *Choice is needed, e.g. around cultural or gender specific support* • *Information/data are not always shared to support care/improve outcomes*
Inputs	• *System understands/values lived experience*
	• *Flexible approaches to commissioning and support, integrated services that wrap around the individual*
	• *System understands SMD as 'everyone's business', recognises that support is needed to improve outcomes, including culturally/gender specific support*
	• *System sees the value of work done through the programme, continuing to provide support*
	• *Improved access to data/information*
Activities	• ECF works directly with services, advising on service/organisational level strategy/policy
	• SMD IDH and ECF identify requirements re greater flexibility (e.g. thresholds, eligibility, length of support) • CF and ICP gain commitment from partners to work differently • SMD function draws together staff/resources from a range of partners • Function 'houses' Multi-Disciplinary Team (MDT), supporting navigators/staff embedded in services • Investment develops/expands MDT, ToR widen scope, including BAME community partners, partners working with women/survivors
	• IDH works with beneficiaries & workforce leads to develop/deliver/embed programme of training/support • Posts embedded in key services: probation, primary care, social care, mental health services, housing • Navigator capacity improved, additional posts (including specialist posts) supported as a network • Specialist navigators embedded into services working primarily with women/survivors and BAME communities • Access to services less reliant on signposting, more active referral • Peer-mentors employed, including some aligned with specialist navigators • SMD champions network across services, supported through Community of Practice
	• IDH undertakes on-going evaluation/improvement
	• Information/data needs reviewed • Embedded posts facilitate access to information/data and development of information sharing agreements • Existing platform used by NHS partners trialled for joint approaches to care planning
Outputs	• Lived experience informs service planning/development

	• Revised MDT ToR • Team leaders support expansion/co-ordination of the MDT and more people supported
	• 3WTE specialist navigator roles • Year 3: At least 18 navigator posts working across the system, networked for peer learning/sharing of issues/good practice
	• Case for flexibility formally agreed/implemented fewer beneficiaries are excluded
	• 5WTE embedded posts (not including specialist navigators)
	• SMD integrated service launched
	• At least 5 peer mentors embedded in mental health services, 5 available to beneficiaries through CF programme
	• SMD IDH launched, building on current Practice Development Unit
	• Data/information needs mapped out • More information sharing agreements in place • ICP pilot use of technology with beneficiaries
Short-term outcomes	• Increase in joint working through enhanced role of MDT, integrated SMD function and embedded roles • Flexible approaches to commissioning developed, including integrated and personalised approaches • More effective recording/sharing/use of data and learning
Longer-term outcomes	• Services share information easily and lawfully, supported by technology and robust information sharing agreements • Staff are more knowledgeable, understand how to refer clients to the MDT and how to get specialist advice and support • Services can be flexible to meet the needs of people experiencing SMD, not sticking rigidly to thresholds or eligibility criteria
Impacts	• *More skilled, responsive workforce* • *Service development is guided by lived experience* • *Visible function within the system that can provide support to beneficiaries and staff/services, including access to a MDT approach for those in greatest need* • *Greater flexibility and choice in the system, thresholds and eligibility flexed to meet needs* • *More people with lived experience working in services* • *Services/care is more joined up, more integrated working* • *Information sharing leads to better care/decision making*
Key assumptions	• Beneficiaries support use of technology for joined up care/care planning • Joint service delivery/commissioning is not hindered by organisational culture
External factors	• Anticipated structural changes as ICS takes on greater responsibility • Funding for partner agencies that support this work outside of CF funding • Service pressures linked to Covid-19 response/recovery
Unintended consequences	• Embedded roles are drawn into business as usual • SMD function seen as ‘solution’ when wider service change is needed

	Individual level
Context/problem	• *I find services difficult to navigate, they sometimes exclude me because I don't meet their criteria* • *Services can make me feel stigmatised, like they don't understand me or what I have experienced* • *Information about me isn't always shared well, I have to keep re-telling my story*
Inputs	• *Service development is guided by lived experience*
	• *Services/care is more joined up and person-centred, more integrated working and a visible function is available that includes access to a MDT for those in greatest need* • *Greater flexibility/choice in the system, thresholds and eligibility flexed to meet needs*
	• *More skilled, responsive workforce, more people with lived experience working in services*
	• *Information sharing leads to better care/decision making*
Activities	• I can guide how the CF programme develops • Roles such as Beneficiary Ambassadors, peer-researchers and peer-mentors are funded to support me
	• Navigators can provide me with one-to-one support, specialist navigators are available • I can ask for a MDT if I think it would help me • An integrated function brings expertise together, focusing on improving my life and outcomes • I am closely involved in care planning, focussing on my strengths • Organisations work together to support me • I am not only signposted to services, I am supported into them through referral • I have choice around the support I want/need • I can access a personal budget • The person I am most closely supported by understands and/or has similar lived experience or expertise in terms of their ethnic and cultural background, faith/belief sexual orientation, gender and gender identity • Services flex around me – thresholds/eligibility criteria won't automatically exclude me
	• Services that support me access training that helps us work better together, including PIE, TIC and person-centred approaches • Peer-mentors help services engage with me and to understand SMD and how my experiences impact on me
	• Agreements are in place to share my information (with my consent) in a way that makes my care more joined up • New ways of sharing information and being involved in my care are offered to me

Outputs	• ECF in place, affecting change • All beneficiaries have opportunity to be involved • Training/learning opportunities to develop beneficiaries' skills
	• Navigators provide one-to-one ongoing support • Match funding from partners increases peer mentoring/navigator capacity • MDT has wider remit, supporting more people • Personal budgets available/utilised • Jointly commissioned/provided function expanded/launched beyond current rough sleeping focus • Personalised commissioning supports beneficiary choice
	• Co-produced training and support taken up across the system • Peer-mentors available to beneficiaries
	• Information sharing agreements in place • Beneficiaries can use IT platform to facilitate joined up care
Short-term outcomes	• Improvement in care/support leads to stabilisation • People with lived experience/beneficiaries know their experiences shape services/planning • Beneficiaries have greater choice, can get specialist support, can use a personal budget to help them meet their goals and are offered access to technology to aid person centred joint care planning
Longer-term outcomes	• Services share information easily and lawfully, supported by technology and robust information sharing agreements • Staff across services are more knowledgeable, understand how to refer clients to the MDT and how to get specialist advice and support • Services are flexible to meet needs of people experiencing SMD, not sticking rigidly to thresholds or eligibility criteria
Impacts	• *I am central to my own care/support with choice and control around the support I access* • *My life experiences, including my cultural experience, ethnicity and gender, are accepted and understood wherever I receive support* • *My support is consistent, with the same worker wherever possible* • *I don't have to repeat my story constantly* • *My strengths are known/acknowledged* • *I feel respected, not stigmatised* • *I am involved in how my support ends, it happens in a planned way* • *My voice is heard, my opinion valued at all levels*
Key assumptions	• Ongoing support from beneficiaries • Innovative approaches to joint/personalised commissioning supported by partners
External factors	• Increase in need/acuity linked to Covid-19

Unintended consequences	• Beneficiaries/services/programme don't recognise sources of disadvantage, e.g. DSVA, leading to inappropriate exclusion from the programme