Sheffield Changing Futures theory of change

System level

Context	Currently, we think the problem is: • Demand outstrips capacity; widespread across system but particular bottleneck in higher-tier statutory services. Underlying issue is underinvestment. • No specific strategy/approach that has buy-in across the partnership. • Some duplication where commissioning only targets one area of need. • Specialist services concentrated in city centre. • People with lived experience are consulted but aren't equal decision-makers • Data spread across systems, inconsistent information-sharing, no-one has a single picture. • Disparities in professional status and different ways of working cause conflicts and 'gatekeeping' of data and services. • Much of the workforce aren't experienced in working with this cohort, lack confidence and don't know what is available.
Inputs	• Changing Futures central leadership, opportunities to influence national policy • Changing Futures funding • Local funding • Shared values and culture • Strategic input from people with lived experience, with an equal stake in commissioning and funding decisions • Open dialogue between commissioners and delivery partners • Updated information-sharing agreements • Support for involvement of people with lived experience recruitment, learning, development • A learning culture, tolerant of some trial and error

Activities	• Develop a system-wide strategic approach, aligning resources. Increase investment where capacity is causing problems. • Establish strategic and operational multi-agency groups specifically around adults with multiple disadvantage • Mapping of funding (current and opportunities) • Mapping the system and use of the system, especially bottlenecks in capacity • Establish baseline of system measures such as collaboration, coproduction, learning • Strategic review of how commissioning could better enable service user choice and control • Identify strategic and operational blockages • In year 3, evaluation of system change led by people with lived experience • Develop vehicle for sharing best practice • Agree common workforce approaches • Assemble and share directory of services. • Co-produce a single assessment and set of person-centred outcomes as basis of support from range of agencies • Develop multi-agency case management and information-sharing system that gives a single view of each individual • Analyse cost to the public purse of multiple disadvantage in Sheffield; monitor how this changes over the programme period • Co-produce and widely deliver training and awareness-raising on multiple disadvantage, trauma-informed and person-centred approaches • Co-produce toolkit on recruitment and CPD
Outputs	• Number of and attendance at strategic and operational meetings, practice-sharing events • Strategic reviews completed • Information-sharing agreements in place/reviewed • Services listed in directory • Assessments completed/reviewed • Records populated on case management system • Cost-benefit analysis

	• Training sessions delivered • Uses of recruitment toolkit • Posts covered by common workforce approach • People with lived experience identified and trained for coproduction
Short-term outcomes	One-year goals: • Increased workforce capacity and assertive outreach in key areas, trialling/modelling a new way of working together • System directory in place, accessible to workforce and service users • A network of people with lived experience trained and prepared to engage in coproduction • Data sharing system developed/procured and in use by core teams • Increased workforce knowledge about multiple disadvantage and effective responses
Longer-term outcomes	Two-year goals: • Wider range of organisations signed up to the agreed way of working; increased confidence and capacity to work with the cohort • Shared ownership of system-wide and person-centred outcomes, with joint commissioning and decision-making • Commissioning strategies prioritise personalisation, choice and collaboration • People with lived experience are involved in codesigning the system • Comprehensive assessment used by all key agencies, underpinned by information-sharing agreements. • Data system widely in use, delivering regular analytical insights • Best practice being shared through informal and formal networks • Value of this programme demonstrated and a plan for how to continue.
Impacts	Five-year vision:

	• Services have the consistency, capacity and confidence to work with people with multiple disadvantage. • Workforce is led by shared values and skilled in working with multiple disadvantage. • All necessary services are linked up effectively around each vulnerable person, avoiding duplication, making transitions smoother • System promotes personalisation and choice. • Recognition that all parts of the system have a role in improving outcomes and share accountability for doing so • Learning from lived experience, frontline delivery and data analysis is used to make evidence-informed decisions. • Regular information sharing contributes to shared assessment of need and risk, shared plan of support for each individual. • Reduced demand on crisis services meaning resources can be shifted to more preventative approaches.
Key assumptions	• Increased capacity for multiple disadvantage can be ring-fenced against other demands • Agencies will be willing and able to agree values and compromise to align priorities, resources and ways of working • People with lived experience will be willing to devote time and energy to coproduction and will have strategic insights • Data protection and security concerns can be overcome to develop shared data system • Training will translate into changes in practice
External factors	• Interaction with strengthened locality approaches • Organisational reforms: how these relate to place-based systems • Changes of local political/organisational leadership/policy • Opportunities/challenges provided by new technologies/applications • Legislative/national policy changes regarding key issues such as benefit entitlements • Economic situation (recession/recovery)

Unintended consequences	Negative: • Resources directed to multiple disadvantage reduce critical capacity elsewhere • Perceptions (correct or not) that people with multiple disadvantage are receiving a ‘special’ service Positive: • Collaborative, person-centred, trauma-informed approaches extend to benefit other cohorts

Service level

Context	Currently, we think the problem is: • High caseloads hinder offers of persistent engagement, intensive support and continuity of care. • Chain of assessments, referrals and waiting times between services. • Support is stepped down once a crisis is resolved, cannot easily be stepped back up. • Services address one need rather than the whole person. • Interventions focused on minimising service user's needs and risks rather than building on their strengths. • Lack of suitable accommodation • Service offers are not always differentiated for characteristics such as gender, age or ethnicity • Harder to engage some service users where workforce does not reflect the population • Unaware who else is working with a service user, what they are doing and what they know. • Not enough knowledge and skills around multiple disadvantage and trauma • Based in 'institutional' settings.
Inputs	• Investment in more capacity • Prioritising continuity of relationships • Alignment of strategic objectives and approach between organisations; expectation to work collaboratively • Agreed cohort for core team • Core team testing and modelling effectives way of working, acting as point of expert reference • Defined expectations regarding coproduction • Support for people with lived experience to participate in coproduction • Reliable single view of a service user's current circumstances and goals

Activities	• Recruit core delivery team; develop operating model, allowing for significant flexibility and creativity • Identify dedicated capacity and differentiated offer for women with multiple disadvantage • Recruit/identify additional posts in areas of most constrained capacity • Source/adapt suitable properties and provide support to maintain/move towards independent living • Identify impact and benefits of core team's way of working and other needs that would be better met this way; modify service models accordingly • Identify/redesign trauma-informed spaces • Multi-disciplinary health and care discussions, enabled by remote meetings/tech • Increase capacity in services to allow continuity of relationships and gradual transitions • Develop out-of-hours contact point and associated information-sharing system • Train and support services to use information-sharing / assessment and outcomes system • Analyse data from this system • Identify potential peer mentors from range of backgrounds; provide training and ongoing support. • Invest in activities that help individuals to grow in confidence, skills and social capital • Workforce development on coproduction, trauma-informed approaches, positive transitions and challenging stigma • Dialogue with communities and businesses
Outputs	• Staff in post • Additional supported housing units • Staff and volunteers with lived experience • MDT discussions taking place • Active users of data system • Number of and attendance at training sessions
Short-term outcomes	One-year goals:

	• Core team working with target cohort, has links to relevant services • Coproduction is valued, helping determine operational decisions in core team • Data system in place, used by core team • OOH contact point being piloted • Greater workforce awareness of multiple disadvantage and effective responses
Longer-term outcomes	Two-year goals: • Shared learning from core team produces service changes elsewhere, including for specific sub-groups of the cohort • Transitions between services are more effective • Multi-agency OOH contact point in place • People with lived experience involved in providing support through different roles • Service users have greater influence in decision-making, beyond core team. • Data system being used by services beyond core team • Workforce more confident in delivering trauma-informed, joined-up support
Impacts	Five-year vision: • Key services have more capacity, and workers have greater skills and autonomy, allowing more meaningful interactions, support that can start rapidly and sustain as required to see transitions through. • Services take a flexible, holistic and strengths-based approach. • Services are better at understanding and meeting the needs of a diverse range of people, with specific offers for sub-groups. • Services are committed to coproduction and (ex-)service users have an equal stake in decision-making. • Services contribute to/access a data system that gives comprehensive, up-to-date view of each individual

	• Increased workforce understanding and confidence about working effectively with people with multiple disadvantage.
Key assumptions	• We will secure other funding to sustain some increased capacity after Year 3 • Some individuals will transition to a lower level of support, allowing new referrals • Commissioning cycles and conditions will allow for the changes we want to see • Providers will be willing and able to work in a more collaborative and holistic way • Sufficiency of suitable properties • People with lived experience will be willing to be involved in coproduction and will have operational insights • Services will see the value of a shared data system and be willing to use it • Training will translate into changes in practice
External factors	• Levels of demand for services, including impact of Covid • Sufficient skilled/qualified and motivated workforce to draw on • Sufficient buildings that can be adapted • Future funding rounds and whether their objectives align
Unintended consequences	Negative: • Upskilled workers leave their posts, impacting continuity of relationships • Requiring providers to work in new ways is more expensive, causing them to withdraw and/or pressure on commissioning budgets Positive: • Workers moving posts take their knowledge and skills to other areas and organisations • Learning/practices of coproduction are used to improve other services Both:

	• Wider awareness and advertising of referral routes and support services could raise expectations of change.

Individual level

Context	Currently, we think the problem for individuals is: • Multiple, interlinked disadvantages, including some that haven't been properly recognised yet. • Usually significant past and ongoing trauma. • Stigma and discrimination, both for multiple disadvantage and other characteristics. • Unable to get effective support due to eligibility/exclusion thresholds and/or inflexible, disconnected service offers. • Distrusting of some offers of help. • Difficult to contact someone who understands their circumstances and support plan out of usual service hours. • Cannot take control of what change they want to see in their lives and how that happens. • May not feel that they belong to a community at all, or may be part of a community which features entrenched substance misuse, crime etc.
Inputs	• Skilled workers with capacity and flexibility to engage, support and see transitions through. • Places to meet individuals which feel safe and welcoming for them • Offer of a suitable and desirable place to live • Coordination, collaboration and real-time information-sharing between agencies. • Clear out-of-hours contact point developed and advertised. • Shared assessments and plans centred on desired outcomes, overcoming barriers to getting them • Peer mentors, from different backgrounds and life experiences, trained and supported in the role • Co-designed services • Data system that allows for input from the individual. • Range of positive activities available • Pathways into learning, training and employment

	• High aspirations for individuals • Workforce aware of multiple disadvantage and how to signpost for support.
Activities	• Workers and peer mentors spend time engaging and building relationships with individuals. • Coproduce support plans based on the individual's own goals, preferences and strengths with family and other support networks • Keyworker navigates and collaborates with other services to deliver appropriate support at pace of the individual. • Develop links to positive social networks and local community. • Plan gradual transitions out of services.
Outputs	• Times engaged with keyworker • Goals achieved on support plan • Reviews of assessment and plan • Calls to OOH contact point, how resolved • Individual users of data system • # positive social connections
Short-term outcomes	One-year goals: • Individuals having trusted relationship with one or more workers • Feeling safe and supported in at least one service • Basic survival and safety needs being met • Improved wellbeing and self-efficacy
Longer-term outcomes	Two-year goals: • Improved trust in services • Individuals feel in control of their plans, confident in achieving their goals • They enjoy a range of positive community links and healthy relationships

	• Each individual's own goals being achieved. Specifics will vary but common themes may be: health, money, safety, housing, family and friends, things to do, plans for the future. • Individuals have access to the information held about them, can add to it and use it as a 'personal profile' to reduce the need to retell their story. • Cohort-level outcomes (reduced offending/victimisation, reduced use of emergency services, fewer housing moves etc) are improving.
Impacts	Five-year vision: • Individuals who have been supported by the improved services are leading safer, more stable and more fulfilling lives. • They make appropriate use of support, rarely using crisis services. They know where to turn if they hit difficulties. • They are part of positive communities. • They can feed their experiences back into the system to co-produce further improvements..
Key assumptions	• Achievable for individuals and workers to overcome barriers to build trusting and effective relationships • Activities and communities exist to match each individual's interests
External factors	• Relationships with family, friends could be positive or undermine progress • Life events could be negative (e.g. being victim of a crime, a new health condition) or positive (e.g. meeting a new partner)
Unintended consequences	Negative: • Some individuals will not engage with the new/improved service offer – potential consequence that they become even more marginalised. Positive:

	• Individuals with high needs, but not multiple disadvantage, can also access and benefit from some of the activities.