Nottingham City Health and Wellbeing Board: Severe and Multiple Disadvantage Programme

DELIVERY PLAN 2025-2028

1. Purpose

This delivery plan sets out plans to further develop and secure a whole-system response (across all public and voluntary sector partners) to improve the lives of people who experience severe and multiple disadvantage (SMD) in Nottingham City.

It sets out the partnership ambition to introduce new, secure structures that bring together the interdependent interests of system partners (including those relating to health and wellbeing, criminal justice, housing, and other responsibilities) and to make the most effective use of collective efforts and resources to make a difference for some of the most vulnerable and marginalised people within our communities.

A *whole system* approach recognises that no single organisation can meet the complex and overlapping needs of people experiencing severe and multiple disadvantage. "The system" therefore encompasses all partners whose actions impact people who experience SMD, including local authority services, the NHS and Integrated Care Board, police and probation, housing providers, voluntary and community organisations, and people with lived experience.

2. Background

About severe and multiple disadvantage

Severe and multiple disadvantage (SMD) describes the co-occurring experiences (commonly defined as three or more concurrently) of a combination of homelessness, substance use, mental ill-health, interaction with the criminal justice system (offending and/or victimisation), and domestic and sexual violence or abuse. For many, their current circumstances are often shaped by histories of poverty, deprivation, trauma, abuse, and neglect.

People who experience SMD are often caught in their situations for years, facing a cycle of compounded disadvantage, trauma and exclusion, leading to extremely poor health and wellbeing, as well as a very high degree of dependency upon reactive and emergency interventions across our system. Single issue interventions are often ineffective, and practical barriers and responses to trauma (e.g. withdrawal or aggression) and can prevent people from gaining access to effective care and support when they need it most.

Partnership working in Nottingham

Partners in Nottingham have a long history of working together to support people experiencing SMD. Building on the partnership work of statutory and non-statutory agencies, **Opportunity Nottingham** was established in 2014 through the national *Fulfilling Lives* programme, creating a significant platform of learning, lived experience involvement, and operational expertise in the delivery of targeted interventions to address the stark risks and barriers that people affected by SMD experience. Collaboration developed significantly during the Covid-19 pandemic as partners across a range of disciplines came together organically to plan and integrate a diverse range of provision to respond to the urgent needs of people at risk due to underlying experiences of multiple disadvantage. This successful initiative led to agreement by partners to continue to work together to bring together their efforts as the **Nottingham SMD Partnership**, supported through Nottingham City Place-Based Partnership's (PBP) recently agreed priority to improve the lives of people experiencing SMD.

Following the successful application to the government's Changing Futures programme (led by the PBP SMD Partnership), Opportunity Nottingham was succeeded by **Changing Futures Nottingham** in July 2022. This programme included additional emphasis on integrating specialist support into the wider public sector architecture within Nottingham City, as well as the development of shared infrastructure to strengthen wider system delivery and collaboration (including within non-SMD specialist service areas).

Public and voluntary services working across Nottingham contribute a diverse range of activity, planning and expertise to address the needs of people who experience multiple disadvantage. This work encompasses targeted provision where SMD is most prevalent (e.g. Homeless Health / Mental Health teams, Street Outreach, day centres, and substance use treatment for rough sleepers) through to broader public services working to improve equity and manage core responsibilities. Colleagues and services have a long history of working collaboratively (through formal and informal arrangements) to manage individual needs holistically – often a necessity where people are experiencing SMD – and innovations led within statutory services have introduced developments to strengthen links between services to address underlying needs (e.g. local enhanced services for patients experiencing SMD within general practice, and diversion to support through Nottinghamshire Police's Operation Brandberg).

A range of system planning activity has also sought to deliver improvements that both benefit and have significant dependency upon partners' management of multiple disadvantage. These are various and sit across system interests, including (not exhaustive):

- Reducing Reoffending
- Inclusion Health
- High intensity / high frequency service use (NHS)
- Frailty (NHS and Adult Social Care)
- Co-occurring substance use and mental health pathways
- Mental health and housing pathways
- Inclusive Recovery Communities
- Nottingham City Homelessness & Rough Sleeping Prevention Strategy
- Nottinghamshire Police and Crime Plan
- Nottingham Community Safety Partnership Strategy
- Nottingham City Safeguarding Adults Board Strategic Plan
- Nottingham City Substance Use Strategic Partnership
- Modern slavery and exploitation
- Nottingham and Nottinghamshire Trauma Informed Partnership

Partnership arrangements supported by the PBP, Changing Futures and the Nottingham SMD Partnership have facilitated rather than replaced wider system development, with partnership forums, research, workforce development initiatives, lived experience involvement, organisational development (aided by embedded SMD specialists within statutory services), and oversight from the partnership Changing Futures Board helping to align efforts and encourage partners' progress to achieve more widespread and sustainable change.

Significant progress has been made by system partners drawing together their interests to connect care and support around people experiencing SMD, with a range of process and pathway improvements, integrated planning and service delivery, organisational and workforce development, targeted initiatives, lived experience involvement, and far greater system awareness achieved to date. These steps have delivered meaningful improvements in access, experiences, and coordination of effective help to improve the lives of people experiencing SMD, although with clear potential for far greater impact through more robust system coordination and oversight.

Next steps

While collaboration between partners has improved, demand for specialist-SMD services has continued to rise, and further opportunity exists to improve the interface between specialist and non-specialist services to manage partners' overlapping interests.

A strategic review of the system response to SMD (led by Nottingham PBP) completed in early 2025 identified a high-functioning, problem-solving partnership model with inherent vulnerabilities and constraints arising from the absence of embedded partnership structures and shared governance. The review found:

- While most of the right partners involved, some key partners are not engaged
- High trust between partners masks a high-risk partnership model
- Nottingham's SMD model operates within a challenging external environment
- There are opportunities to take more preventative approaches
- While there is significant potential, there are limited established SMD pathways or working protocols between specialist-SMD and non-specialist services
- As a partnership, there is an underdeveloped understanding of the number of people services are supporting at any point in time
- There is a requirement for commensurate prioritisation of SMD within individual partners' organisational strategies
- Current partnership oversight arrangements are limited to specialist-SMD provision

3. Programme overview

The Changing Futures Board and PBP have agreed the following mission and vision for the programme:

Our mission: We want to make Severe and Multiple Disadvantage (SMD) everyone's business.

This means embedding awareness, responsibility and action around SMD across all parts of healthcare system and wider public services, not just in specialist teams. Everyone, from frontline staff to strategic leaders, should understand and pro-actively respond to the complex needs of people facing SMD.

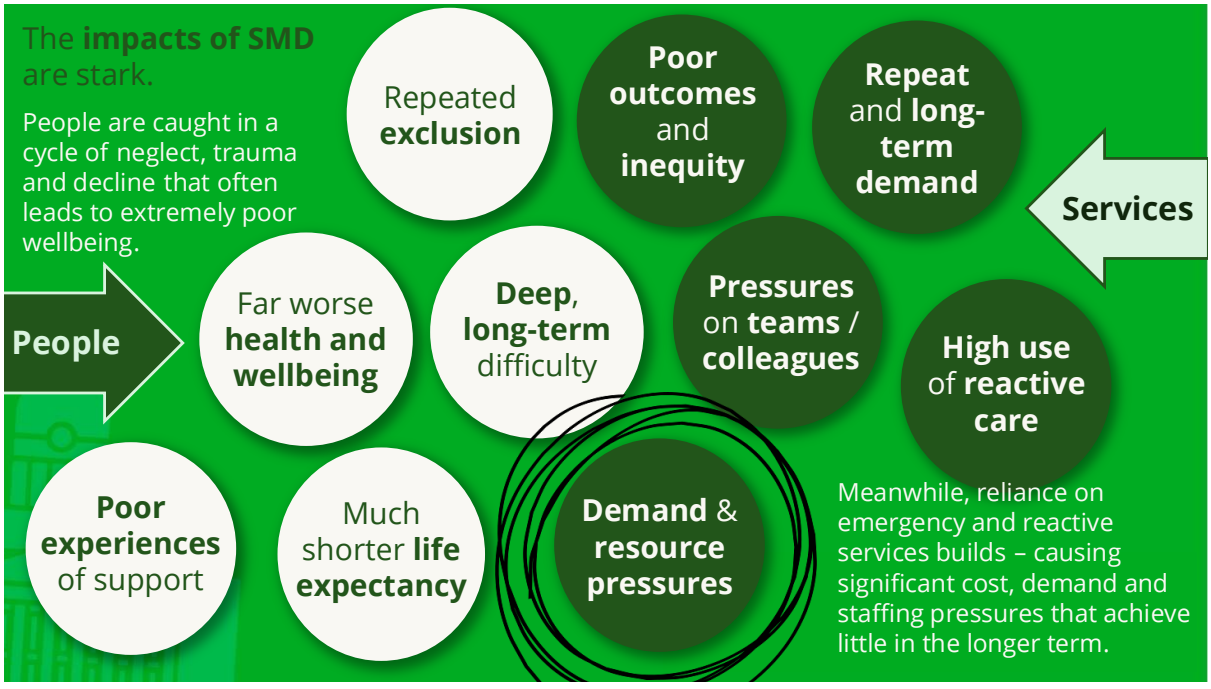
Our vision: By 2028, people experiencing Severe and Multiple Disadvantage will receive joined-up, trauma-informed support from a system that recognises and responds to the complexity of their lives, with shared accountability across all public services.

All public services take shared ownership for people's outcomes, delivering coordinated, compassionate, and person-centred care. This will be achieved by reducing duplication and closing service gaps – improving outcomes for people facing the greatest inequality and exclusion.

Why multiple disadvantage matters

People who experience severe and multiple disadvantage face some of the most extreme health inequalities within our population, including the much earlier onset of preventable chronic health conditions and significantly shortened life expectancy. The challenges they face often relate to structural inequalities, and often leaves people unable to live safe and fulfilling lives or to contribute to their communities.

Multiple disadvantage is a systemic problem. People's experiences of disadvantage are often compounded by the siloing of responsibilities for different areas of their needs across public services, creating gaps in support and difficulties combining help, and making it harder for them to improve their circumstances. This often results in longer term decline and far more frequent and prolonged contact with reactive services, including homelessness responses, intensive and emergency healthcare (e.g. A&E attendances and hospitalisation), escalation of social care needs, and interactions with the criminal justice system. As such, the impacts of SMD are stark for people, but also reflect poor outcomes, inequity, demand and staffing pressures, and challenges achieving financial sustainability across partners within our system.



Evidence has shown that more coordinated and person-centred interventions across statutory and voluntary agencies can improve people's lives and reduce the use and cost of crisis services. This depends upon collaboration between partners, with greater coordination of efforts and resources across the system to manage their interrelated responsibilities.

4. Thematic priorities

Improved coordination of the system response should aim to use collective efforts and resource as efficiently as possible to minimise the overall occurrence of multiple disadvantage.

A number of thematic priorities and corresponding areas for delivery will be used to guide the delivery of the programme:

- **Prevention** – develop and implement an evidence-informed framework to support the secondary and tertiary prevention of multiple disadvantage

- **Responsiveness** – develop further understanding of the unmet needs of people experiencing multiple disadvantage, and ensure specialist pathways are in place at sufficient scale and capacity

- **Intersectionality** – strengthen the approach to addressing the intersecting needs of people who experience SMD considering the impacts of 'multiple marginalisation' and the additional disadvantages that people experience relating to ethnicity, gender, sexuality, neurodivergence, and other characteristics

- **Recovery** – describe and champion recovery for people who experience multiple disadvantage through alignment to the Inclusive Recovery City approach, and develop, promote and evaluate approaches for supported access to employment for people who experience SMD

A further outline of specific opportunities to address the thematic priorities through the delivery of this plan is included in **Appendix 1**.

5. Objectives

Five core objectives have been agreed by the Changing Futures Board and PBP for 2025-28 to support the ambition to embed system-wide management of the response to SMD in Nottingham. These are:

1. Improve data capture and analysis of SMD to better inform decision making and evidence impact of SMD on partner services.
2. Ensure appropriate prioritisation of SMD in organisational strategies and plans.
3. Ensure a sustainable funding model that is reflective of the partnership approach and in turn responds to the needs of people experiencing SMD.
4. Improve formal oversight of interrelated activities and accountabilities / responsibilities between partners.
5. Enhance SMD pathways and joint working protocols between specialist-SMD and non-specialist services.

5. Approach

This plan sets a path for maturing the existing partnership structures and arrangements that draw together interests, efforts and resources to respond to the needs of people experiencing multiple disadvantage into a more comprehensive and sustainable approach to system-wide management.

A phased approach is outlined for the focus of activity over the next three years to deliver the partnership mission, vision and objectives:

- **Phase 1: Foundation and infrastructure** – reviewing the current evidence base for population need, establishing comprehensive partnership leadership and oversight, and the introduction of clearer arrangements for ongoing insight needed to deliver the vision

- **Phase 2: Integration and delivery** – working with individual system partners to establish the links between multiple disadvantage and their core, organisational priorities to embed SMD approaches into organisational strategies and plans; reviewing the interfaces between partners' services, and rationalising and improving pathways according to the opportunities to improve the overall system response (e.g. improved outcomes, strengthened prevention, improved management of resource); and reviewing and improving workforce development requirements to empower colleagues across service areas to deliver the vision

- **Phase 3: Evaluation and system maturity** – evaluating the impact of the programme against the vision for improved system coordination as well as the attainment of shared outcomes and partners' organisational priorities corresponding to multiple disadvantage, and producing recommendations for further improvement

6. Working together as a partnership

The current Nottingham City PBP SMD model of specialist delivery and partnership infrastructure has been co-produced and refined through wide and ongoing involvement of colleagues working in a range of roles (e.g. strategic, commissioning, operational delivery), organisations and sectors (e.g. health, local authority, criminal justice, housing, social care, and voluntary and community services), and with particular emphasis on collaboration with people with their own lived experiences of multiple disadvantage.

The active and ongoing engagement of partners is a key dependency for the delivery of the programme, providing diverse insight, direction, and shared understanding and commitment to the implementation of the mission and vision.

The following core groups will help to guide the development and implementation of the plan under the overall direction of the PBP and Nottingham City Health and Wellbeing Board:

Group	Membership	Role
SMD Oversight Group	Senior leaders with representation across public and VCS partners	System leadership, alignment of resource* and oversight of strategic objectives & thematic priorities
Experts by Experience Board	People with first-hand lived experience of SMD	Guidance, direction and support with delivery of workstreams and thematic objectives, and lived experience recommendations to SMD Oversight Group
Nottingham SMD Partnership	Wide, open invitation forum for colleagues, stakeholders and lived experience experts across roles, services and organisations	Guidance, direction and support with workstreams and thematic objectives, and ongoing alignment to emerging developments and opportunities across the system

**via commissioning sub-group*

7. Principles for implementation

Delivery of the plan will be underpinned by the following cross-cutting principles:

- **Co-produced:** embedding the meaningful and ongoing involvement of stakeholders, including lived experience experts and the Nottingham SMD Partnership, in design, oversight and evaluation of the programme
- **Strategically aligned:** aligning the system-wide response to wider local and national strategies and agendas (e.g. those corresponding to health, housing / homelessness, criminal justice, substance use, DSVA, employment, and national multiple disadvantage policy) and other significant developments (e.g. boundary changes for local government and NHS administration)
- **Led by evidence**: informed by evidence and expertise in relation to need and what works across available across the system, with a focus on alignment of insight, research and evaluation, and data capture to that meet partners' requirements
- **Sustainable**: responsive to partners' individual priorities and interests to enable sustainable, long-term development (including management of core responsibilities and outcomes, budgetary sustainability, alignment to strategic priorities, and provision of sustainable staffing)
- **Realistic**: ambitious, but developed with appreciation of partners' ongoing responsibilities and time / resource requirements to develop effective and sustainable partnership infrastructure

8. Outcomes and impact – how will we know we have made a difference?

Multiple disadvantage impacts across the system, and individual partners have responsibilities corresponding to the delivery of core outcomes for the wider population (including the delivery of statutory interventions) and for management of resources that are affected by the collective ability of the system to manage SMD.

These responsibilities include (but are not limited to) the following outcomes previously identified by the Changing Futures Programme Delivery Board (**Appendix 2**). The programme will revise these outcomes in collaboration with individual system partners, seeking alignment of organisational priorities to the opportunities for improved system management of SMD.

As part of the development of the SMD model, members of the Nottingham SMD Partnership and lived experience experts worked collaboratively to develop a 'Theory of Change' encompassing outcomes sought for the coordination of the system and benefits sought for people experiencing SMD (**Appendix 3**). The current programme will review and update this approach in line with the partnership's ambition to establish comprehensive collective oversight of wider system activity beyond the Changing Futures programme.

Identifying outcomes and impact for people experiencing multiple disadvantage across public services is often recognised as very challenging. SMD is complex by nature, with people's individual experiences often following a path of non-linear recovery, and shifting patterns of interaction across multiple service areas. In addition, despite evidence of extremely poor overall outcomes and high interaction with intensive and crisis interventions, identification of people experiencing SMD (and standardisation of reporting) is still limited. The fragmentation of data held across different service areas and barriers to sharing data often masks people's interactions across the system as a whole, creating difficulties in understanding overall system performance and scope for improvement.

Significant progress has been made in Nottingham towards increased standardisation in the identification of partners' services, and innovative approaches have been developed to help determine the prevalence of SMD experiences, patterns of interaction and outcomes from existing datasets. Recent breakthroughs have also been realised in the targeted matching of data (e.g. between recipients of specialist SMD support and use of reactive healthcare), creating the potential for much richer understanding of outcomes.

The programme will prioritise the development a partnership framework for the evaluation of the programme (including both reporting measures and 'healthy system indicators', as well as the creation of a dashboard for ongoing reporting of key measures to enable the SMD Oversight Group to monitor system demands and outcomes. Improvements to the identification of people SMD within individual partners' service areas and steps to bring together partners' data are also to be prioritised to feed improved insight into these frameworks.

A range of qualitative evaluation projects, research projects (including though collaboration with lived experience peer researchers) and partnership learning initiatives have been delivered over recent years to help build understanding of multiple disadvantage and approaches that work to help people to improve their situations. These arrangements will continue to be incorporated into strengthen the evidence base for effective strategies for delivery.

Finally, a new partnership Insight and Development Hub will be formed to bring together insight capacity (e.g. analysts, research and evaluation leads, etc) and across partner agencies and improve collaboration to improve overall system insight.

Expected improvement to system co-ordination by 2028

- Severe and multiple disadvantage (SMD) embedded as a system priority and recognised within partner strategies in relation to individual organisational priorities
- Collective system infrastructure, insight capacity and leadership in place to enable effective system coordination of response to multiple disadvantage
- Active and comprehensive partnership involvement across leadership, service planning, commissioning, and delivery
- Strengthened interface between SMD specialist and non-specialist services
- System oversight and coordination is responsive to partners' overlapping and interdependent interests and responsibilities
- Sustainability in the retention of staffing expertise required for effective delivery
- Rationalised pathways and processes developed / under development with reduced duplication and improved effort and resources
- Improved balance of alignment of partners' resources to infrastructure and SMD activity in commensurate to organisational opportunity (e.g. for improved outcomes and equity, capacity management, and sustainability of budgets)
- Improved use of learning and insight across the system to guide the development of priorities, service planning, commissioning and investment, operational delivery, and understanding of impact
- Improved capacity within workforce and colleagues empowered with knowledge of how to manage SMD and partnership pathways
- Established cross-system governance and data framework sustaining coordinated delivery beyond 2028

8. Implementation phases and key activity

Phase 1 – Foundation and Infrastructure (2025/26)

Objective: Establish the structures, data systems, and partnership oversight needed to deliver the vision.

Enabler	Key Activities	Lead	Deliverables	Timeline
1A. Joint Strategic Needs Assessment (JSNA)	• Multi-agency steering group established and scope agreed • Consultation and engagement plan produced to involve people lived and living experience, and key stakeholders including health and social care, voluntary and community social enterprise organisations • Review and analysis of available evidence and data • Share findings to inform ongoing service developments and develop cross-partner action plan	NCC Public Health	JSNA chapter on Inclusion Health and SMD	Complete by end of Dec 2025
1B. Establish SMD Partnership Board	• Consult senior system partners, EbE Board and SMD Partnership on remit • Draft terms of reference (ToR) and proposed governance framework • Define accountability framework • Seek approval from PBP Executive	PBP Director of Strategy & Partnerships	Operational SMD Oversight Group	Q3 2025/26

Enabler	Key Activities	Lead	Deliverables	Timeline
	• Appoint independent chair and senior representatives			
1C. Establish Partnership Insight and Development Hub	• Host scoping meetings with system partners (SMD Board, SMD Partnership and EbE) to identify requirements and potential models for delivery • Develop terms of reference and agree with SMD Oversight Group • Form cross-partner analytical team • Revise theory of change for system-wide development with SMD Partnership and lived experience experts • Develop performance dashboard / KPIs for system outcomes (e.g. housing, health, criminal justice, etc) – consider prevention, responsiveness, intersectionality, and recovery • Include attention to thematic priorities (prevention, responsivity, intersectionality, and recovery) within dashboard • Develop agreed proxy indicators for SMD (service usage, costs, outcomes) and undertake analysis across system partners	SMD Programme Lead	SMD "Data Currency" and performance dashboard Collective learning & insight 'hub' responsive to system requirements	Q4 2025/26

Enabler	Key Activities	Lead	Deliverables	Timeline
	• Review and update tho • Seek approval from SMD Board and establish link to guide priorities for insight and analysis			
1D. Communications	• Map partners' relevant channels of communication • Develop communications strategy corresponding to mission and vision • Agree key messages for shared partnership / system narrative on SMD • Undertake communications activity in accordance with strategy	Changing Futures / PBP Communications Leads	System-wide awareness campaign in place	Q4 2025/26

Phase 2 – Integration and Delivery (Q4 2025/26 - 2026/27)

Objective: Embed SMD approaches into organisational strategies, pathways, and workforce practice.

Enabler	Key Activities	Lead	Deliverables	Timeline
2A. Inclusion of SMD in System Partners' Strategies and Plans	• Conduct SMD development sessions with individual partners' executive teams • Identify links to organisational priorities to reflect in system outcomes framework • Integrate SMD metrics into business plans and commissioning frameworks according to case • Identify investment requirements for 26/27 and 27/28 cycles.	SMD Programme Lead	All partner organisations include SMD objectives in corporate plans.	Q4 2025/26 – Q4 2026/27
2B. Review of SMD Pathways	• Develop project plan for approval by SMD Board • Map all specialist and non-specialist SMD pathways • Identify overlap, duplication, and gaps • Review opportunity for improvements relating to thematic priorities (prevention, responsiveness, intersectionality, and recovery) within scope • Host co-production workshops with frontline teams and lived experience experts	SMD Programme Lead / Commissioning Manager	SMD Pathway	Q1–Q3 2026/27

Enabler	Key Activities	Lead	Deliverables	Timeline
	• Engage with Insight and Development Hub and explore opportunities for interoperability between data / CRM systems • Develop joint-working protocols and escalation routes • Produce recommendations for SMD Board / for individual partners			
2C. Workforce Development	• Convene partners' workforce development leads – and consider related system agendas / priorities (e.g. trauma) • Review common workforce development needs in relation to SMD (considering prevention, responsiveness, intersectionality, and recovery) • Review workforce development programme and resource requirement • Establish evaluation process / metrics • Seek approval from SMD Board • Implement programme	SMD Programme Lead	System-wide workforce development programme and evaluation framework	Q1–Q4 2026/27

Phase 3 – Evaluation and System Maturity (2027/28)

Objective: Achieve sustained, whole-system ownership of SMD and measurable impact on outcomes.

Enabler	Key Activities	Lead / Governance	Deliverables	Timeline
3A. System Evaluation and Analysis of Impact	• Develop evaluation framework (considering e.g. individual partners' and system outcomes, demand management, financial impact, and lived experience) • Include system measures (e.g. partner engagement, sustainability, etc) • Conduct multi-agency evaluation (using e.g. proxy data, SMD dashboard, qualitative evaluation projects) • Consult with senior leaders / SMD Board members, lived experience experts, and wider stakeholders / SMD Partnership • Produce annual impact report • Produce recommendations for SMD Board and PBP Executive	Insight and Development Hub / SMD Board	SMD Evaluation Report & ROI analysis Recommendations for future delivery	Q1–Q3 2027/28

Appendix 1 – Opportunities to Progress Thematic Priorities

Thematic priority	Key opportunities
Prevention – develop and implement an evidence-informed framework to support the secondary and tertiary prevention of multiple disadvantage	• Understand antecedents to SMD (research and data) • Improve management across non-specialist provision to reduce escalation, including through further development of Embedded Practitioner partnerships • Introduce targeted, time-limited preventative interventions by SMD-specialist services • Review association with health conditions (e.g. respiratory illness, multimorbidity / frailty) and preventative opportunities in healthcare (e.g. screening, vaccinations, public health) • Introduce wider-system prevention maturity framework for SMD
Responsiveness – build further understanding of the unmet needs of people experiencing multiple disadvantage, and ensure specialist pathways are in place at sufficient scale and capacity	• Review and strengthen pathways between services to support timely access to appropriate interventions • Undertake analysis of 'throughput' and demand to identify pressure points within the system • Further exploration of use of Embedded Practitioner partnerships within statutory services to increase responsiveness and connections to holistic support • Review, rationalise and maximise benefit of multi-disciplinary team approaches and opportunity for direct involvement of individual beneficiaries in planning their care and support • Strengthen access to support through contact with police responses • Promote widespread awareness and improvements to practice via workforce development

Thematic priority	Key opportunities
	• Strengthen and broaden adoption of trauma informed care and psychologically informed environments • Review opportunity for proactive support people with a high level of unmet need / at high risk who may be reluctant to engage with existing service offers

Intersectionality – strengthen the approach to addressing the intersecting needs of people who experience SMD considering the impacts of 'multiple marginalisation' and additional disadvantages / opportunities arising from intersectionality	• Further research and engagement on SMD and intersectionality
	• Further develop links with community specific organisations / groups and agendas to SMD response to support learning, capacity building, and opportunities for support (in both directions)
	• Initial focus on development within known areas of intersectionality, including those affecting:
	  ○ Women
	  ○ Minoritised ethnicities (including through links to PBP Race Health Inequalities programme)
	  ○ LGBTQ+ groups
	  ○ Neurodivergence, speech and language needs, and brain injury

Recovery – describe and champion recovery for people who experience multiple disadvantage through alignment to the Inclusive Recovery City approach, and develop, promote and evaluate approaches for supported access to employment for people who experience SMD:	• Embed strengths-based and anti-stigma approaches throughout engagement • Embed a focus on recovery within multiple disadvantage • Introduce and develop local models of employment support that are responsive to SMD • Review factors (e.g. housing, social engagement, etc) that promote longer-term sustainment • Facilitate development of / engagement within recovery communities for people who

Thematic priority	Key opportunities
	have experienced SMD (including links to Inclusive Recovery City agenda)

Appendix 2 – Partnership Outcomes (provisional)

Mental and Physical Health	• Reduction in health inequalities • Reduction / delay in avoidable morbidity (including onset of frailty) • Reduction / delay in avoidable mortality • Increase in appropriate and timely engagement (including sustainment) with healthcare interventions and treatment to prevent avoidable escalation of disease • Increased sustainment of the benefits from healthcare interventions • Reduced exposure of patients to environmental harms (e.g. lack of accommodation, persistent substance use, etc) that increase the risk of occurrence and progression of avoidable illness • Reduction in unplanned inpatient admissions • Reduction in use of emergency services (e.g. ambulance conveyances, ED attendances) • Improved equity of access, outcomes and experience of healthcare services
Housing and homelessness	• Increase in homelessness prevention • Reduction in homelessness arising from transitions / institutional discharges (e.g. from hospital, prisons, etc) • Reduction in repeated and/or long-term homelessness • Reduction in rough sleeping • Increase in access to suitable accommodation • Increase in sustainment of suitable accommodation • Increase in timely engagement in statutory homelessness assessments

Domestic and Sexual Violence and Abuse	• Reduction in repeated and long-term perpetration towards survivors • Reduction in victimisation towards survivors • Increased access to help and reporting where DSVA has occurred • Reduction in modern slavery • Increase in sustainment of required engagement with probation services / adherence to orders
Criminal Justice	• Reduction in repeated and long-term offending • Reduction in victimisation • Reduction in police callouts • Reduction in modern slavery • Reduction in arrests • Reduction in anti-social behaviour • Increase in sustainment of required engagement with probation services / adherence to orders
Mental Health	• Increase in timely and appropriate engagement in community mental health services • Increase in sustainment in community mental health services • Reduction avoidable admission to in-patient mental health services • Reduction in delayed discharges from in-patient mental health services
Substance and Alcohol Use	• Increase in engagement with substance use treatment • Improved sustainment of substance use treatment • Improved sustainment of positive outcomes from substance use treatment • Reduction in drug related deaths

Adult Social Care	• Increased access to preventative support and reduced progression of needs associated with SMD delays the requirement for social care • Timely and appropriate engagement with Adult Social Care (including planning pre-crisis) • Increased access to complementary forms of assistance and community support to maximise independence for people in receipt of social care
Safeguarding	• Increased detection / timely awareness of safeguarding concerns • Reduction in avoidable progression of safeguarding concerns to threshold for statutory intervention
General Partnership Outcomes	• Reduced burden on staff time managing links to external provision (i.e. beyond main remit) • Earlier resolution of individual issues requiring partnership engagement • Increased access to information to support complementary and timely interactions by individual partners in their work with people experiencing SMD • Increased awareness of SMD and approaches that work to meet people's needs and address organisational and system prior to escalation

Appendix 2 – Theory of Change: Nottingham City Changing Futures Programme

Theory of Change

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