Department for Levelling Up,
Housing & Communities

Evaluation of the Changing Futures Programme

Baseline report

April 2023

CFE research

CordisBright

revolving doors

The University Of Sheffield.

April 2023
Department for Levelling Up, Housing and Communities

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About

The Changing Futures programme is a £64 million initiative between the UK Government and The National Lottery Community Fund. It seeks to test innovative approaches to improving outcomes for people experiencing multiple disadvantage – including homelessness, drug and alcohol problems, mental ill health, domestic abuse and contact with the criminal justice system. The programme is running in 15 areas across England from 2021 to 2024.

The Department of Levelling Up, Housing and Communities (DLUHC) appointed a consortium of organisations, led by CFE Research and including Cordis Bright, Revolving Doors Agency, and the School of Health and Related Research (ScHARR) at The University of Sheffield, to undertake an independent evaluation of the Changing Futures programme.

This report presents the baseline position across key indicators at the start of the programme evaluation.

This report was written by CFE Research with Cordis Bright in October 2022.

For more information about this report please contact cfp@levellingup.gov.uk

Acknowledgements

We would like to thank colleagues at DLUHC, members of the Evaluation Advisory Group and our team of peer researchers for reviewing and commenting on drafts of this report. We would also like to thank the staff, volunteers, programme participants, people with lived experience and stakeholders from funded areas for contributed by organising and participating in the systems mapping workshops, completing questionnaires and compiling data for the evaluation.

Foreward

This report presents initial insights about the people using services as part of the Changing Futures programme, and the public service systems responsible for supporting them. The programme is funded by the government's Shared Outcomes Fund and aims to improve services and outcomes for adults experiencing multiple disadvantage in 15 areas of England, in addition to contributing funding to boost front line service delivery. Multiple disadvantage is defined as combinations of: homelessness; substance misuse; poor mental health; domestic abuse; and contact with the criminal justice system. The Changing Futures programme builds on the existing work and evidence from programmes such as Fulfilling Lives and the Making Every Adult Matter Approach.

This first report summarises the findings of baseline research and data collection undertaken between November 2021 and October 2022. It sets out people’s current experience of disadvantage; their levels of wellbeing; and access to services. The report also draws on a survey of local system partners and qualitative systems mapping to describe the ways wider systems of support are working for people experiencing multiple disadvantage, focusing on key strengths and barriers. Alongside this report we are publishing two rapid evidence assessments. The first report assesses the literature on frontline support models and identifies approaches producing a positive impact for people experiencing multiple disadvantage; the second focuses on the evidence around trauma-informed approaches specifically.

The programme is already reaching people who most need help, with almost 7 in 10 reporting experience of both mental ill health and drug and alcohol problems, and over half experiencing four or five forms of disadvantage. A broad range of local partners have begun positively contributing to our understanding of how collaborative approaches; a supported workforce; and the contribution of people with lived experience are related to outcomes for people experiencing multiple disadvantage.

I would like to thank CFE Research and their partners for their hard work conducting the research and synthesising large volumes of data for this report; the evaluation advisory group for their expertise and advice in reviewing our research outputs; and colleagues at DLUHC who helped develop research materials and gave feedback on the reports. I am also extremely grateful to all local programme and service staff for their support for our evaluation activities, and their ongoing work collecting data directly from people on the programme. Most importantly, I would like to thank programme beneficiaries for their time and sharing their experiences with us.

DLUHC and government partners are committed to using learning from Changing Futures to transform services and contribute to an important evidence base. The evaluation of the programme, through this series of research reports, is key to achieving this.

Stephen Aldridge
Director for Analysis and Data & Chief Economist
Department for Levelling Up, Housing and Communities

List of acronyms and abbreviations

DLUHC: Department for Levelling Up, Housing and Communities

Fulfilling Lives: An eight-year programme funded by The National Lottery Community Fund supporting people experiencing multiple disadvantage

ICS: Integrated Care Systems – partnerships of organisations that come together to plan and deliver joined-up health and care services

ICB: Integrated Care Board – each ICS has an ICB, a statutory organisation bringing the NHS together locally to improve population health and establish shared strategic priorities

MEAM Approach Network: The **‘**Making Every Adult Matter’ Approach Network has supported partnerships across the country to develop coordinated approaches to tackling multiple disadvantage

NDTA: The ‘New Directions Teams Assessment’ is a tool for assessing need and risk across ten areas including engagement with services, self-harm and social effectiveness

ReQoL: Recovering Quality of Life is a patient reported outcome measure assessing the quality of life for those with mental health problems

LGBTQ+: Lesbian, gay, bisexual, transgender and queer

KPIs: Key performance indicators

Executive Summary

About Changing Futures

The Changing Futures programme is a £64 million initiative between the UK Government and The National Lottery Community Fund. It seeks to test innovative approaches to improving outcomes for people experiencing multiple disadvantage. The programme is running in 15 areas across England from 2021 to 2024.

The programme seeks to achieve change at three levels:

- for **individuals** in the local areas, improving health, safety, wellbeing and access to services,
- for **services**, with greater integration and collaboration across local services to provide a person-centred approach and reduce demand on reactive services, and
- for the **wider system of services and support**, resulting in strong multi-agency partnerships, governance and better use of data to inform commissioning.

This report summarises the findings of baseline research and data collection undertaken between November 2021 and October 2022. It describes the profile of people engaged by the programme up to July 2022 and considers the extent to which the programme is reaching its intended target audience. The report sets out people's current experience of disadvantage, levels of wellbeing and access to services. It also describes the wider system of support for people experiencing multiple disadvantage, focusing on current strengths and barriers. Progress in improving individual- and systems-level outcomes will be measured against this baseline position in future reports.

Programme engagement

By end of June 2022, 1,701 people had received direct support from the programme across the 15 local areas.

Changing Futures areas are seeking to engage and work with the most excluded adults – those experiencing three or more of homelessness, substance misuse, mental health, domestic abuse and contact with the criminal justice system. Analysis of questionnaire data from 844 participants up to July 2022 indicates that at least half have experience of four or five forms of disadvantage.

Mental ill health was the most prevalent form of disadvantage experienced by participants, with 83 per cent reporting mental health problems in the past 3 months. It is important to understand the overlapping nature of disadvantage and the impact this can have on access to support. The baseline data shows almost 7 out of 10 participants had experience of both mental ill health and drug and alcohol problems.

Changing Futures participants

Available demographic data showed that whilst the majority of participants were male, there is a larger proportion of women than in other similar multiple disadvantage programmes. There were fewer Asian participants than in the general UK population, although we do not know if this is as a result of lower prevalence of multiple disadvantage in this community or lower levels of engagement in services. A third of participants had some form of neurodiversity, including learning disability, ADHD and acquired brain injury.

As well as high levels of mental ill health, substantial proportions of respondents reported experiencing poor physical health: 29 per cent had experienced severe or very severe physical health problems in the past week. Just under half of the cohort had visited A&E in the last 3 months, with ambulances called out to 36 per cent of participants.

Programme participants are often at greater risk of abuse and exploitation themselves than they are to other people. In the past three months, more than a third had been a victim of a violent crime and just under a third of the cohort had experienced domestic abuse.

Financial and housing needs were also prevalent amongst participants. Just over half of participants reported being homeless, either rough sleeping or in unstable or temporary forms of accommodation. 72 per cent of participants relied on Universal Credit as their main source of income. At this stage in the programme, most participants are some way off being able to engage in the labour market. Only five per cent of those responding to our baseline questionnaire had been involved in any employment, training, or volunteering in the past three months. Over 60 per cent were in debt or behind on their bills.

Social support networks are important when it comes to coping with life challenges. Whilst many indicated that they had someone to talk to apart from a paid worker, a substantial minority – 21 per cent – indicated that they had no one.

Access to services

Most participants responding to the baseline questionnaires had had contact with a support service in the last three months (this could include time prior to joining the programme) – most commonly drug and alcohol and mental health services. Fewer women than men had been in touch with homelessness services despite a similar proportion of each having recent experience of homelessness.

‘Contact’ with services does not necessarily mean ongoing and effective support. Systems mapping workshops identified barriers to people experiencing multiple disadvantage getting support. These included people being deemed ‘too complex’ or high risk for a service to support, or alternately, people not meeting eligibility criteria for services until they reach crisis point. These barriers may be linked to service capacity or expertise/skills. Prejudice and discrimination (stigma) was identified by most systems mapping workshops as an underpinning factor in many of the barriers to people getting effective services.

A survey of partners in funded areas indicated a need for more understanding of and specialist services for people from ethnic minority backgrounds. Furthermore, workshop participants highlighted low representation of people from ethnic minority backgrounds working in support services outside of entry-level and night roles.

The workforce

Whilst respondents to our partners survey working in the voluntary and community sector generally indicated that they feel valued, trusted and have access to the support they need, this was much less the case for respondents from the public sector. The systems mapping exercise also identified overstretched staff and uncompetitive salaries as key barriers to the development of an effective system of support for people experiencing multiple disadvantage.

Frontline staff funded by Changing Futures generally have small caseloads that align with what other evidence suggests is manageable for supporting people experiencing multiple disadvantage.

A high proportion of people experiencing multiple disadvantage are also likely to have experienced trauma. While trauma-informed practice is being rolled out across specific sectors and services in some areas, there appears to be inconsistency in both understanding of what it means to be trauma-informed and levels of willingness and ability to adopt trauma informed ways of working.

Lived experience

Workshop participants agree that there are many benefits of involving people with lived experience of multiple disadvantage in all levels of service design and delivery, and there is wider evidence to support this. In most Changing Futures areas, we found examples of people with lived experience being involved in helping shape local services. However, this tends to involve a relatively small and non-diverse group of people who are easy to engage. Workshop participants felt that different approaches were required to involve a more diverse group.

People with lived experience of multiple disadvantage have much to offer the support service workforce. They can act as role models and have insights into what makes support effective. However, there is often little resource or capacity available to help ensure that there are progression opportunities that support and encourage people with lived experience of multiple disadvantage to volunteer, train and become part of the workforce.

Collaborative approaches

Whilst most partners responding to our survey stated they shared goals and priorities with multiple organisations in their local area, this did not necessarily extend to collaboration in designing and developing services, with only a third of survey respondents doing this regularly. There was substantial variation amongst Changing Futures areas in the extent to which organisations jointly apply for funding or commission services.

Workshop participants identified a number of barriers to aligning priorities and joining up services, including siloed and competitive commissioning of services (locally and nationally) and organisations operating across different geographical boundaries, such as two-tier counties comprising several districts. Short-term funding of services was said to contribute to high staff turnover and a constantly changing landscape of support.

Sharing data and information

People with lived experience who participated in our systems mapping workshops highlighted that repeatedly being asked for lots of information about themselves can create a barrier to accessing support and reduce trust in services. The baseline picture for effective data sharing and usage was mixed, with partners survey results more positive than mapping workshops feedback.

Most partners survey respondents reported sharing client records and using data to better understand multiple disadvantage and improve service design, planning and delivery. But organisations supporting people tend not to have shared case management systems and we found limited evidence of other mechanisms for accessing live information about people’s interactions with services, restricting the extent to which services can share user information and offer joined up support.

1 Introduction

1.1 About this report

This report presents the baseline position at the start of the Changing Futures programme. It describes the profile of people engaged by the programme up to July 2022 and considers the extent to which the programme is reaching its intended target audience. The report sets out people's current experience of disadvantage, levels of well-being and access to services. It also describes the wider system of support for people experiencing multiple disadvantage, focusing on current strengths and barriers. Progress in improving individual- and systems-level outcomes will be measured against this baseline position in future reports.

The report draws on evaluation activities completed up to October 2022. These include:

- analysis of quantitative data on programme delivery and participants (people experiencing multiple disadvantage who are receiving direct support from the programme)
- survey of local stakeholders disseminated by all funded areas ('the partners survey')
- system mapping exercise with all funded areas.

In addition, baseline social network analysis is also being undertaken in four areas. The findings from this activitiy will be reported in spring 2023.

Future evaluation reports will also include findings from:

- qualitative research with funded area staff, volunteers, stakeholders and participants
- an assessment of programme value for money

1.2 Programme aims and progress to date

The Changing Futures programme aims to improve outcomes for adults experiencing multiple disadvantage, developing a more joined-up 'whole person' approach to support. The programme seeks to make an impact at the individual, service and systems level:

- **Individual level**: stabilised and improved outcomes for local cohorts of adults experiencing multiple disadvantage.
- **Service level**: greater integration and collaboration across local services to provide a person-centred approach, and reduced demand on reactive services.
- **System level**: strong multi-agency partnerships, governance and better use of data, leading to lasting system change and informing commissioning. Learning from evaluation and partnerships between government and local areas improves cross-government policy.

By ‘system’ we mean the services and support that might be accessed by a person experiencing multiple disadvantage, including how different organisations and people within the system interact with each other and with people experiencing multiple disadvantage.

The Department for Levelling Up, Housing and Communities (DLUHC) has developed a theory of change, which underpins the programme activity and evaluation. This includes short and longer-term outcomes and is provided in Appendix 1.

There is local flexibility in how the programme is delivered, but funded areas are expected to work within a set of core principles:

- **Work in partnership** across local services and the voluntary and community sector at a strategic and operational level.
- **Coordinate support** and better integrate local services to enable a ‘whole person’ approach.
- **Create flexibility in how local services respond**, taking a system-wide view with shared accountability and ownership and a ‘no wrong door’ approach to support.
- **Involve people with lived experience** of multiple disadvantage in the design, delivery and evaluation of improved services and in governance and decision-making.
- **Take a trauma-informed approach** across the local system, services and in the governance of the programme.
- **Commit to drive lasting system change**, with long-term sustainable changes to benefit people experiencing multiple disadvantage and a commitment to sustaining the benefits of the programme beyond the lifetime of the funding.

The 15 areas to receive funding were announced in July 2021. Appendix 2 provides a full list along with a summary of each area’s approach. The first people to receive direct support from the programme joined in September 2021, and all areas had recruited at least some participants by July 2022. As well as providing direct support to people experiencing multiple disadvantage, activities funded by the programme include:

- **strategic collaboration**, such as investment in partnership infrastructure and joint commissioning
- **lived experience** involvement, such as peer researchers and structures for involving people in governance
- **workforce development** and training in, for example, trauma-informed practice
- case management and **data systems** to improve joint working across local agencies and improve use of data

The Changing Futures programme and evaluation was preceded by Fulfilling Lives – an eight-year programme funded by The National Lottery Community Fund to better support people experiencing multiple disadvantage.[1] The programme ran in 12 areas of England, some of which have gone on to become Changing Futures areas. Since 2013, the Making Every Adult Matter (MEAM) Approach Network[2] has supported partnerships across the country to develop effective, coordinated approaches to tackling multiple disadvantage. Evaluations of both Fulfilling Lives and the MEAM Approach have provided a significant evidence base on multiple disadvantage and we have supplemented findings from the Changing Futures evaluation with insights from these evaluations.

1.3 Evaluation objectives

DLUHC has set three objectives for the evaluation, namely to:

- Provide evidence on whether (and why/how) Changing Futures has made a difference to individuals who experience multiple disadvantage.
- Provide evidence on whether (and why/how) Changing Futures has made a difference to how public service systems operate, including considering how systems-level changes affect the way services operate and are delivered and experienced by people who experience multiple disadvantage.
- Assess the value for money of the programme and make recommendations on the most effective use of any additional resources going into this area in the future.

This report focuses on the baseline position for individual- and systems-level outcomes. Value for money will be covered in future reports.

In order to test, refine and develop the programme theory of change, we have developed an evaluation framework detailing how progress towards the short- and longer-term outcomes will be measured. As well as providing evidence of programme achievements, progress towards these outcomes will be used to learn about and reflect on the implementation of the programme. A summary of the evaluation framework is provided in Table 1. This focuses on the outcomes considered in the current report.

Table 1: Summary evaluation framework

Individual level outcomes

Domain of disadvantage	Outcome	Indicators	Data sources
Experience of services	Individuals have timely access to the services and treatment they need	• Increase in participants who have been able to access a GP/dentist when needed in the last 3 months • Increase in participants who are receiving treatment for drug or alcohol problems • Increase in people who have had contact with key services in the last 3 months • Increase in positive outcomes from referrals, and reduction in waits of more than 3 months for outcome from referral • Participants and support workers report that outcome has been achieved • Systems barriers to access to services reduced or removed	• Outcomes questionnaires • Service-held outcomes data • Interviews with participants and service providers • Systems mapping
Health and well-being	Improved well-being, physical and mental health	• Increase in total Recovering Quality of Life (ReQoL) score by 5 points or more • Reduction in New Directions Team Assessment (NDTA) score • Reduction in reported physical health problems • Reduction in reported feelings of anxiety • Increase in people who say they can effectively manage mental health difficulties • Increase in people who say they can cope with problems without using drugs or alcohol • Participants and support workers report that outcome has been achieved	• Outcomes questionnaires • New Directions Team Assessment (NDTA) • Interviews with participants and service providers

Domain of disadvantage	Outcome	Indicators	Data sources
Health and well-being	Reduction in the use of emergency services	• Reduction in visits to A&E • Reduction in ambulance call outs	• Outcomes questionnaires
Safety and domestic abuse	Individuals feel supported, trusted, valued, safe and in control	• Increase in people who say they feel generally safe/feel safe where they are living • Increase in people with experience of domestic violence who say they have ways to stay safe • Reduction in experience of crime • Participants and support staff report outcome achieved	• Outcomes questionnaires • Interviews with participants and service providers
Housing and homelessness	Reductions in homelessness and rough sleeping	• Reduction in people experiencing homelessness in the last month/3 months • Increase in people in settled accommodation in last month/last 3 months • Reduction in people experiencing rough sleeping in the last month/last 3 months • Reduction in the duration of rough sleeping • Systems barriers to appropriate housing reduced or removed • Participants and support staff report outcome achieved	• Outcomes questionnaires • Systems mapping • Interviews with participants and service providers
Criminal justice system	Reductions in contact with the criminal justice system	• Reduction in offending/contact with the criminal justice system	• Outcomes questionnaires
Financial inclusion	Improved financial security	• Increase in people getting help with benefits • Increase in people receiving benefit entitlements • Increase in people whose main source of income is benefits and/or paid work • Reduction in people receiving income from unsafe sources	• Outcomes questionnaires • Service-held outcomes data

Domain of disadvantage	Outcome	Indicators	Data sources
		• Increase in people with access to their own bank account • Participants and support staff report outcome achieved	• Interviews with participants and service providers
Social inclusion	Improved capacity, opportunities and motivation	• Increase in people actively thinking about/undertaking employment-related opportunities, training, or volunteering • People make progress towards their personal goals	• Service-held outcomes data • Outcomes questionnaire • Interviews with participants and service providers
Social inclusion	Improved connectivity and supportive relationships	• Increase in people who say they have someone (other than support worker) to talk to • Increase in extent to which people are well connected to family • Participants and support staff report outcome achieved	• Outcomes questionnaire • Interviews with participants and service providers

Systems-level outcomes

Aspect of systems change	Outcome	Indicators	Data source
Collaborative approaches	Strategic alignment evidenced across local strategies	• Increase in extent to which organisations work together to assess service demand and share overall goals and priorities • Increase in extent to which organisations jointly design or develop services with others • Funded area staff and stakeholders report outcome achieved • Systems maps show strategic alignment as a strength	• Partners survey • Systems mapping • Social network analysis • Interviews with staff and stakeholders •
Collaborative approaches	Co-commissioning, pooled budgets and KPIs joined across services	• Increase in extent to which organisations make joint applications for funding • Increase in extent to which organisations jointly commission/fund services • Funded area staff and stakeholders report outcome achieved • Systems barriers to joint working/commissioning reduced or removed	• Partners survey • Interviews with staff and stakeholders • Systems mapping
Workforce	Staff (including peer supporters and volunteers) feel valued and trusted across the service and system and have access to the training and support they need	• Increase in number of staff participating in training • Improved perceptions of the extent to which organisations value individual skills and contributions • Increase in extent to which people state they have access to the support, training and resources necessary to perform their role • Funded areas assign adequate resources for staff training, support and resilience (budgets, FTEs per line manager) • Staff and volunteers report outcome achieved	• Partners survey • Interviews with staff and volunteers • Operational data • Systems mapping

Aspect of systems change	Outcome	Indicators	Data source
		• Systems barriers to recruiting and retaining staff reduced or removed	
Workforce	Reduced staff burnout	• Staff have caseload size that is manageable and appropriate to the complexity of cases (expected to be between 6 and 10 cases per staff member) • Reduction in staff leave due to illness or stress • Staff report outcome achieved	• Operational data • Interviews with staff
Workforce	Staff have the appropriate knowledge of, and contacts across, the system	• Increase in extent to which staff/volunteers are aware of services available • Strengthened working at operational level between organisations • Staff and participants report outcome achieved	• Partners survey • Social network analysis • Interviews with staff and participants
Workforce	Staff have flexibility, autonomy and capacity to best meet the needs of people experiencing multiple disadvantage	• Systems barriers of lack of staff capacity and flexibility reduced or removed • Staff report outcome achieved	• Systems mapping • Interviews with staff
Workforce	All staff deliver trauma-informed care and support	• Increase in extent to which staff/volunteers say they have a thorough understanding of, and the resources to engage in, trauma-informed practice • Increase in extent to which staff/volunteers support individual choice, recognise strengths, and have tailored interactions with people • Increase in extent to which organisations consider personal trauma when supporting people • Staff and participants report outcome achieved	• Partners survey • Interviews with staff and participants

Aspect of systems change	Outcome	Indicators	Data source
Lived experience	Lived experience co-design and delivery embedded	• Increase in extent to which organisations have formal processes for involving people with lived experience/provide opportunities for people with lived experience to develop • Increase in extent to which people with lived experience are actively involved in decision-making • Systems barriers of lack of diversity and tokenistic involvement reduced or removed • Staff and participants report outcome achieved	• Partners survey • Systems mapping • Interviews with staff and participants
Lived experience	Lived experience involvement is embedded and guides commissioning	• Increase in extent to which there are formal channels for people with lived experience to contribute to decision-making. • Increase in the extent to which people with lived experience are actively involved in activities and decision-making, and are helping to improve services and systems • Systems strength of lived experience involvement in commissioning evident or increased • Staff and participants report outcome achieved	• Partners survey • Systems mapping • Interviews with staff and participants
Access to services	Clear lines of communication/referral processes to other services	• Strengthened working at operational level between organisations • Systems barriers of poor communication and referral processes reduced or removed • Staff and stakeholders report outcome achieved	• Social network analysis • Systems mapping • Interviews with staff and stakeholders
Access to services	Clear referral pathways	• Increase in extent to which staff/volunteers say it is easy to refer people to services	• Partners survey • Systems mapping

Aspect of systems change	Outcome	Indicators	Data source
		• Systems barrier of referral pathways reduced or removed • Staff, stakeholders and participants report outcome achieved	• Interviews with staff, stakeholders and participants
Access to services	Improved offers for people from ethnic minority backgrounds	• Equality of outcomes for people from ethnic minority backgrounds • Increase in extent to which services have a good understanding of the needs and preferences of people from ethnic minority backgrounds who experience multiple disadvantage/extent to which people from ethnic minority backgrounds have access to the support they need • Increase in perception that there are sufficient services available to effectively meet needs of people from ethnic minority backgrounds • Systems barriers for people from ethnic minority backgrounds reduced or removed • Staff and participants report outcome achieved	• Service-held outcomes data • Outcomes questionnaires • Partners survey • Systems mapping • Interviews with staff and participants
Sharing data and information	Data shared appropriately	• Increase in extent to which staff/volunteers understand when and how to share information and do so to reduce the need for people to share the same information multiple times • Increase in extent to which organisations share client records, data management or information systems with others • Systems barrier of data sharing reduced or removed	• Partners survey • Systems mapping • Interviews with staff, stakeholders and participants

Aspect of systems change	Outcome	Indicators	Data source
		• System strengths of joint data sharing protocols/mechanisms evident or increased • Staff, stakeholders and participants report outcome achieved	
Sharing data and information	Data shared and used effectively to better understand multiple disadvantage and respond appropriately	• Increase in extent to which staff/volunteers use data to better understand people experiencing multiple disadvantage/to improve service design, planning and delivery • Increase in proportion of staff/volunteers who participate in multi-agency meetings to share information about/plan support for people • Staff, stakeholders and participants report outcome achieved	• Partners survey • Interviews with staff, stakeholders and participants
Sharing data and information	Co-ordinated information sharing, e.g. common case management system	• Systems strength of effective case management systems evident or increased • Staff and stakeholders report outcome achieved	• Systems mapping • Interviews with staff and stakeholders

1.4 Methods and data sources

Our evaluation uses a mixed-methods approach, combining qualitative and quantitative data from a wide range of sources. The findings in this report draw on quantitative data on participants (people experiencing multiple disadvantage who are receiving direct support from the programme) and on programme delivery, a survey of local stakeholders and a systems mapping exercise.

Quantitative data

Quantitative data is collected by funded areas and submitted to the evaluation team on a quarterly basis. Table 2 summarises the different quantitative data sources, frequency of collection and who provides the information.

Table 2: Quantitative data sources and frequency of collection

Source	Type of data	First completed	Updated	Completed by
Outcomes questionnaire	Outcomes since joining the programme and experiences in the previous 3 months (could be before joining)	Within 6 weeks of joining the programme	Quarterly	Participant (can be with support from worker)
Historical questionnaire	Participants' characteristics and experience of disadvantage	Within 12 weeks of joining the programme	One-off questionnaire	Participant (can be with support from worker)
New Directions Team Assessment (NDTA)	Assessment of participants' levels of need, risk and engagement with services	Within 6 weeks of joining the programme	Quarterly	Support worker
Service-held outcomes data	Participants' engagement dates, referrals to other services and outcomes of referrals since the start of the programme	Quarter 1 (January to March) 2022	Quarterly	Programme staff
Operational data	Details of delivery of direct support to participants, such as caseload sizes and staff absences	Quarter 1 (January to March) 2022	Quarterly	Programme staff

Outcomes and historical questionnaires were designed to incorporate trauma-informed principles. Questions were tested with people with lived experience of multiple disadvantage and feedback provided by service delivery staff. No questions are mandatory, with the option for beneficiaries to select “Don’t want to say” throughout. Factual questions can be populated using staff knowledge to reduce the need for people to repeat their stories multiple times. To support learning and quality assurance, open text boxes are provided for staff to give further detail about why questionnaires could not be completed with the participant. Training was delivered to staff on conducting trauma informed research.

Partners survey

The partners survey seeks to capture information from stakeholders in Changing Futures areas to understand the extent to which local service- and systems-level outcomes are achieved over the programme’s lifetime. The survey includes questions relating to understanding, attitudes, culture and practice relevant to the programme’s outcomes.

The baseline survey was carried out between August and September 2022. We adopted a snowball approach to sampling. Changing Futures area leads were encouraged to circulate a link to the 10-minute online survey as widely as possible amongst staff and volunteers working in the local system supporting people experiencing multiple disadvantage.

In total, 480 survey responses were received. Response levels ranged substantially across areas, from one response to 99 responses. See Table 76, Table 77 and Table 78 in Appendix 4 for a full breakdown of responses by area, sector and respondent role.

Towards the end of the programme, we will repeat the partners survey in order to compare the results and assess change over time.

Systems mapping

The evaluation team ran a systems mapping exercise with each Changing Futures area between late March and early July 2022. Our aim was to identify the elements of the local system that help people experiencing multiple disadvantage get the help they need and to make improvements in their lives (strengths); we also sought to identify the elements that hinder this (barriers). Systems maps will be revisited towards the end of the programme to assess change.

The output of the exercise was a “system map” for each funded area, that is, a visual representation of the system’s strengths and barriers and the relationship between them, as well as an accompanying narrative document. We then reviewed the maps as a whole and identified the most important barriers and strengths based on the frequency of their occurrence across the 15 areas and the significance of their impact on the system supporting people experiencing multiple disadvantage.

As it would not have been feasible, or proportionate, to try to map the entirety of each funded area’s system, the evaluation team worked with key Changing Futures contacts in each of the funded areas to agree up to four systems change themes that would form the focus for their local map. These were based on local priorities and interests.

We held systems mapping workshops with each area. A first workshop (or two workshops for areas opting for online sessions) focused on identifying strengths and barriers, after which the evaluation team produced a first draft of the system map. A follow-up workshop focused on reviewing the draft map and suggesting improvements, after which the evaluation team revised the map and drafted an accompanying narrative. Maps and narrative were finalised through one more round of feedback with local partners in each area.

In total, over 420 people across all areas took part in the baseline systems mapping exercise. The participants in the workshops represented a wide range of organisations, sectors, roles and levels of seniority, including people with lived experience of multiple disadvantage.

Limitations

The following caveats on the data and limitations of the methods should be taken into consideration when reading this and related evaluation reports.

Limitations of interim report
This is an early interim report setting out the baseline position based on data collected to date. Data collection and other evaluation activities are ongoing. Although the report presents our best understanding of the current position, it is a partial picture and does not yet include key sources of evidence, such as qualitative research.

Evaluation in a complex system
The programme aims to make an impact at the individual, service and systems levels. All of these levels are also interrelated systems in themselves. As set out in HMT's supplementary guidance on the topic, complex systems can be challenging to evaluate. Not only is proving causality difficult, but complex systems can also be particularly sensitive to context and vulnerable to disruption.[3] However, the guidance also highlights the importance of an appropriate evaluation strategy to aid understanding and increase the effectiveness and impact of a policy.

Qualitative methods, including systems mapping, will be used to help understand how the different elements of the systems interact and to identify key mechanisms of change. This is in line with HMT's Magenta Book, which states that theory-based evaluations are suited to situations where there is a complex policy landscape or system. Regular reporting will ensure that emerging process findings can feed into the ongoing development of the programme.

Challenges of conducting an impact evaluation
The evaluation adopts a theory-based and largely qualitative approach to explaining outcomes observed during the programme. As part of DLUHC's aim to provide evidence of the impact of the programme on individuals experiencing multiple disadvantage, we have been asked to assess the feasibility of conducting a robust impact evaluation using a suitable comparison group. Work to establish whether this is feasible is ongoing. In the meantime, we do not currently have a comparison group, which limits our ability to robustly attribute any changes observed to the Changing Futures programme. Work is also underway within DLUHC to explore options for administrative data linking to understand trends in experience of service use and multiple disadvantage both prior to, and after engaging with the Changing Futures programme.

Quantitative data
Gathering data from people experiencing multiple disadvantage can be challenging. Previous evaluations in this field[4] highlight the importance of trusting relationship for both providing support and collecting data. We want people to feel comfortable telling us about themselves and their experiences. Therefore, it was decided that quantitative data would be collected from participants by support staff who have a relationship with them rather than by professional research staff.

Funded areas are encouraged to adopt a trauma-informed approach to completing questionnaires with people and so not all have been undertaken within the desired timeframes. As highlighted above, factual questions in the outcomes questionnaire and the historical questionnaire can be populated using staff knowledge to reduce the need for people to repeat their stories multiple times. We have excluded from our analysis questions that ask for value judgements or assessments of emotion that have been completed without input from the participant. Not all participants have data for all four of the sources, and so base sizes vary throughout this report, depending on the indicator.

At the end of July, 613 participants had completed the outcomes questionnaire compared to 325 for the historical questionnaire. Service-level data is available for 851 participants and NDTAs are available for 605. Both percentages and the base count for each question are reported. As Table 3 shows, not all of the 15 funded areas had submitted data in time for it to be included in this report. As a result, the general profile of participants may change as additional data is submitted. This is partly a result of staggered programme mobilisation, meaning data has naturally become available at different points for each area. Challenges with staff recruitment and turnover have also played a role. The evaluation team are working closely with DLUHC to improve the quality and coverage of the data available. Quantitative data will continue to be collected as more participants join the programme and the baseline position will be updated in future reports.

As participants complete baseline outcomes questionnaires up to six weeks after joining the programme, their circumstances could change in the interim period between signing up and providing baseline data. For example, participants may receive help to access benefits or secure temporary accommodation very soon after starting on the programme. Such early changes are anticipated to be relatively limited, but they could affect the accuracy of the baseline picture and thus the extent to which change on some measures is captured.

Partners survey
The partners survey sample is potentially skewed due to the wide range of response rates received from the different Changing Futures areas. To some extent, variation in responses reflects the differing sizes of the funded areas. We considered weighting the data to reflect the number of partners per area but discounted such an approach as this population is unknown. Instead, we identify in the findings where results for individual areas differ from the overall results.

Systems mapping
Representation from people with lived experience of multiple disadvantage was strongly encouraged, but not evident in all systems mapping workshops. Three areas did not have any lived experience representation at the workshops, although in two of these the local themes and maps were separately discussed with people with lived experience. We anticipate that there will be better representation of people with lived experience when we revisit the maps towards the end of the programme, once networks and relationships with

people with lived experience are better developed in the areas where they are currently more limited.

Most areas also had some roles or sectors that were under-represented in the mapping exercise, often where an organisation or sector has so far been less involved in partnership work related to multiple disadvantage. Funded areas will work on developing these relationships over the course of the programme. Overall, we have attempted to ensure that a good range of views are reflected, although, as with all qualitative research, the views of those engaged may not necessarily be representative or generalisable more widely. Repeating the exercise with different participants may surface different perspectives.

2 Individuals experiencing multiple disadvantage

This Chapter provides a descriptive overview of the characteristics and experiences of Changing Futures participants when they first join the programme. The first section describes participant characteristics and explores the extent to which the programme is reaching its intended participants. The following sections set out baseline measures organised by key individual-level outcomes – these will be used to examine the extent of changes over time in future reports.

2.1 Characteristics of Changing Futures participants and programme reach

Key findings

- By June 2022, 1,071 people had received direct support from the Changing Futures programme across the 15 areas.
- At least half of participants have experienced four or five of the types of disadvantage targeted by the programme.
- Mental ill health is the most prevalent form of disadvantage experienced by programme participants – 83 per cent reported mental health problems in the past 3 months. There is a high degree of overlap between mental ill health and drug and alcohol problems – almost 7 out of 10 participants have experience of both.
- Asian participants are under-represented in the data compared to the wider population. This may be due to lower prevalence of multiple disadvantage among this community or lower levels of engagement with services.
- Women were far more likely to have experienced domestic abuse than men (79 per cent compared to 19 per cent).
- A third of participants are neurodivergent, including having learning disabilities, ADHD and acquired brain injury.

By June 2022, Changing Futures areas had reported to DLUHC 1,071 people as having received direct support from the programme. As of the end of July 2022, the evaluation team had received data on 844 participants. Table 3 shows how these are spread across funded areas. A high level of variation in numbers of participants is expected across funded areas as they have differing scales of funding and delivery plans. For example, some areas are directly funding substantial frontline services, whilst others are using a small-scale test and learn approach or investing more heavily in strategic and operational improvements to services in order to improve services for a wider group of indirect beneficiaries. Further, a few areas have experienced difficulties in recruiting staff and mobilising their programmes across large and complex geographies, which has resulted in delays in the recruitment of participants.

Table 3: Total programme participants by Changing Futures area – 'total participants' refers to all those who have received direct support from the programme to date, including both current active participants and those who have left

Area	Total participants reported to DLUHC June 2022	Total participants recorded in service data return July 2022
Bristol	11	40
Essex	50	65
Greater Manchester	235	104
Hull	56	20
Lancashire	265	313
Leicester	19	0
Northumbria	8	8
Nottingham	52	53
Plymouth	116	0
Sheffield	70	69
South Tees	81	111
Stoke-on-Trent	26	13
Surrey	21	0
Sussex	25	0
Westminster	40	48
Total	**1,071**	**844**

Of the participants included in the data provided to the evaluation team, 80 per cent, or 677, were actively engaged with the programme in July 2022. Already we see that some people have disengaged from the programme (11 per cent, 97 people) or moved on (5 per cent, 46 people). The rest have an unknown status (see Table 17 in Appendix 4).

Of those who are said to have disengaged, most (77 per cent, 75 people) simply could not be reached, in some cases due to being in prison or hospital, and 3 people (3 per cent) had sadly died. These figures emphasise the challenge of engaging, and building trust with, people experiencing multiple disadvantage. Of those who had moved on, 13 people (28 per cent) no longer required support, 17 (37 per cent) were getting appropriate support elsewhere and have 9 (20 per cent) had left the area (see Table 18).

Just over two-fifths of participants (44 per cent; base=325) indicated that they had a service working to support them across all the different parts of their life in the 12 months before joining the Changing Futures programme (see Table 19). This reflects the significant number of people being transferred to Changing Futures funded services at the beginning of the programme from legacy or other similar intensive support programmes (such as Fulfilling Lives and the MEAM Approach Network). We will take this into consideration when assessing the baseline position and change over time; people who have received holistic support recently may be at a different stage in their recovery journey and making progress in different areas of their lives compared to those who have not received similar support recently.

Experience of disadvantage

Lifetime and recent experience of all forms of disadvantage are shown in Table 4. Of the five types of disadvantage targeted by the programme, experience of mental ill health was the most prevalent, with over 80 per cent of participants confirming they had experienced this at some point in their lives. The same proportion had experienced mental health problems in the past 3 months. Nearly 80 per cent had experienced drug and alcohol problems at some time, with 75 per cent reporting problems in the last 3 months. There is a substantial amount of missing data on participants’ experiences, which results, at least in part, from survey respondents declining to answer a question, rather than confirming they had not experienced a particular issue. As such, the figures likely under-report experiences (see Table 20 through to Table 24 in Appendix 4).

Reasons for referral to the Changing Futures programme (as reported by staff) perhaps gives a better indicator of current needs than self-reported lifetime experiences (also in Table 4). By this measure, prevalence of the different forms of disadvantage were generally higher but follow the same pattern.

Table 4: Self-reported experience of different forms of disadvantage ever (base=613), in the last 3 months (base=613) and the reason for referral to the Changing Futures programme (base=843)

Type of disadvantage	Ever experienced – per cent	Experienced in last 3 months – per cent	Reason for referral to Changing Futures – per cent
Mental ill health	83	83	89
Drug or alcohol problems	79	75	84
Contact with the criminal justice system (as offender or victim)	66	59	61[*]
Victim of violent crime	-	35	-
Victim of other crime	-	30	-
Homelessness (all forms)	60	56	69
Rough sleeping	53	35	N/A
Domestic abuse	32	21	35

Experience of the different forms of disadvantage were broadly similar to that of beneficiaries of the Fulfilling Lives programme, although experience of offending at Fulfilling Lives was higher (77 per cent),[5] and Fulfilling Lives did not collect data on experience of domestic abuse.

Our definition of homelessness encompasses staying in emergency accommodation (such as a night shelter), short term hostels, temporarily with friends or family (sofa surfing), in a refuge, or rough sleeping. Over half of participants (53 per cent, base=613) had experienced rough sleeping, the most extreme and visible form of homelessness, at some time, and 35 per cent had experienced rough sleeping in the last 3 months.

Experience of domestic abuse was much lower than the other types of disadvantage. This is perhaps unsurprising as women are generally more likely than men to experience domestic abuse.[6] Of the women who provided information, 76 per cent (base=123) said they had experienced domestic abuse (including coercive control) at some point since the age of 16. In comparison, 19 per cent of men (base=183) providing data reported the same experience – a much lower percentage than women but still a substantial proportion (see Table 5).

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[*] The referral reason reported by areas is 'offending' rather than 'experience of the criminal justice system'. The latter is a broader category than offending and encompasses experience as a victim of crime as well as being an offender.

Table 5: Self-reported experience of main forms of disadvantage ever by gender (base males=183, females=123) * indicates a statistically significant difference between males and females

Ever experienced	Males (per cent)	Females (per cent)
Mental ill health	79	88
Drug or alcohol problems	85	83
Contact with the criminal justice system	78	72
Homelessness (all forms)	85	76
Rough sleeping*	77	60
Domestic abuse*	19	76

Levels of experience of other forms of disadvantage were similar amongst those with and without experience of domestic abuse – 92 per cent of those experiencing domestic abuse also reported mental health problems and 86 per cent drug or alcohol problems (base=195, see Table 26). Just over half (51 per cent) reported experiencing, at some time, all five forms of disadvantage targeted by Changing Futures (see Table 27).

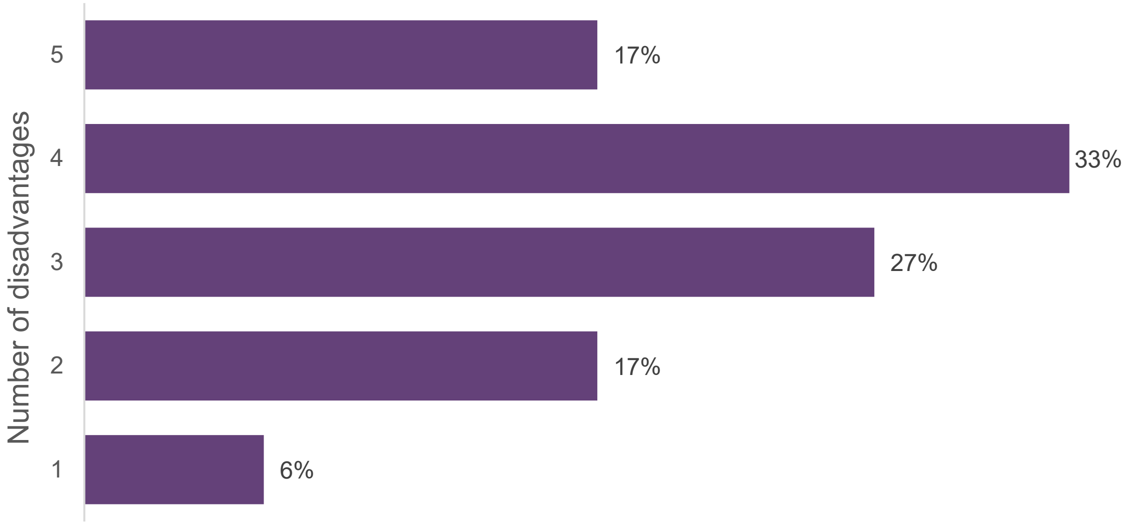
There were gender differences for other forms of disadvantage. Women were more likely to be victims of non-violent crime than men – 41 per cent of women (base=123) compared to 26 per cent of men (base=183) had been victims of non-violent crime in the last 3 months (see Table 28).[†] Men were significantly more likely to be arrested and convicted of a crime than women (21 per cent of men had been arrested and 11 per cent convicted in the last 3 months (base=183) compared to 12 per cent and 3 per cent of women (base=123), respectively – see Table 29).

Reaching the target cohort

Figure 1 illustrates the proportion of participants reporting multiple forms of disadvantage. At least half of participants have experienced four or five forms of disadvantage. The programme aims to work with those experiencing three or more of the five types of disadvantage, yet currently just under a quarter (23 per cent) of people on the programme report experiencing two or fewer forms. Some of this is due to participants responding 'don't know' or 'don't want to say' to questions. For example, we are currently missing data on experience of domestic violence for 66 per cent of participants, and for all 17 per cent of those who have not explicitly confirmed they have experience of mental ill health this is due to missing data (see Table 20 through to Table 24 in Appendix 4 for further information). We have complete data on experience of all forms of disadvantages for only 135 participants; this data indicates that only 4 per cent experienced 2 or fewer forms of disadvantage (Table 25).

[†] A greater proportion of women (46 per cent, n=123) than men (33 per cent, n=183) had also been victims of violent crime in the last three months, though this difference was not statistically significant.

Figure 1: Experience ever of multiple forms of disadvantage (base=581)



It may also be that there were some early inappropriate referrals to the programme. Using reason for referral to the programme as the basis for determining experience of disadvantage, we find similar results as in Figure 1; 53 per cent were referred in relation to 4 or 5 of the core forms of disadvantage, and 21 per cent were referred in relation to 2 or fewer (see Table 30). The Fulfilling Lives programme also received a high volume of inappropriate referrals to some projects in the early stages.[7] Things improved as programme criteria became better known and partnerships honed their communications. Furthermore, some Changing Futures areas indicated to us informally that it is likely to take longer to build relationships with and engage those experiencing the most severe forms of disadvantage. Although 11 out of 15 areas have at least some people with experience of 2 or fewer forms of disadvantage, 4 areas appear to have more than 30 per cent of their beneficiaries with experience of 1 or 2 forms of disadvantage only (see Table 31). DLUHC and the evaluation team will explore reasons for apparent lower levels of experience of disadvantage than anticipated. We will continue to monitor this to ensure that the programme successfully reaches those experiencing the most severe forms of disadvantage.

It is important to understand the overlapping nature of disadvantage and the impact this can have on access to support. Systems mapping workshop participants highlighted some of the challenges faced by those experiencing multiple forms of disadvantage. For example, services tend to assess need in relation to a single issue (see also the impact of siloed commissioning described in Section 3.1). This means that the compounding effects of multiple disadvantage are often overlooked, and people experiencing multiple disadvantage can be excluded from the support on the grounds of not meeting eligibility thresholds related to a specific area of need, despite having high levels of need overall.

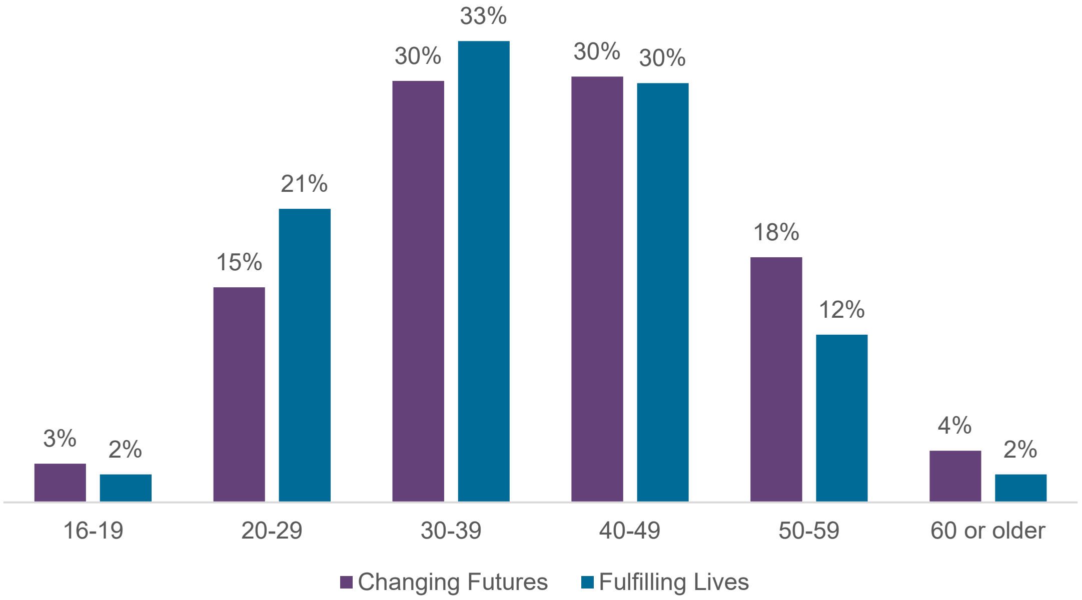
Of particular interest is the overlap between mental health problems and problems with drugs and alcohol. Almost 7 out of 10 participants had experience of both forms of disadvantage (69 per cent, base=613, Table 32), or, looking at it another way, 89 per of those with experience of drug or alcohol problems had also experienced recent mental health problems (base=457, Table 33). This is in line with wider evidence: most users of drug and alcohol services also experience mental health problems.[8] See Section 2.2 for further information on how this 'dual diagnosis' affects access to services.

Demographic profile of participants

The majority of programme participants identified as male (59 per cent) and 40 per cent as female (base=324, Table 34). This is a larger proportion of women than for both the Fulfilling Lives programme and the MEAM Approach Network, where only 35 per cent and 36 per cent of participants respectively were female.[9] This may be down to the decision to include domestic abuse in the definition of multiple disadvantage for the Changing Futures programme. As the 2020 Gender Matters report[10] demonstrated, changing the way multiple disadvantage is conceptualised reveals a substantial proportion of women who face combinations of disadvantage that are at least as serious as those faced by men.

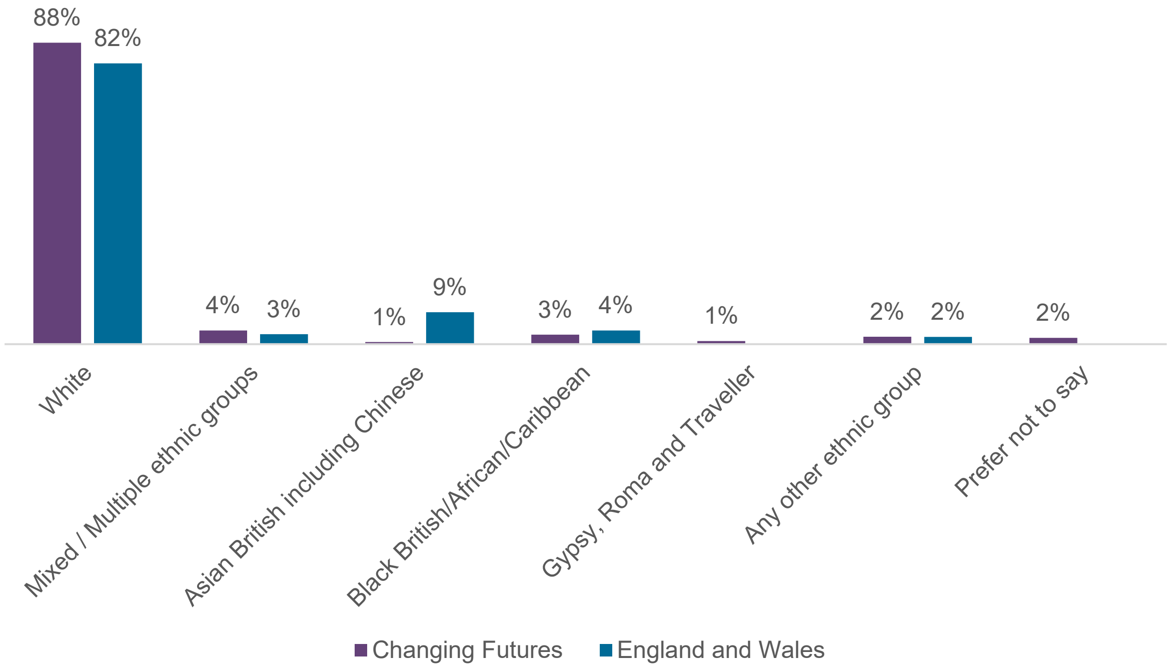
The majority of the participants are aged between 30 and 49 – this is in line with wider research on multiple disadvantage[11] and the Fulfilling Lives programme and MEAM Approach Network demographics, although Changing Futures has a larger proportion of participants aged 50 and over and fewer people under 30 (Figure 2).

Figure 2: Age profile of Changing Futures (base=325) and Fulfilling Lives (base=2,645)



The ethnic profile of Changing Futures participants is also comparable to that of beneficiaries of the Fulfilling Lives programme and the MEAM Approach Network, as well as the latest population estimates for England and Wales (see Figure 3). However, the very low proportion of Asian or Asian British participants compared to the wider population is notable. Asians are under-represented in other measures of multiple disadvantage based on use of services.[12] It is not possible to say whether this is due to lower levels of prevalence of multiple disadvantage amongst this community, or lower levels of engagement with services.

Figure 3: Ethnic profile of Changing Futures participants (base=325) and 2021 census of the population of England and Wales[13]



Of those willing to provide this information, 92 per cent (base=302, Table 35) identified as heterosexual or straight. This is roughly in line with the wider population.[14] It is important to monitor sexual orientation, as LGBTQ+[‡] people are disproportionately affected by social inequalities and experiences of stigma and discrimination, which can further harm relationships with services.[15] A recent report from the Centre for Homelessness Impact highlighted how sexual orientation and gender identity can be a contributory factor in homelessness and how LGBTQ+ people are likely to experience homelessness differently to others.

Approximately half of participants (51 per cent, base=324, Table 36) declared that they have children. This could include children not currently in their care and adult children – given the programme is designed to support individuals rather than families, we expect this would generally be the case. Women were more likely to have children than men (65 per cent compared to 41 per cent, Table 37). Families, and in particular children, can act as a catalyst for change, motivating parents through a sense of duty and guilt.[16] However, there is also an increased risk that children of people experiencing multiple disadvantage will also develop complex problems.[17]

The proportion of participants with a long-term physical or mental health condition or illness was very high at 85 per cent (base=325, Table 38), although this does include mental health conditions, which most participants said they were affected by. Approximately two-fifths of Fulfilling Lives participants (41 per cent, base=2,303) were disabled or had long-term health conditions in addition to, or other than, mental health

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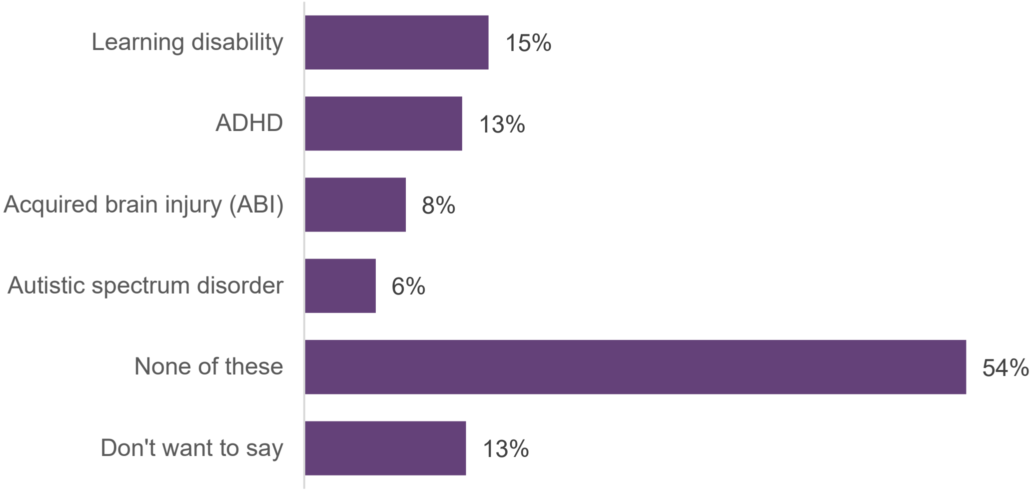
[‡] Lesbian, Gay, Bisexual, Transgender, and Queer

conditions.[18] Almost a fifth of the wider population of England and Wales (18 per cent) reported that they were limited in their daily activities as a result of health problems or disability.[19] The Changing Futures questionnaire only asks about experience of long-term conditions and not the degree to which these affect respondents' daily lives.

A third of participants (33 per cent, base=325, Table 39) declared some form of neurodivergence (acquired brain injury, ADHD, Autistic Spectrum Disorder or learning disability) – see Figure 4 for full breakdown. Revolving Door's recent policy briefing on neurodiversity[20] illustrates links between neurodiversity and problems with drugs and alcohol and the challenges faced by neurodivergent people navigating the criminal justice system. A review of neurodiversity in the criminal justice system undertaken by HM Inspectorate of Prisons and HM Inspectorate of Probation[21] conservatively estimated that 50 per cent of people entering prison may have a neurodivergent condition. The report also highlighted inconsistent screening and consistently low levels of awareness and understanding across police, prison and probation staff.

Figure 4: Do you consider yourself to have any of the following conditions? Please select all that apply (base=325)



2.2 Experience of services and support

Key findings

- According to baseline questionnaires, most participants had contact with a support service in the last 3 months, most commonly drug and alcohol and mental health services. This could include contact prior to joining the programme.
- Reporting by Changing Futures teams in August 2022 showed that the majority of people referred to drug and alcohol services in the previous three months were in treatment. Similarly, most of those referred to homelessness services had been placed in temporary accommodation.
- With regard to recent mental health referrals, 27 were actively engaged in treatment and 14 per cent had been placed on a waiting list. Over a third were still awaiting an outcome.
- Fewer women than men had been in touch with homelessness services despite a similar proportion of each having recent experience of homelessness.
- Almost two-fifths of participants said they had not been able to access a dentist when they needed to in the past 3 months.
- Systems mapping workshops highlighted barriers to accessing services include people being deemed ‘too complex’ or high risk to support. Workshops pointed out some people may not meet eligibility criteria for services until they reach crisis point.

Intended outcome: Individuals have timely access to the services and treatment they need
Intended outcome: Reduced service drop-out/missed appointments/re-referrals for people experiencing multiple disadvantage
While questionnaire data indicates that most people had been in contact with some kind of support services around the time they joined the programme, the systems mapping workshops highlighted barriers for people experiencing multiple disadvantage when it comes to getting support. The questionnaire data provides only a snapshot and ‘contact’ does not necessarily indicate effective and ongoing support.

Barriers revealed by the systems mapping include:

- Some services perceive people experiencing multiple disadvantage as ‘too complex’.
- Staff and services may lack the capacity, skills, knowledge and/or evidence base to effectively support people. They might fear placing someone they understand to be high risk on their caseload or believe that the person is better supported by other services for which they meet the needs threshold and eligibility criteria.

- Services may reject a referral or ‘pass the client along’ to other services, rather than accepting them onto their caseload or working collaboratively with other services to best support the person.

The range of services and pathways accessible for people experiencing multiple disadvantage is therefore limited, particularly for people with co-occurring problematic substance use and mental ill health, people with brain injuries, and people with a history of violence or arson.

Health services

Access to a GP is important not only for primary health care, but also as a key referral route to secondary care, including help with mental health. Most people (64 per cent, base=613, Figure 5) were able to access a GP when they needed to in the previous 3 months, although 16 per cent were not able to. We have little further detail as to why, but four questionnaire respondents offered additional comments suggesting lack of flexibility and stigma as reasons for not accessing a GP. One person highlighted how their support worker enables access.

> Can only speak to GP during particular times.
>
> I can’t receive help as GP refuses to see me.
>
> Can access GP when needed as support worker arranges telephone appointments and collects medication

Quotes from beneficiary questionnaires

Figure 5: In the past 3 months, have you been able to access a GP when you need to? (base=613)

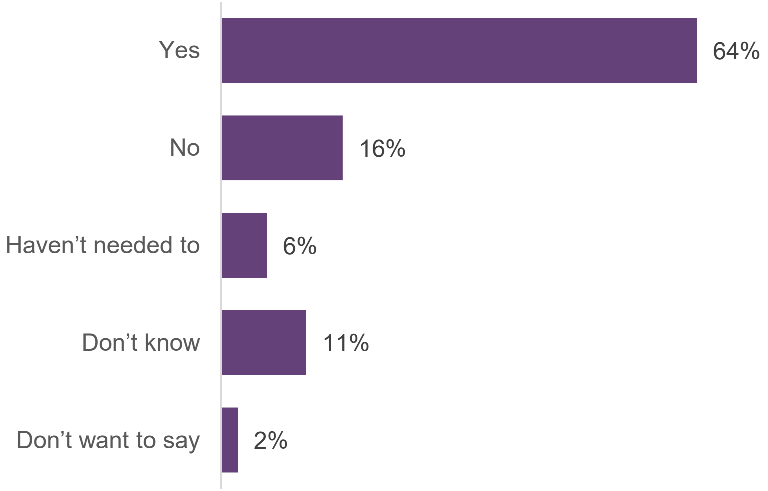
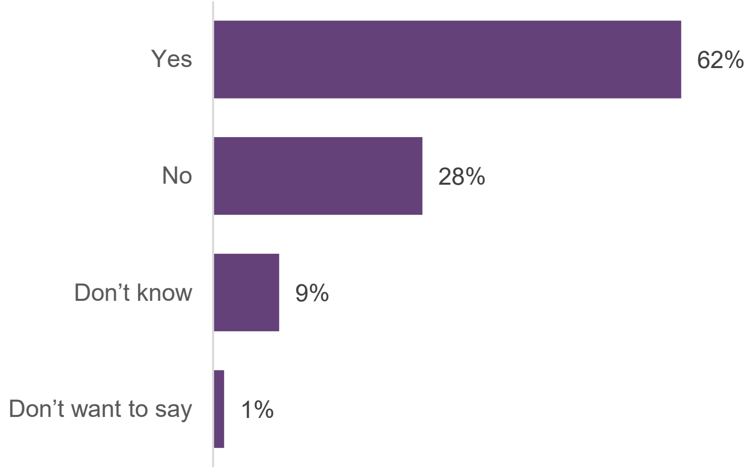


Figure 6: Are you registered with a GP? (base=137)



Of those who were unable to access a GP or had not needed to in the past 3 months, 62 per cent were registered with a GP (base=137, Figure 6). Peer research with homeless people in different parts of the country has found that registration with a GP can be difficult for those with no fixed abode and a lack of understanding about the rights of homeless people[22] (NHS guidance indicates that proof of a fixed address is not required for GP registration[23]).

Almost two-fifths of participants (37 per cent, base=613, Figure 7) said they had not been able to access a dentist when they needed to in the past 3 months. Only 17 per cent said they had been able to. Of those who had not been able to access a dentist, or did not need to, only 9 per cent (base=362, Figure 8) were registered with a dentist. Almost a quarter of participants said they had dental/teeth problems (24 per cent, base=444, Table 10).

Figure 7: In the past 3 months, have you been able to access a dentist when you need to? (base=613)

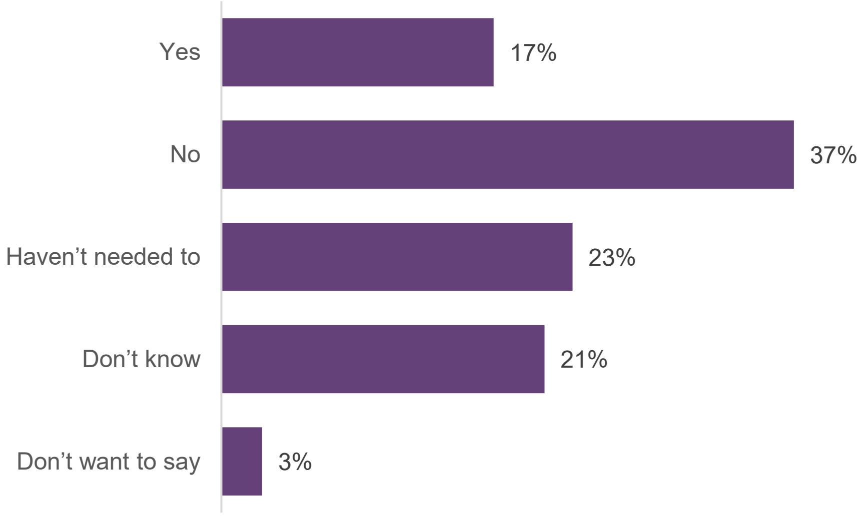
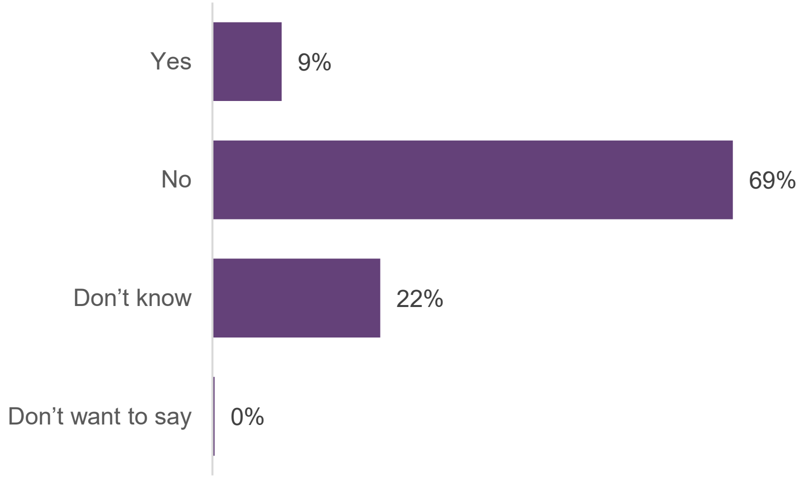


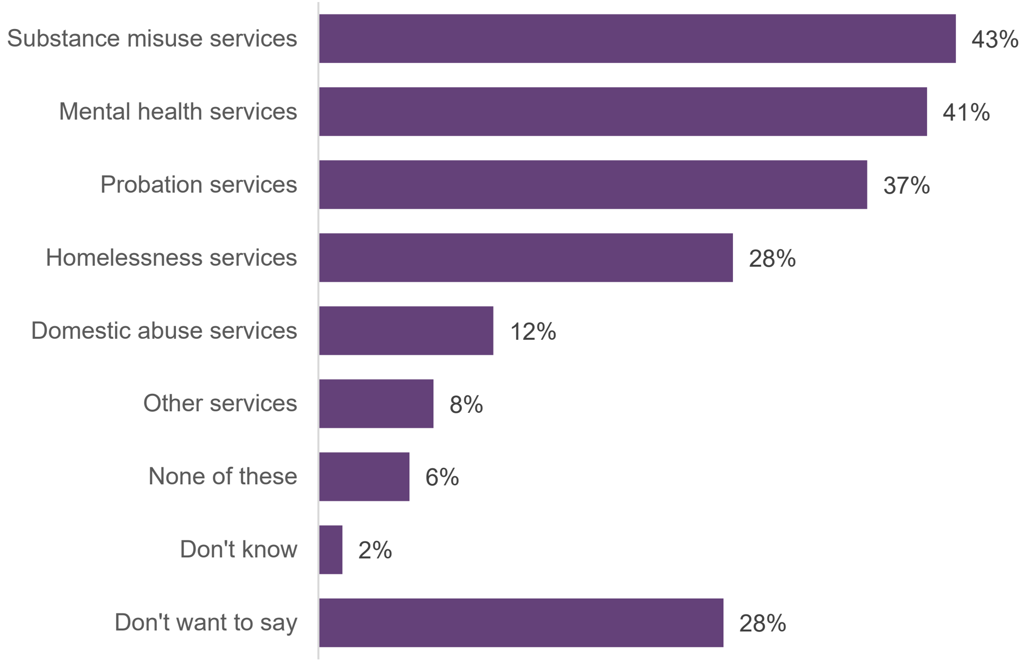
Figure 8: Are you registered with a dentist? (base=362)



Support services

Most participants stated that they had been in contact with some kind of support services in the past 3 months (this could include Changing Futures and/or services they accessed prior to joining the programme) – just 6 per cent said they had no contact (base=613, see Figure 9). The most common services that people were in contact with were drug and alcohol services and mental health services.

Figure 9: In the last 3 months, have you been in contact with any of the following services? Please select all that apply



Unsurprisingly, most of those in contact with domestic abuse services were women. There is also a statistically significant difference between the proportion of men and women who had been in touch with homelessness services recently – only 16 per cent of women (base=123) compared to 36 per cent of men (base=183, see Table 40). This is despite the fact that there were no significant differences between men and women in terms of the proportion who had experienced homelessness recently (see Table 41). The Fulfilling Lives evaluation found that women may be particularly fearful of disclosing homelessness (and rough sleeping in particular) to statutory services, particularly if they also have children.[24] Women with experience of abuse can feel unsafe in mixed-sex accommodation, but there is a lack of women-only temporary housing.[25]

Of those who reported current drug or alcohol problems, just over half (53 per cent, base=458, Table 42) were receiving treatment. And just under half of those reporting recent mental health problems (48 per cent, base=510) had been in contact with mental health services in the past three months (Table 43). Early work by the Changing Futures evaluation team mapping systems in funded areas, as well as the Fulfilling Lives and MEAM Approach programmes, shows that there are significant barriers to accessing statutory mental health and drug and alcohol services for those people with co-occurring mental ill health and problematic substance use.[26] Addressing this issue was a priority for the Fulfilling Lives lived experience representative group.[27]

Referral outcomes

In addition to self-reported use of services described above, funded areas provide data on participant referrals to services and the outcomes of those referrals. This provides a snapshot in time of how services are responding to referrals, rather than a baseline position at the start of people's engagement with Changing Futures. Tracking the outcomes of referrals is another way to assess the accessibility of services. We will continue to update these measures as the programme progresses to help understand who is being referred, how long they have to wait for an outcome, and the extent to which services are both offered and taken up. Swift access to services is particularly important for people experiencing multiple disadvantage. There is often a short 'window of opportunity' to capitalise on when people ask for support.[28] Long waits are likely to result in disengagement and mistrust.[29]

In the three months to August 2022, slightly over a quarter of participants had been referred by programme staff to homelessness, mental health and drug and alcohol services (Table 44 through to Table 46). A smaller proportion (7 per cent, base=740) had been referred to domestic abuse services (Table 47). Reasons for not referring people to services included people already being in contact with services, getting adequate support from Changing Futures, or not having a need for a particular service. However, a substantial amount of data on referrals to drug and alcohol services and mental health services is missing or recorded as 'not known'.

Table 6 to Table 8 below show the reported outcomes of referrals to homelessness, drug and alcohol and mental health services. Positively, the majority of people referred to homelessness services had been provided with accommodation (albeit temporary). Similarly, the majority of people referred to alcohol and drug services were actively engaged in treatment. Getting help with housing problems or being supported to find accommodation are the two most important types of help that people said they had accessed in the past 3 months (see Table 48). Low levels of rejections of referrals suggests that staff are making appropriate referrals.

Outcomes from referrals to mental health services were less clearly positive. Although 27 per cent resulted in active engagement with treatment, 14 per cent had been placed on a waiting list. 36 per cent were awaiting an outcome from the referral. We will track how long people are waiting for outcomes as the programme progresses.

Table 6: Outcome of homelessness referrals (base=236)

Outcome of referral	Per cent
Provided temporary accommodation	61
Receiving support/providing further information	10
Found accommodation in hostel/short-term accommodation	9
Outcome pending	7
Rejection of referral/no duty owed	6
Found accommodation in private rented sector	5
Don’t know	3

Table 7: Outcome of drug/alcohol referrals or existing treatment (base=91)

Outcome of referral	Per cent
Active engagement in treatment	64
Service offer made, no active engagement yet	13
Outcome pending	12
Rejection of service offer or treatment not sustained	7
Rejection of referral	2
Placed on a waiting list	1
Don’t know	1

Table 8:Outcome of mental health referral or existing treatment (base=108)

Outcome of referral	Per cent
Outcome pending	36
Active engagement in treatment	27
Placed on a waiting list	14
Service offer made, no active engagement yet	9
Rejection of service offer or treatment not sustained	6
Rejection of referral	3
Don’t know	3
Treatment completed	1
Not applicable	1

Systems mapping workshops identified that many services have high thresholds for access to services with restrictive eligibility criteria. In a context of high demand on services and limited capacity, these eligibility thresholds are designed to enable services to prioritise their limited resources towards those in greatest need. However, this means that many people are either unable to access support at all or are only able to access support once they reach crisis point. This is a particularly frequent and significant issue in relation to mental health services, as reported by systems mapping workshop participants. Such a situation creates a sense of a ‘crisis bias’ in the system, where it is felt that resourcing is focused on the provision of crisis support rather than early or preventative interventions.

Just over 1 in 10 (13 per cent) of referrals to drug and alcohol services and 9 per cent of referrals to mental health services resulted in a service offer but no active engagement as yet. Engagement may take time to establish, and it is imperative that services are suitably flexible and tailored to meet the needs of people experiencing multiple disadvantage in order to secure their engagement. Similarly, the extent to which people experience accommodation as safe and suitable for their needs has a substantial impact on whether they will continue their living there and the risk of repeat homelessness.

2.3 Health, safety and well-being

Key findings

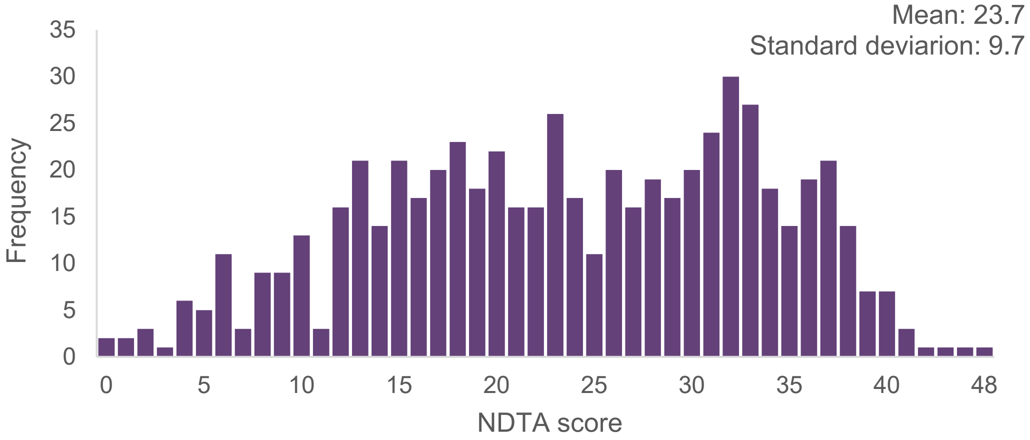
- Baseline levels of need and risk, as measured by the New Directions Team Assessment (NDTA), appear low for the target cohort when compared to people who received support from similar programmes (Fulfilling Lives and MEAM Approach areas).
- The average Recovering Quality of Life (ReQoL) score – a measure of quality of life – indicates a high prevalence of mental ill health.
- Participants completing the outcomes questionnaire at baseline reported high levels of anxiety and 72 per cent said they had not been able to cope with problems without misusing drugs or alcohol.
- Just under half of the cohort had visited A&E in the last 3 months, with ambulances called out to 36 per cent.
- In total, 32 per cent experienced domestic abuse in the last 3 months. Of these participants, 72 per cent said there was at least some risk of it happening again.

  Moreover, 35 per cent had been the victim of a violent crime in the last 3 months.

Intended outcome: Improved well-being, physical and mental health
The New Direction Team Assessment[30] (or NDTA) assesses need and risk across 10 items. Each item is rated on a 5-point scale with 0 being a low score and 4 being the highest score. Each score has a description of behaviour to anchor assessments. There are two items (risk to others and risk from others) that are double weighted – 0 is the lowest score and 8 is the highest. Average scores for each of the 10 items are provided in Table 9 below, along with the descriptive statement for the score.

The mean average total NDTA score at baseline was 23.7 (out of a total of 48). This is a surprisingly low baseline score (lower scores indicating less need and risk) in comparison to the mean baseline score for Fulfilling Lives beneficiaries[31] (31) and MEAM Approach area clients[32] (30). The mean score for Changing Futures participants is skewed by a substantial proportion of very low scores, indicating no or only minor concerns on most issues – over 10 per cent have a score of 10 or below (see Figure 10).

Figure 10: Frequency of total NDTA scores



Those who had received holistic support from another service in the 12-months before joining Changing Futures had higher (worse) scores than those who had not, although the difference was not statistically significant (see Table 49). This suggests overall low scores are not due to people joining from legacy programmes with lower levels of need. Low scores may be a result of early inappropriate referrals to the programme or there could errors in the completion of the assessment.

There were few significant differences in mean total NDTA score between demographic groups (see Table 50 and Table 51). The one exception was disabled people, where people with long-term conditions scored significantly higher than those without (22 compared to 14) – although the group of non-disabled people is very small (see Table 52).

However, there are significant differences in mean score between those with and without experience of different forms of disadvantage. People with experience of drug and alcohol problems, homelessness (and rough sleeping specifically) and the criminal justice system all scored significantly higher than those without these experiences (although this reference group is very small) (see Table 53).

Table 9: Mean average NDTA scores for each domain (base=650) * domains are double weighted

Item	Average score	Score description
Engagement with frontline services	2.2	Follows through some of the time with daily routines or other activities; usually complies with reasonable requests; is minimally involved in tenancy/treatment.
Intentional self-harm	1.5	Minor concerns about risk of deliberate self-harm or suicide attempt.
Unintentional self-harm	2	Definite indicators of unintentional risk to physical safety.
Risk to others*	3	Minor antisocial behaviour – risk to property and/or minor risk to physical safety of others.
Risk from others*	3.9	Definite risk of abuse or exploitation from other individuals of society.
Stress and anxiety	2.4	Moderately reactive to stress; needs support in order to cope.
Social effectiveness	1.7	Marginal social skills, sometimes creates interpersonal friction; sometimes inappropriate.
Alcohol/Drug abuse	2.7	Recurrent use of alcohol or abuse of drugs, which causes significant effect on functioning; aggressive behaviour to others.
Impulse control	1.9	Some temper outbursts/aggressive behaviour; moderate severity; at least one episode of behaviour that is dangerous or threatening.
Housing	2.3	Living in short-term/temporary accommodation; medium-to-high housing support needs.

Recovering Quality of Life (ReQoL) is a patient-reported outcome measure developed to assess the quality of life of people with different mental health conditions. It encompasses 10 different domains of mental health. Research by the University of Sheffield, the developer of the measure, has shown that a score of 24 or lower indicates that someone has mental health-related problems and may require help or intervention, whilst 25 and over is seen as falling within the range of the general population. The mean average score for participants was 12.9 (out of a maximum score of 40, base=438). The responses for individual ReQoL questions are shown in Figure 11 (negative statements) and Figure 12 (positive statements).

Whilst female Changing Futures participants scored, on average, slightly lower than males, the difference was not statistically significant (see Table 54). Similarly, we found no significant differences between those with experience of more types of disadvantage and those with experience of fewer (Table 56), or between those who had received holistic support from another service in the 12 months prior to joining Changing Futures and those who had not (Table 57). This perhaps reflects the high prevalence of mental health problems across participants.

Figure 11: Responses to individual ReQoL questions – negative statements (base=453-454); questions relate to the last week

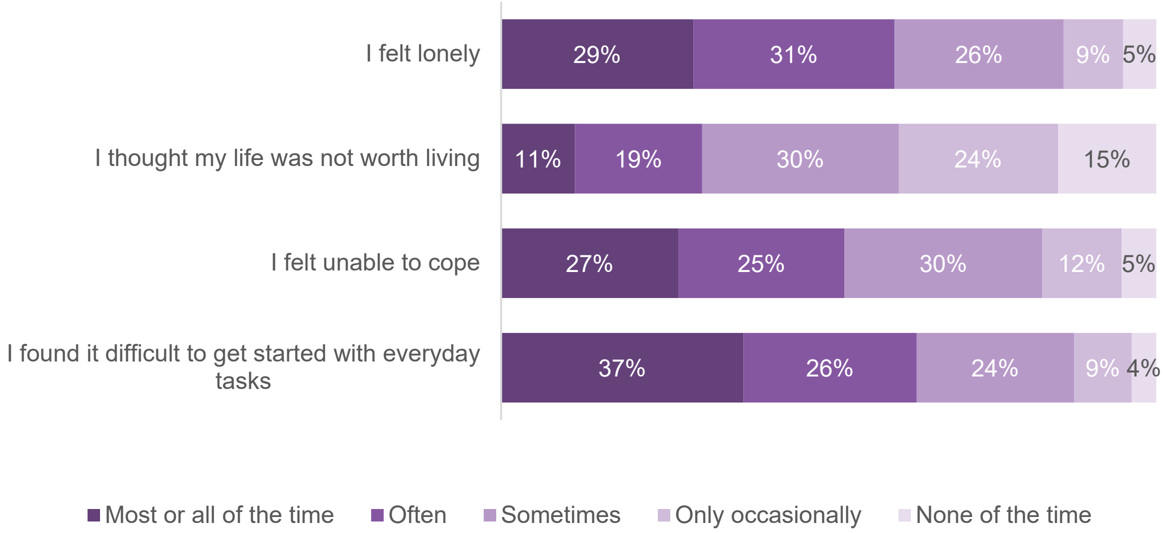
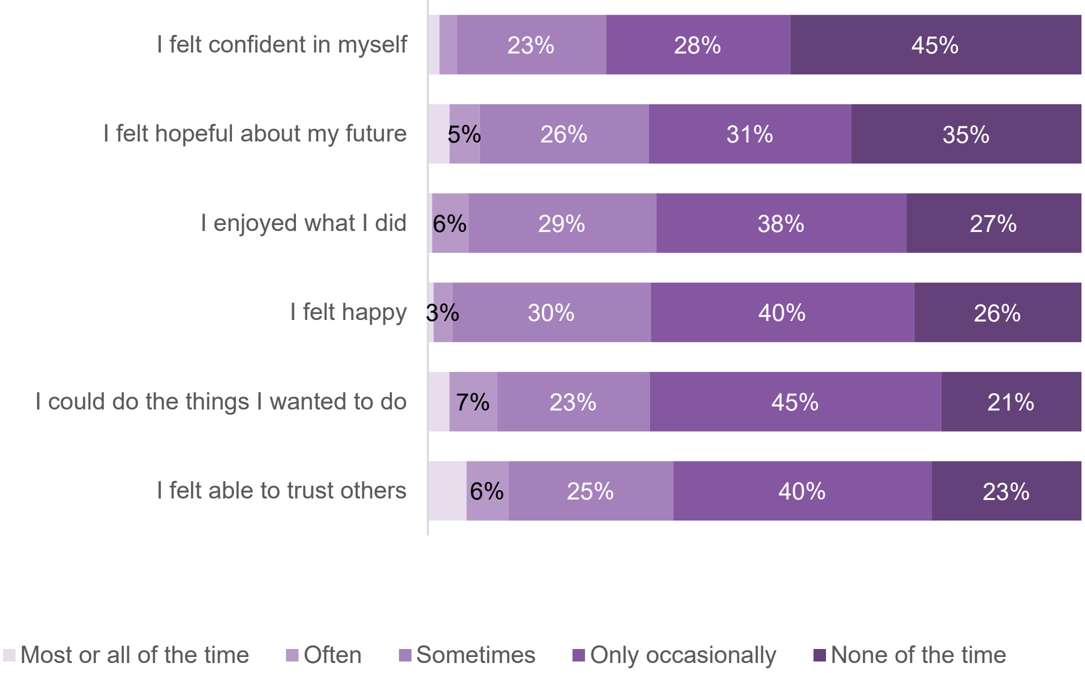


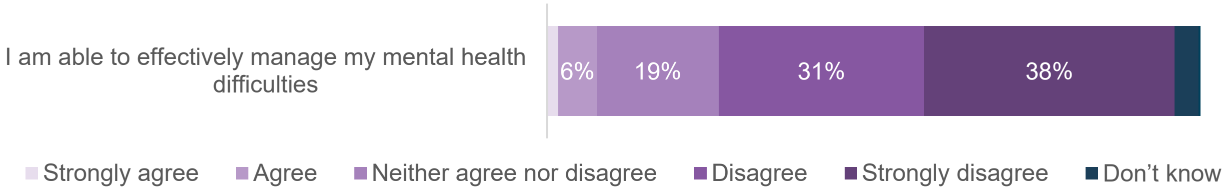
Figure 12: Responses to individual ReQoL questions – positive statements (base=451-455); questions relate to the last week



Participants appeared to experience high levels of anxiety. When asked to rate their anxiety yesterday on a scale of 0 to 10, where 0 is not at all and 10 is completely, the mean average response was 6.6 (base=460, see Table 58). The most frequently given score was 8 (selected by 21 per cent), and almost three quarters of people (73 per cent) gave a score of 6 or higher.

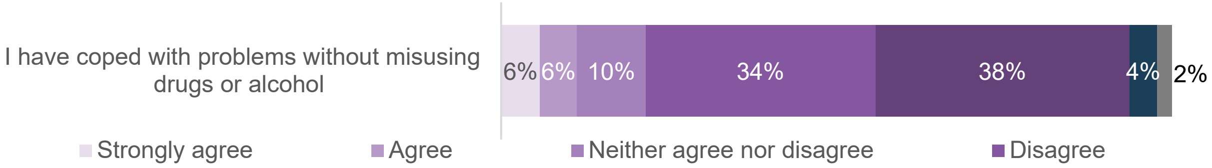
Recovery from mental health means different things to different people – for some, it may be more about managing symptoms rather than being free of them.[33] The majority of participants said that they are not currently effectively managing their mental health difficulties, and just 8 per cent (base=407) said that they are (Figure 13).

Figure 13: Thinking about now, how much do you agree or disagree with the statement "I am able to effectively manage my mental health difficulties"? (base=407)



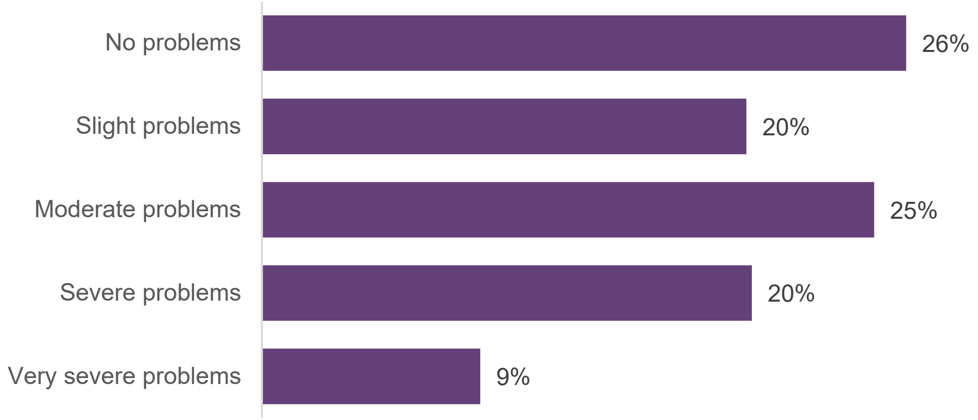
The majority of those with a recent drug or alcohol problem (72 per cent, base=362) said they had not been able to cope with problems without misusing drugs or alcohol (Figure 14). The links between mental ill health and problems with drugs and alcohol are well documented, and people facing multiple disadvantage will often use drugs or alcohol to self-medicate.[34] This further highlights the importance of holistic support that tackles all of the issues that people face together. Dame Carol Black's recent independent review of drugs highlighted the importance of integrated commissioning of mental health and drug and alcohol services.[35]

Figure 14: Thinking about the past 3 months, how much would you agree or disagree with the statement "I have coped with problems without misusing drugs or alcohol"? (base=362 – those who experienced drug or alcohol problems in the past 3 months or had contact with drug and alcohol services in the past 3 months)



The ReQoL mental health questions are accompanied by a question on physical health. This shows that 46 per cent of participants had no or only slight problems, whilst 29 per cent experienced severe or very severe physical health problems over the previous week (base=460, Figure 15). Younger participants (aged 20-29) were more likely to report no problems than were those aged over 40 (see Table 59).

Figure 15: Please describe your physical health over the last week (base=460)



The most common physical health problems experienced by participants in the past 3 months were joint aches/problems with bones and muscles (46 per cent, base=444), followed by problems with mobility (34 per cent, Table 10). Roughly a quarter of participants experienced chest pain or breathing problems (26 per cent) and stomach/bowel problems (24 per cent). This further highlights the range of services that people experiencing multiple disadvantage require (though may not currently have access to – see Section 2.2) and emphasises the importance of providing wide-ranging and holistic support.

Table 10: Could you let me know what physical health problems you have experienced in the last 3 months? Please select all that apply (base=444)

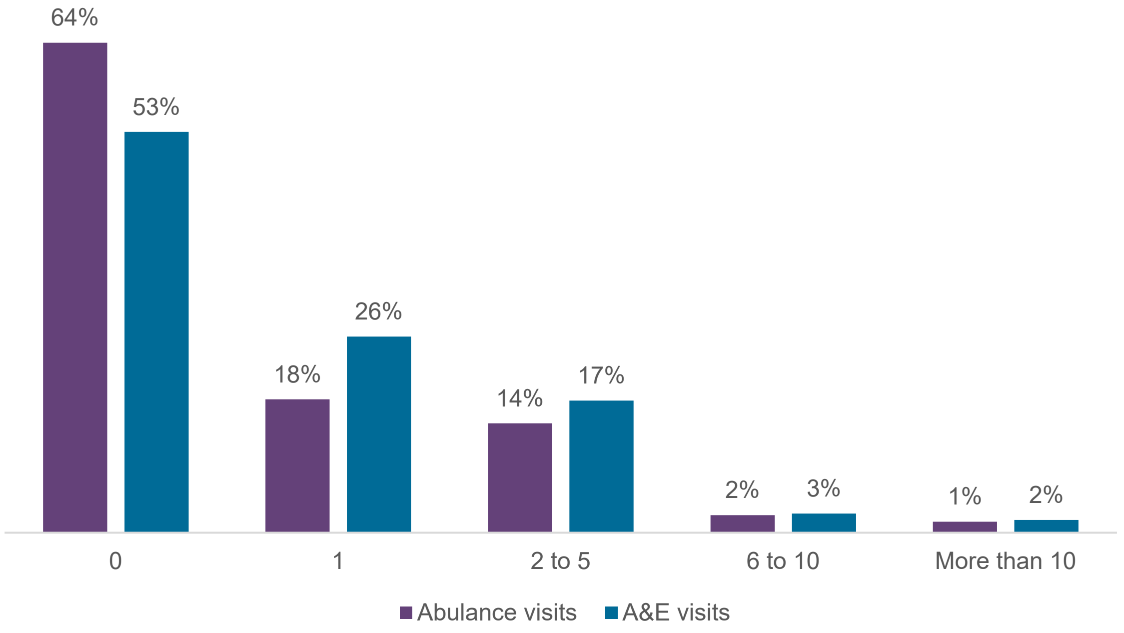
Physical health problem	Count	Per cent
Joint aches/problems with bones and muscles	206	46
Problems with mobility (such as difficulty with walking or problems with your feet)	153	34
Chest pain/breathing problems	117	26
Stomach or bowel problems	106	24
Dental/teeth problems	105	24
Skin/wound infection or problems	99	22
Difficulty seeing/eye problems	44	10
Other physical health condition	103	23
None of the above	4	1
Don’t know	33	7

Don’t want to say	26	6

Intended outcome: Reductions in the use of emergency services
One of the aims of the Changing Futures programme is to reduce the use of inappropriate emergency and crisis services. People experiencing multiple disadvantage generate significant costs for the public purse through repeated but ineffective contact with local services.[36] Understanding the baseline position is important for monitoring any change over the course of the programme.

Just under half of participants (47 per cent, base=357) had visited an A&E department at least once in the past 3 months (see Figure 16). The highest number of visits per individual was 45, with 21 people having visited 5 times or more. Ambulances had been called out to assist 36 per cent of participants in the previous 3 months (base=348, Figure 16). The highest number of estimated ambulance call outs per individual was 60.

Figure 16: Frequency of visits to A&E (base=357) and ambulance call outs (base=348) in the past 3 months



Intended outcome: Individuals feel supported, trusted, valued, safe and in control

Individual statements on the ReQoL provide an indication of the extent to which people feel in control. Only 10 per cent (base=453) said they could do the things they wanted to do often or most of the time. Moreover, 5 per cent (base=451) said they felt confident in themselves often or most of the time (see Figure 12).

NDTA scores (see Table 9) show that people experiencing multiple disadvantage are often at greater risk of abuse and exploitation themselves than they are to other people. As highlighted in Section 2.1, 32 per cent of participants have experience of domestic abuse – 21 per cent in the past 3 months. Most people with recent experience of domestic abuse (72 per cent, base=112) reported that there was at least some risk of it happening again, with a quarter feeling that they were ‘very much’ at risk of a repeat of their experience (see Figure 17). Most people also agreed to some extent that they had ways to help themselves stay safe (Figure 18).

A third (34 per cent) of those with recent experience of domestic abuse said they had told the police, whilst 28 per cent said they were able to, but did not want to report it (base=124, see Figure 19).

Figure 17: Thinking about your current situation (recent experience of domestic abuse), to what extent do you feel there is a risk that this will happen again or keep happening? (base=112)

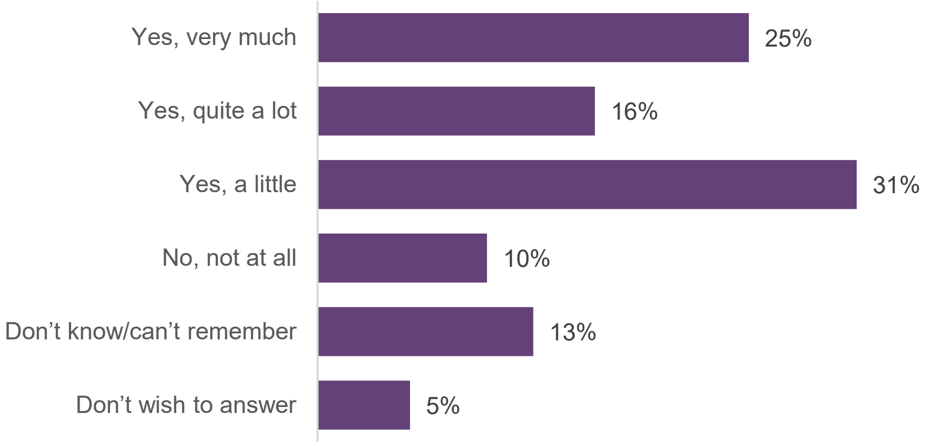


Figure 18: Thinking about your current situation (recent experience of domestic abuse) to what extent would you say that you have strategies to help you stay safer? (base=112)

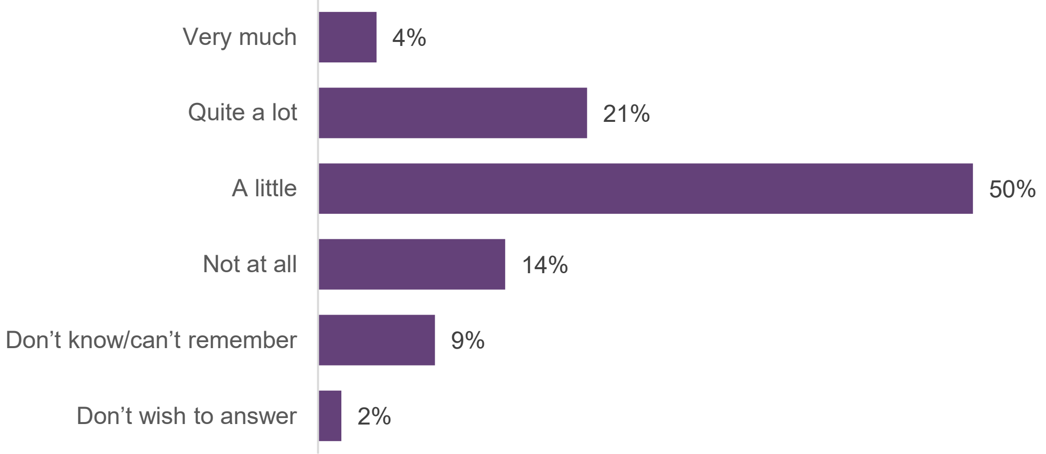
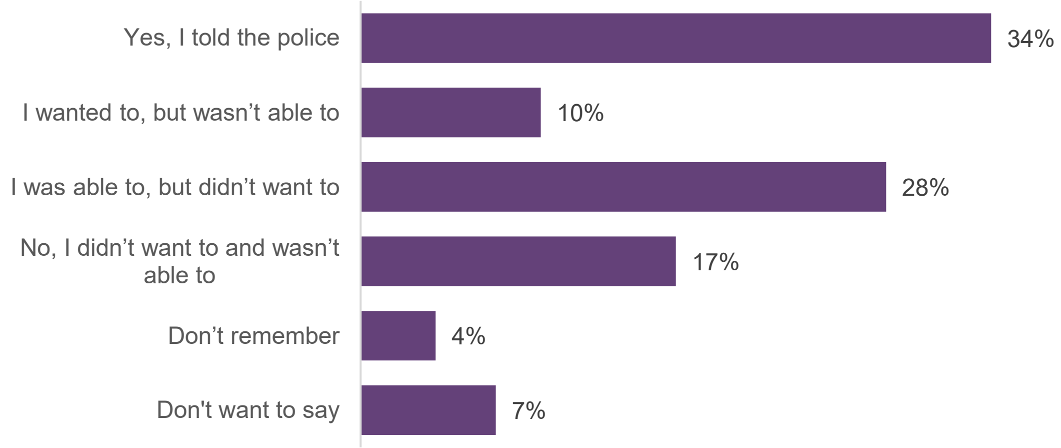
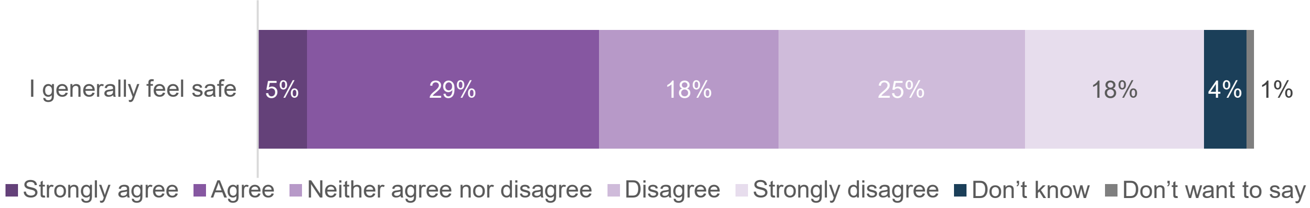


Figure 19: Thinking about the last 3 months, did you feel you wanted to or were able to tell the police about this (domestic abuse)? (base=124)



Domestic abuse is not the only way people experiencing multiple disadvantage are at risk. At least 35 per cent (base=610, Table 60) had been a victim of violent crime in the past 3 months, and 30 per cent (base=609, Table 61) had been the victim of other crime. Amongst those with no experience of, or at low risk from, domestic violence,[§] more people disagreed that they felt safe than agreed (43 per cent compared to 34 per cent, base=283, Figure 20).

Figure 20: How much to you agree or disagree with this statement: I generally feel safe? (base=283)



[§] Defined as those who have experienced domestic violence but say there is no risk of it happening again AND agree very much or quite a lot that they have ways to stay safe.

2.4 Stability, including housing, financial and social connectedness

Key findings

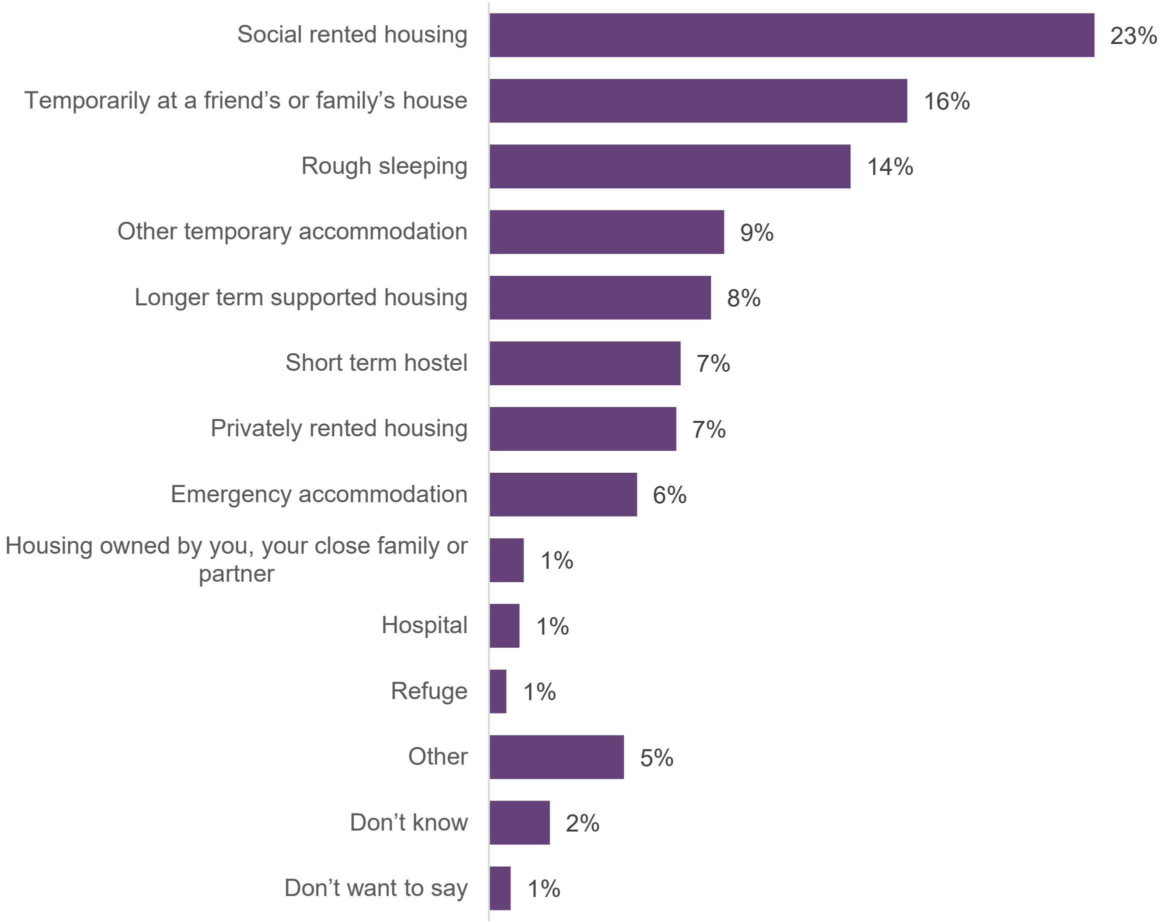
- Just over half of programme participants were homeless for most of the month prior to completing the baseline questionnaire. This includes 14 per cent who were mainly rough sleeping. Of those mainly in stable accommodation, over a third were not confident this would last 6 months.
- For most participants (72 per cent), their main source of income was Universal Credit. A small proportion received income from begging and sex work, although these two categories may be under-reported.
- At this stage in the programme, most participants were some way off being able to engage in the labour market. Only 3 per cent were in paid work and 5 per cent had been involved in any employment, training or volunteering in the past 3 months.
- At least 60 per cent were in debt or behind on their bills, and over half of these said they were unable to manage paying these debts off.

The personal goals of participants, as described in the baseline questionnaire, were varied. These mainly related to moving into appropriate accommodation, overcoming drug and alcohol issues, improving mental health, getting into education or work, and reconnecting with children and family.

Intended outcome: Reductions in homelessness and rough sleeping
Addressing homelessness and supporting people in maintaining stable accommodation is an important element of tackling multiple disadvantage. A lack of suitable accommodation can affect people's ability to engage in other support services,[37] whilst stable housing provides a foundation on which people can rebuild their lives.[38,39]

As shown in Table 4, 60 per cent of participants reported experiencing homelessness at some time. Just over half of participants (51 per cent, base=613) were homeless for most of the month prior to completing the baseline questionnaire. This encompasses people who were rough sleeping, staying temporarily with friends or family, in a short-term hostel, and using emergency accommodation, refuges, and other temporary accommodation. In total, 3 out of 10 (30 per cent) were in rented accommodation (private or social) and 8 per cent were in longer-term supported accommodation (Figure 21).

Figure 21: Where have you stayed most of the time for the last month? (base=613)



Of those who were not currently in homeless accommodation or sofa surfing, over a quarter (27 per cent, base=321) had spent time in these type of accommodation over the past 3 months (Table 62). Over a third (36 per cent, base=179) of those who were mainly in stable accommodation during the last month were not confident they would still be in stable accommodation in 6 months' time (Table 63). Similarly, most of those who were not in stable accommodation last month (60 per cent, base=252) were not confident that they would be in stable accommodation in 6 months' time either (Table 64). The Fulfilling Lives evaluation found that patterns of accommodation were often chaotic, with people moving frequently between different types, even when they had their own tenancy.[40]

Approximately one in seven (14 per cent) had spent most of the time rough sleeping in the month prior to completing the baseline survey, and a further 25 per cent of the remaining participants had spent some time sleeping rough in the previous 3 months (base=528, Table 65). Of those with recent experience of rough sleeping, nearly a third (30 per cent, base=139) had spent over a month sleeping rough (see Table 11). Interestingly, there were no significant differences between the proportion of men and women who had recent experience of rough sleeping – although this may be due to the relatively small dataset (Table 66).

Table 11: Roughly how much time have you spent sleeping rough (in the past 3 months)? (base=139)

Time spent rough sleeping	Count	Per cent
Once	5	4
More than once but less than a week	36	26
One to two weeks	30	22
Three weeks to four weeks	7	5
More than a month	42	30
Don’t know	13	9
Don’t want to say	6	4

Systems mapping workshops identified insufficient and inadequate housing provision as a key barrier. People experiencing multiple disadvantage may be referred to inappropriate housing provision due to there being a low supply of quality accommodation and associated services. For example, participants from one funded area described how people were being placed with a particular local supported housing provider, despite the housing stock being of low quality and the support component being insufficient, because it was all that was available. Participants also described how people with high-level needs might be referred to general needs hostels, or young people accommodated in adult hostels because there is no appropriate youth accommodation available. Many areas were also said to have a lack of gender-appropriate accommodation for women.

Intended outcome: Reductions in contact with the criminal justice system

Just under half of participants (46 per cent, base=613) had come into contact with the criminal justice system in the previous 3 months. Most of these had been arrested. Almost 1 in 10 (9 per cent) had been convicted of a crime, and the same proportion had spent time in prison (Table 12).

Table 12: In the last 3 months have any of these happened to you? Please indicate all that apply (base=613)

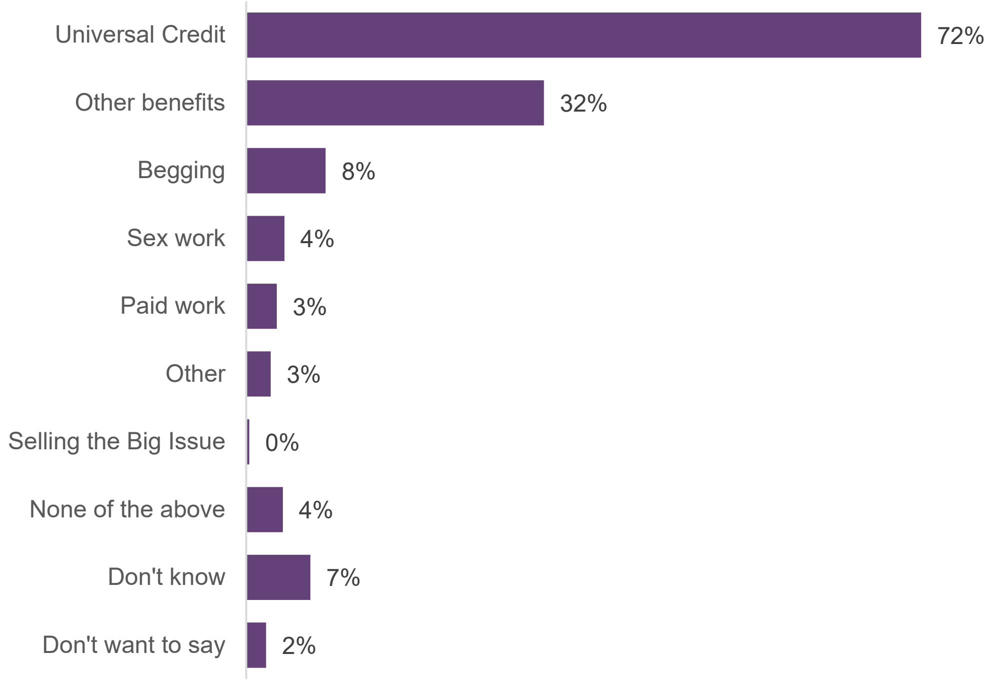
Type of contact with the criminal justice system	Count	Per cent
Been arrested	113	18
Been convicted of a crime	54	9
Spent time in prison	54	9
Received a caution	43	7
Received an injunction or criminal behaviour order	35	6
None of these	33	54
Don't know	6	11
Don't want to say	40	7

As reported in Section 2.1, men were more likely than women to have been arrested and convicted of a crime. As with other aspects of multiple disadvantage, contact with the criminal justice system is linked to other issues, such as drug and alcohol use and homelessness,[41] and there is a risk of repeated contact if these wider issues go unaddressed.

Intended outcome: Improved financial security

Ensuring people have a safe and secure source of income that is sufficient to cover their needs is an important step in supporting people in their recovery journeys. For the majority of participants (72 per cent, base=613), their main source of income was Universal Credit; 32 per cent received other benefits. A small proportion received income from begging (8 per cent) and sex work (4 per cent) (Figure 22). It is known that survey questions asking about sensitive topics can be distorted by social desirability bias, and so these two categories may under-report engagement in such activities.[42]

Figure 22: Main sources of income in the last 3 months. Please select all that apply (base=613)



Only 3 per cent of participants said they were in paid work. Moreover, 31 per cent (base=324) had never had a job, whilst a slightly larger proportion (37 per cent) had (Table 67). The remainder either could not remember or did not want to say. Of those who had worked in the past, for most, this was over a year ago (83 per cent, base=119,Table 68).

Just over a fifth of respondents (22 per cent, base=613) stated that they had help with benefits applications in the past 3 months (see Table 69), and 16 per cent (base=527) indicated that getting help with benefit applications had been very important for them (see Table 48). Funded areas reported that at least 13 per cent of participants (base=745) were not receiving the benefits they were entitled to (Table 70).

Generally, a bank account or equivalent is required in order to get Universal Credit and other benefits. Approximately one in eight of participants (12 per cent, base=613) did not have access to their own bank account (Table 71), and 6 per cent (base=613) had received help setting up a bank account in the past 3 months (Table 69).

Debt can also be a problem. At least 60 per cent (base=460) of participants said they were in debt or behind on their bills, and over half of these (54 per cent, base=274) said they were unable to manage paying such debt off (Table 72). Almost a fifth (17 per cent, base=613) had received help or advice with money in the past 3 months (see Table 69). It will be important to monitor this in light of the current cost of living crisis.

Intended outcome: Improved capacity, opportunity and motivation

Participation in meaningful activity is an important element of recovery and helps people to form social networks and build positive identities.[43,44] However, most participants were some way off being able to engage with the labour market. As noted above, very few participants were in paid work or had undertaken paid work in the last year. According to funded areas, just 5 per cent (base=836) of participants had participated in any employment, training or volunteering in the past 3 months, and only 3 per cent were thinking about working towards employment, volunteering or training (Table 13).

Table 13: In the last 3 months has the beneficiary… (base=836)

Workforce related activity	Count	Per cent
undertaken employment, volunteering or training	41	5
actively worked towards employment, volunteering or training	19	2
been thinking about working towards employment, volunteering or training	28	3
No known activity or intention for working towards employment, volunteering or training	748	89

Only 7 per cent of participants (base=742) had attended an appointment with a work coach in the previous 3 months. 80 per cent had not. For 35 per of participants (base=742) this was because they were reported by programme staff to not to be work ready (Table 73).

People have varying goals in life; 'getting better' means different things to different people.[45] Personalised goal setting is regularly used by mental health and rehabilitation professionals as a way of focusing support towards outcomes that are important to the client.[46] Just over half of participants (45 per cent, base=593) said they had a personal goal. Of those who shared their goals, by far the most frequently mentioned theme was accommodation (113 people) – people wanting to maintain their accommodation, move to safer, more appropriate or independent accommodation, or just to have a home of their own.

> To get a roof over my head and get a good night's sleep.
>
> To avoid eviction, to sort out council tax arrears.
>
> Moving into independent accommodation away from problem areas.
>
> **Quotes from beneficiary questionnaires**

Other frequently mentioned goals included overcoming drug and alcohol issues, improving mental health, getting into education, volunteering and/or work, and reconnecting with children and other family members.

> Would like to reduce drug use and reconnect with family.
>
> To finish my engineering degree and go back to work.
>
> **Quotes from beneficiary questionnaires**

The desperate situation some people find themselves in is all too evident in goals to simply survive or make it through the day. Some of the goals are highly personal and often seemingly modest – to attend appointments or to take up a hobby. Prescribed outcomes that form service KPIs can often overlook progress people make in achieving goals that are important to them. Peer researchers supporting the evaluation highlighted that focusing on inappropriate outcomes risks support not feeling personalised and/or positive change not being sustained.

> I want to visit the swans in the park but it is difficult for me to get there.
>
> Would like to see my son again and go out for days like we did before. Going back to church and going on the church holiday.
>
> Get through the day.
>
> **Quotes from beneficiary questionnaires**

At this early stage in the programme, less than half of participants (42 per cent, base=264) felt they were making progress towards their personal goals (Table 74).

Intended outcome: Improved connectivity (e.g. to family/community) and supportive relationships

Social support networks are important when it comes to coping with life challenges. Nearly half of participants (44 per cent, base=459) did not feel connected to their family members compared with 14 per cent who felt very connected (see Table 14).

Table 14: Thinking about family members you have that you do not live with, do you feel well connected to them? (base=459)

Response option	Count	Per cent
Yes, very	66	14
Yes, slightly	135	29
No	202	44
Don't know	27	6
Don't want to say	16	3
Does not apply	13	3

Just over a quarter of participants (27 per cent, base=460) said they would turn to their families first if they needed someone to talk to (other than their support worker) and just under a quarter (23 per cent) would turn to friends. A substantial proportion (21 per cent) said they had no one to talk to. There is relatively strong international evidence[47] on the effectiveness of peer support for contributing to better outcomes amongst homeless populations; just 7 per cent of respondents said they turned to peers for support (see Table 75).

3 Public service systems

Changing Futures seeks to make an impact at the individual, service and systems levels. In the previous chapter we explored the experiences and characteristics of individuals receiving direct support when they first join the programme. In this chapter we describe key features of the services and systems of public support in Changing Futures areas at the start of the programme. Again, we have structured findings by intended outcome, although at this stage we are yet to assess the extent to which these have been achieved.

3.1 Collaborative approaches

Key messages

- Most partners responding to our survey stated that they share goals and priorities with multiple organisations in their local area.
- Evidence for collaboration in designing and developing services is mixed, with only a third of survey respondents doing this regularly.
- Barriers to aligning priorities include working across different geographical areas, such as two-tier counties comprising several districts. Varying service boundaries can also make it difficult for people seeking support to navigate the system.
- Siloed and competitive commissioning – in both local and national funding streams – was identified as a key barrier to effective and joined-up service delivery.
- There was substantial variation between Changing Futures areas in the extent to which organisations jointly apply for funding or commission services.
- Short-term funding of services also contributes to numerous other systems barriers, such as high staff turnover and a constantly changing landscape of support.

Intended outcome: Strategic alignment across local strategies
The previous chapter highlighted the range of services that people experiencing multiple disadvantage need. In order to successfully collaborate and provide joined-up support, organisations and sectors need a shared understanding of multiple disadvantage and a shared vision for change.

The survey of partners provides evidence of strategic alignment across local strategies. The majority of survey respondents (88 per cent, base=479) said they share their overall goals and priorities with multiple organisations involved in the local system. Over 80 per cent of respondents across almost all areas[**] and across most sectors said they had shared goals and priorities; the exceptions were education, skills and training, where the

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[**] The one area where agreement was below 80 per cent had a very small number of responses.

percentage of respondents was lower at 72 per cent. The majority of respondents (81 per cent base=478) also said that they work with multiple organisations to jointly assess need and demand for services. This was consistent across funded areas, apart from those with very low numbers of survey responses.

Evidence was more mixed on the extent to which organisations collaborate to design and develop services. One-third of respondents (34 per cent, base=476) said their organisations regularly jointly design or develop services with other organisations involved in the local system and just over one-third (37 per cent) stated that their organisations do this sometimes.

The aim of aligning local strategic priorities is made more challenging by the fact that the system of support for people experiencing multiple disadvantage operates across different administrative areas, which do not always align. The support system may include multiple local authorities (upper tier, lower tier, and unitary) that can be culturally, economically and politically diverse. The system might also include different types of organisations, such as Integrated Care Systems,[††] police forces and voluntary and community sector organisations, which operate over different and overlapping footprints that do not correspond with local authority boundaries.

Systems mapping participants described how these complex geographies make the system even more difficult to navigate for people seeking to access support, as well as for staff working in the services. This means that there are different policies, processes and services in place depending on the locality, which can make it difficult to know what support is available and how it is accessed. For example, in two-tier counties comprising several districts there may be different local policies and approaches in relation to homelessness and housing provision. It can also mean that certain services are only available in specific places for particular people, requiring people to make long journeys to access support or excluding people from services that are local to them because they reside on the other side of a boundary.

The complexity can also significantly reduce efficiency in commissioning and service delivery by increasing the number of relationships that each worker may need to develop with colleagues in other services, as well as the number of different multi-agency partnerships and meetings that staff may need to attend.

Intended outcome: Co-commissioning, pooled budgets and KPIs across services
Siloed and competitive commissioning – in both local and national funding streams –was identified as a key barrier to effective service delivery by participants in the systems mapping workshops. This contributes to a poor system of support for people experiencing multiple disadvantage in several ways and is a key underpinning factor in many other barriers.

Stakeholders highlighted how the commissioning process engenders compartmentalised services, whereby services are commissioned to focus on single issues rather than to work with a person to address all the issues they may be facing, which often inter-relate. This makes it more likely that people will ‘fall between the gaps’ in services if, for example, they

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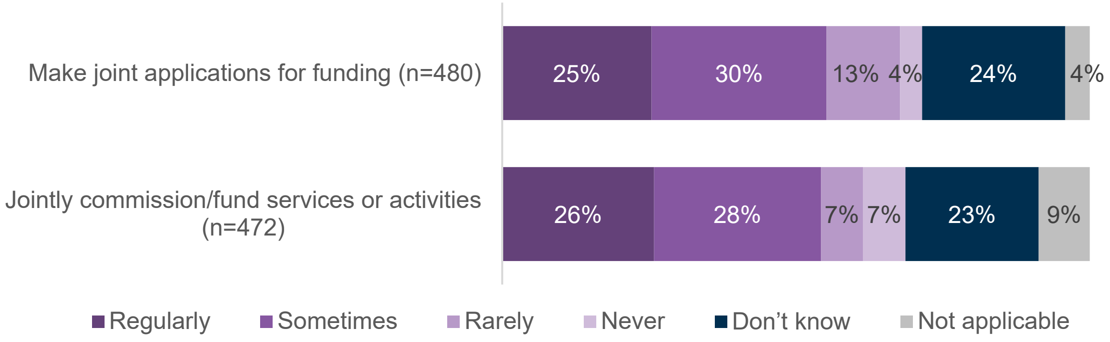
[††] Integrated care systems (ICS) are partnerships of organisations that come together to plan and deliver joined-up health and care services.

do not meet eligibility criteria or services reject a referral and 'pass the client along' to another service. It also means that any support people do receive from different services is less likely to be joined-up or coordinated, and this leads to different services having different referral pathways and processes. This in turn contributes to a more complex system that is difficult to navigate for people trying to access services as well as the staff in services who may be supporting them.

In addition, workshop participants noted that traditional procurement processes put voluntary and community sector organisations in competition with each other and discourage the collaboration that is required to ensure support is coordinated and joined up across a complex service landscape.

Results from the partners survey provide mixed evidence as to whether organisations in funded areas are jointly applying for funding or commissioning services (see Figure 23). One quarter (25 per cent, base=480) stated that they regularly make applications for funding with other organisations, and a further 30 per cent said they sometimes do this. However, there was substantial variation across the funded areas. For example, in five areas over 70 per cent of respondents reported that they sometimes or regularly make joint funding applications, whereas for six funded areas less than 50 per cent of respondents reported this. Additionally, one-quarter of respondents (26 per cent, base=472) said their organisations regularly jointly commission/fund services or activities with other organisations in the local system, and a further 28 per cent declared that this happens sometimes.

Figure 23: How often does your organisation…



Related to the siloed nature of commissioning, systems mapping participants also noted that commissioned services are often funded only on a short-term basis. This is a contributing factor to many of the other barriers identified in the systems mapping exercise. For example, short-term funding for services is linked to short-term contracts, which result in high levels of staff turnover. Short-term funding for services therefore leads to unstable support for people (due to change in services and/or support staff) and systems that are more complex for staff to navigate due to the constantly changing landscape of available support. It can also contribute to fatigue and a loss of motivation amongst staff, who may have seen many funding programmes and services come and go without wider systems change.

3.2 The workforce

Key messages

- Whilst respondents to our partners survey working in the voluntary and community sector indicated that staff generally feel valued, trusted and have access to the support they need, this was less so for those working in the statutory sector. In addition, the systems mapping exercise identified overstretched staff and uncompetitive salaries as key barriers to the development of an effective system of support for people experiencing multiple disadvantage.
- Frontline staff funded by Changing Futures generally have small caseloads that align with what other evidence suggests is manageable for supporting people experiencing multiple disadvantage.
- There appears to be great variation between services and sectors in the extent to which staff have access to good quality reflective supervision and support.
- Staff generally said they have good awareness of local services and there are examples of well-developed partnerships in many funded areas.
- However, many staff lack the capacity to prioritise working with partners because they are dealing with more immediate internal pressures.
- Systems mapping participants perceived services often lack flexibility in how they provide support.
- Trauma-informed practice is being rolled out across specific sectors or services in some areas, though there appears to be inconsistency in both understanding of what it means to be trauma informed and levels of willingness and ability to adopt this way of working.

Intended outcomes: Staff (including peer supporters and volunteers) valued and trusted across the service and system and have access to the training and support they need
Intended outcome: Reduced staff burnout

There is some inconsistency between the findings from the partners survey and those from the systems mapping workshops in relation to working experiences. The reasons for this are not known but may be due to differences in the stakeholder groups that attended the workshops and completed the survey, and differences inherent in the method and the way topics were explored in the survey and workshop discussions.

Insights from the partners survey provide evidence that staff generally feel valued and trusted by their organisation (see Figure 24). Respondents tended to agree that their organisations have a culture of valuing staff and volunteers, with most rating their level of agreement with this statement as 10 – the strongest level of agreement – and 83 per cent providing a rating of 6 or above. A similar proportion also agreed that they have access to the support they need in their role – 84 per cent gave a score of 6 or above. However, there were notable differences in perspective between those working in the voluntary and community sector and those in the statutory sector. 82 per cent of those in the voluntary and community sector indicated strong agreement (a score of 8 or above) that their organisation has a culture of valuing staff and volunteers. Only 47 per cent of those in the statutory sector gave a similar score.

Figure 24: On a scale of 0-10, to what extent do you agree or disagree with the following statements (0=strongly disagree and 10=strongly agree)?

Participants from the systems mapping workshops emphasised that there is a collective sense of willingness and commitment amongst staff and/or ‘the system’ to learn about how best to support people experiencing multiple disadvantage and to change their local system to achieve the best possible outcomes for this group.

However, in contrast with the partners survey results, participants in the systems mapping workshops identified overstretched staff and uncompetitive salaries as key barriers to the development of an effective system of support for people experiencing multiple disadvantage. They noted that both these factors contribute to relatively high levels – or risk – of burnout and turnover amongst staff. This, in turn, leads to a loss of knowledge, experience and relationships from services, and instability of support for people accessing services. The above factors also hinder the recruitment of new staff, who may be attracted to other roles with better pay and conditions. Staff were reported to often be on short- or fixed-term contracts with uncompetitive salaries.

In addition, when staff feel over-stretched and under-resourced, they may not have the capacity or bandwidth to think about how to do things differently and to contribute to changing the system for the better. As workers come under increasing pressure, this can also contribute to negative staff attitudes and behaviour, as well as less flexible approaches to supporting people.

Workshop participants described how staff working in services supporting people facing multiple disadvantage are often carrying high volume, challenging caseloads and are working in services for which demand far exceeds current staffing capacity. Conversely, respondents to the partners survey tended to agree that they have the time and resources needed to perform their role; the extent of agreement here was more equivocal than for some other statements about working experiences (see Figure 24). Generally, frontline staff funded through the Changing Futures programme currently have an average caseload of between 4 and 8. This aligns with learning from Fulfilling Lives, i.e. that a caseload of between 6 and 10 people experiencing severe and multiple disadvantage is optimal.[48] Some areas had very small average caseloads (2 was the smallest), presumably because they were still in the early stages of recruiting participants. However, two areas had much larger average caseloads of 15 and 22 respectively.

Changing Futures-funded line managers were, on average, responsible for six full-time equivalent frontline workers. The smallest number of line reports was 2 and the largest was 12. Partners survey respondents tended to agree that they received appropriate line management/guidance in their role. The most frequent response (selected by 31 per cent of respondents) was 10, indicating strong agreement.

The mean average number of days' leave taken by frontline and direct line managers as a result of illness or stress between May and July 2022 was 23 per funded area. This is skewed by some areas with very high levels of leave; some areas reported no absences. The median number of days leave due to illness or stress was 6 per funded area. The two areas with the highest number of days' leave reported 87 and 95.6 sick days; one area had a single member off on long-term sick for the full quarter, which accounts for many of these days. Several areas reported absences relating to COVID-19.

Workshop participants reported that the extent to which they have access to good quality reflective supervision and support varies greatly between sectors and services. Those responding to the partners survey generally agreed that their organisations encourage reflective practice, with the majority of respondents (81 per cent) giving a score of 6 or above. Of the 13 Changing Futures areas providing data in July 2022, 10 said they had a budget for staff support. However, expenditure on staff support for the most recent quarter ranged from £70 to nearly £5,000, and 5 of the 10 areas reported their spending as 'nil'. Areas highlighted that some staff support was provided free or was funded elsewhere in the system – e.g. clinical supervision provided by a psychologist in the mental health trust.

Partners survey respondents also generally agreed that they have access to the training they need to maximise their confidence and skills in their role. Over four-fifths of respondents (84 per cent) gave a score of 6 or above, and almost a quarter reported a maximum score of 10 (24 per cent). All but one of the Changing Futures areas that submitted an operational data return reported providing at least some training for their staff. The average expenditure on training for the 3 months up to the end of July 2022 was just under £1,500, although many had provided access to free or internal training for their staff in addition. Training included introductions to roles, use of monitoring/data systems, trauma-informed care, first-aid, domestic violence, use of Naloxone (medication to reverse the effects of opioids) and conflict management.

Intended outcomes: Staff have the appropriate knowledge of, and contacts across, the system.

Responses to the partners survey indicate that staff tended to agree that they are aware of services to support people with multiple disadvantage. In all funded areas, the mean level of agreement was above 5.5. Almost one-quarter of respondents (23 per cent) gave a score of 9 or above.

Similarly, the systems mapping workshops highlighted that there are already well-developed partnerships between organisations and strong relationships between individual workers in many Changing Futures areas. Most areas were able to identify at least one example of well-developed local multi-agency work, such as multi-agency panels/meetings, teams and pathways, which contributes to strong partnerships and relationships and vice versa. These multi-agency structures enable local partners to work together to plan and coordinate care and share client information on a case-by-case basis, thus helping to overcome key barriers such as the lack of a shared case management system, gaps in support at transition points, and the siloed and compartmentalised service landscape. The multi-agency work also provides a forum for partners to identify and address systems barriers, and to pinpoint and exploit system strengths; such work also enables partners to develop and share understanding of multiple disadvantage and learning on how best to support this group.

Participants in some areas also described a local culture that encourages partnership working and where partners are keen to work together. This is often supported by a history of partnership working through, for example, Fulfilling Lives and MEAM Approach Network.

Yet, whilst staff may have appropriate knowledge and contacts, participants in the systems mapping workshops also noted that many staff lack the capacity to prioritise working with partners (to support and coordinate care for people or to collectively resolve problems and create solutions), because they are dealing with more immediate internal pressures. This is contributing to patchy or inconsistent attendance at multi-agency meetings in some areas/sectors, and/or partners being unable to spend time building meaningful relationships. Participants suggested that the reason why people may not be engaging as effectively as they could is limited funding to support collaborative work, such as resources for back-filling posts to enable people to attend meetings.

Intended outcome: Staff have flexibility, autonomy and capacity to best meet the needs of people experiencing multiple disadvantage.

Participants in the systems mapping workshops perceived that some services and staff are not flexible in their approach to providing support. This can result in people being excluded either directly/explicitly, such as where services operate on a ‘three strikes and you are out policy’, or indirectly, where the standard approaches and policies render the service difficult to access or engage with. There are many possible contributing factors to this inflexibility. For example, pressure on services or organisational cultures may mean that staff do not have permission or capacity to work flexibly to accommodate different needs; siloed commissioning can restrict the ability of staff and services to operate outside of their commissioned remit, whilst limited understanding of multiple disadvantage and the impact of trauma can mean that some staff and services do not understand why it is necessary to offer more flexibility when working with this client group.

On the other hand, respondents to the partners survey tended to agree that people delivering services in funded areas are allowed to shape support around the people they are working with (see Figure 24). However, with a mean average score of 6.6, there is room for staff to be afforded greater autonomy to work more flexibly as the programme progresses.

Intended outcome: All staff deliver trauma-informed care and support

Trauma-informed care describes a way of working or process of change that can be applied across different geographies, services and activities. The Office for Health Improvement & Disparities has recently published a working definition of trauma-informed practice.[49] Underlying principles include building trust between staff and service users, , ensuring safety and choice, recognising that people may have trauma, and making efforts to not re-traumatise. Research suggests that 85 per cent of people facing multiple disadvantage as adults experienced trauma as children.[50] Therefore, interventions that recognise and address this trauma are more likely to enable people to access and benefit from services and increase the likelihood of a positive experience.

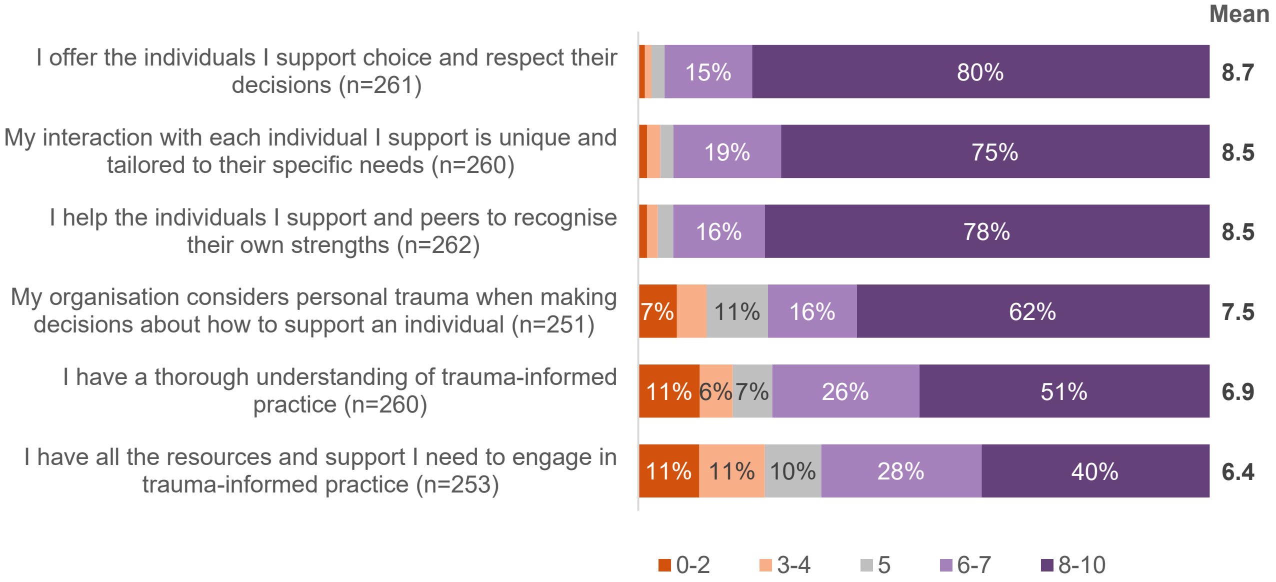
The systems mapping workshops revealed that person-centred and trauma-informed approaches are not adopted everywhere and are applied differently. Additionally, there are varied understandings of what the terms mean, as well as varied levels of willingness and capacity to adopt these ways of working. This applies to referral processes as well as services and support, and results in services unwittingly excluding or re-traumatising people. For example, taking a rigid and punitive approach to appointments and timekeeping and/or asking people to go into detail about their experiences of trauma before they can access a service are factors which are likely to create barriers to people getting the support they need.

On the other hand, systems mapping participants noted that trauma-informed approaches are being rolled out across specific sectors or services in some areas, such as the police, with a noticeable impact on the way staff understand and work with people experiencing multiple disadvantage. This is in line with the findings from the partners survey; over two-thirds (69 per cent, base=271) of respondents said they have received training related to trauma-informed practice. Over half of these (54 per cent, base=188) received the training within the last 12 months, and for a further 25 per cent, within 2 years. There were just two funded areas where fewer than half of respondents had received training on trauma-informed practice.

The partners survey responses show strong agreement overall with the statement that staff are following good practice in helping people to recognise their strengths and providing support that is tailored to individuals' needs (see Figure 25). Almost half of respondents strongly agreed that they offer the individuals whom they support choice and respect their decisions. Respondents were a little less emphatic about their understanding of trauma-informed practice, although three-quarters of respondents (76 per cent) still tended to agree, and only one funded area had a mean level of agreement below 5.

Respondents also tended to agree that their organisation considers personal trauma when making decisions about how to support an individual. The majority of respondents (62 per cent) gave a score of 8 or above. Respondents were less likely to agree that they have all the resources and support they need to engage in trauma-informed practice. Just under a quarter (22 per cent) gave a score of below 5, indicating that they disagree. Two funded areas had an overall average score below 5.

Figure 25: On a scale of 0-10, to what extent do you agree or disagree with the following (where 0=strongly disagree and 10=strongly agree)?



3.3 Lived experience

Key findings

- In most Changing Futures areas there are examples of people with lived experience being involved in helping shape local services.
- Partners survey evidence supports this, indicating that people with lived experience are valued within organisations and services.
- However, lived experience involvement tends to involve a relatively small and non-diverse group of people who are easy to engage. Workshop participants felt that different approaches to lived experience engagement are required if a more diverse group of people are to be involved.
- People with lived experience of multiple disadvantage have much to offer the support service workforce. They can act as role models and have insights into what makes support effective. However, there is often little resource or capacity available to support and encourage people with lived experience to volunteer, train and join the workforce.
- The voluntary and community sector is understood to be better at creating progression opportunities and supporting people to progress than is the statutory sector.

Intended outcome: Lived experience co-design and delivery embedded
Intended outcome: Lived experience involvement is embedded and guiding commissioning

Workshop participants noted that involving people with lived experience in all levels of service delivery is one of the principal ways to address stigma within services through the development of relationships between staff/volunteers with and without lived experience of multiple disadvantage. The involvement of experts by experience also helps to improve the skills of the general workforce, building understanding of how best to work with people experiencing multiple disadvantage. This can include helping to identify problems, challenging entrenched ways of working, creating solutions, breaking down communication barriers between ‘us and them’, and providing the peer support that many people experiencing stigma find valuable.

In most areas, systems mapping participants were able to identify local examples of successful working with people with lived experience, and specific services or sectors where there is a strong cultural norm of this in practice. In some cases, this involved bringing in a third party with co-production expertise to facilitate the work. These examples are already helping to shape and improve local services.

Findings from the partners survey provide evidence that people with lived experience are valued within organisations and services (see Figure 26). Respondents tended to agree that involving people with lived experience is helping to improve services and systems. Over half (59 per cent) gave a score of 8 or above, indicating a strong level of agreement.

The partners survey responses also show that organisations are involving people with lived experience in decision-making and supporting services to run more effectively. People generally agreed that there are formal processes in their organisation to involve people with lived experience in decision making – over two-thirds of respondents (69 per cent) gave a score of 6 or above. Respondents also broadly agreed that in their local area people with lived experience are actively involved in activities and decision-making to make services more effective – two-thirds of respondents (67 per cent) gave a score of 6 or above. However, with mean average agreements of 6.7 and 6.4, respectively, there appears to be scope to further increase the involvement of people with lived experience in service delivery over the course of the programme.

Figure 26: On a scale of 0-10, to what extent do you agree or disagree with the following (where 0=strongly disagree and 10=strongly agree)?

Nevertheless, findings from the systems mapping workshops highlighted a tendency for feedback and lived experience engagement to involve a relatively small and consistent group of people who are easy to access and engage in the activity. These are often people who are engaging well in their support or people who are now in recovery and able to easily engage with the activities. Reliance on a limited group of people not only restricts diversity of views but can create pressure on those who are repeatedly asked for their input, thus potentially jeopardising their recovery. To ensure that feedback is relevant for a wider group, it is important that a range of people with different experiences and perspectives are involved in the service design process. For example, this should include people who are currently accessing services and those who may struggle to engage more or have less positive relationships with services. It should also include the family, friends and support networks of people, as well as frontline staff. It is vital that people from different demographic groups are involved, so as to ensure that a diverse range of perspectives are helping to shape services.

Workshop participants felt that different approaches to lived experience engagement are required if a more diverse group of people are to be involved. Staff stated that they often use the same methods for gathering feedback and insight from people with lived experience as they would use with colleagues and other professionals. Yet many people with lived experience approach topics in a different way and are not able to feed in meaningfully via these established processes. It can be challenging – with dedicated resourcing required – to develop productive and inclusive co-production processes that meaningfully involve such a wide range of people in shaping services. This will also likely require a more flexible approach to co-production that enables those who only want minimal commitment to get involved.

People with lived experience can also benefit from their involvement in the development and delivery of services, through the development of skills, confidence and experience. Taking up volunteering or paid work opportunities can be an important part of the recovery process, providing a sense of purpose, structure and routine.[51] Having choice in the types of roles to take up is important, but working within support services can help people turn negative experiences into something positive.[52] People with lived experience have much to offer as part of the workforce. Not only do they act as important role models, demonstrating that recovery is possible, but they can also help create sustainable changes to services and systems, as they have particular insights into what makes support effective.[53]

Partners survey respondents tended to agree that their organisation provides opportunities to help people with lived experience develop – over two-thirds of respondents (71 per cent) rated their level of agreement above 6 and almost half of respondents (48 per cent) gave a score of above 8. Yet many workshop participants noted that there is little in the way of resources or capacity available to help ensure that there are progression opportunities that support and encourage people with lived experience of multiple disadvantage to volunteer, train and become part of the workforce. This would require investment in supervision, training, and management, so as to ensure that people are able to learn and progress in their roles, as well as to create appropriate, rewarding and appealing opportunities for people.

Stigma related to multiple disadvantage and cautious approaches to risk management also contribute to the lack of progression opportunities, by discouraging staff and organisations from creating opportunities and perpetuating the lack of resourcing available for this work.

In many, but not all, areas, the voluntary and community sector is understood to be better at creating progression opportunities and supporting people to progress than is the statutory sector.

3.4 Access to services

Key findings

- Systems mapping workshops identified prejudice and discrimination (stigma) against people experiencing multiple disadvantage as a key underpinning factor in many other barriers to people getting effective services.
- Gaps in support or lower quality support often occur at the point of transition between different services.
- Partners survey respondents feel that referring people to the services they need is not easy and referral pathways are not clearly communicated.
- The partners survey results indicate a need for greater understanding of, and more specialist services for, people from ethnic minority backgrounds.
- Systems mapping workshop participants also highlighted low representation of people from ethnic minority backgrounds in the multiple disadvantage workforce outside of entry-level and night roles.

Intended outcome: reduced stigma and discrimination surrounding people experiencing multiple disadvantage

A recurring theme in almost all systems mapping workshops was the existence and impact of stigma and discrimination surrounding multiple disadvantage. Participants suggested that people experiencing multiple disadvantage encounter stigma in services as well as from the public. Stigma was identified as a key underpinning factor in many other barriers to people receiving effective services – prejudice and discrimination in services can lead to reduced access to support for people experiencing multiple disadvantage. For example, some services may perceive people experiencing multiple disadvantage as ‘less deserving’ of their support or as making ‘lifestyle choices’ and will prioritise using their limited resources on other groups. This is a particularly acute issue in relation to drug and alcohol problems. Landlords may also be unwilling to provide accommodation due to their negative perceptions of people experiencing multiple disadvantage.

Intended outcome: Clear lines of communication/referral processes to other services

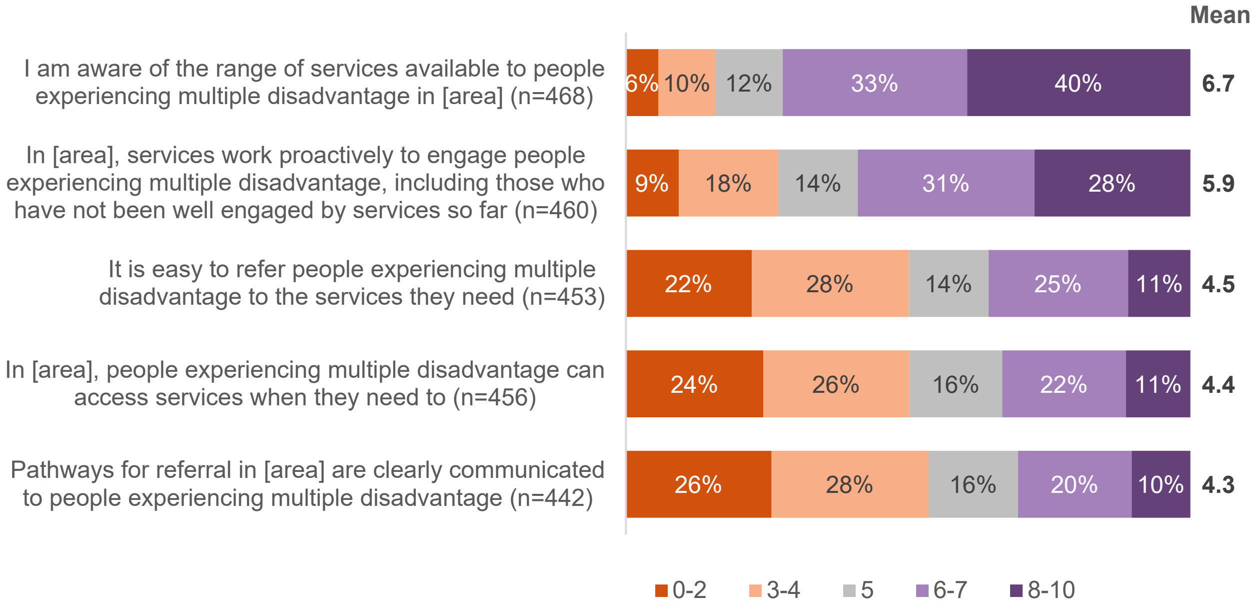
Intended outcome: Clear referral pathways

Findings from the systems mapping workshops suggest that people often experience a gap in support, or lower quality support, when transitioning between different services or teams. This is particularly common when young people transition from children’s services to adult services, or when people are released from prison to no fixed abode. Other examples identified include people leaving detox only to be placed back in hostel accommodation surrounded by people who are drinking alcohol. As mentioned in Section 3.1, findings indicate that the commissioning process creates the foundations for siloed and compartmentalised services, which makes it more likely that people will ‘fall between the gaps’ in services. The consequence of this is that, instead of making progress, people often end up back where they started and needing to re-access more costly, higher-dependency services, when a small amount of bespoke support may have prevented this.

Yet some areas are successfully widening or relaxing the eligibility criteria for services, reducing the risk of people being unable to access support until they are near crisis point or being excluded from support on the basis of other co-existing needs. Partners in some areas were also able to point to particular organisations or sectors where a ‘no wrong door’ approach is effectively in place, meaning that people are connected to suitable support no matter which service or organisation they first contact. However, this does not appear to be a widespread or default approach across any local system.

Responses to the partners survey provide some evidence that services work to proactively engage people experiencing multiple disadvantage, including those who have not been well engaged by services so far – over half of respondents (60 per cent) gave a score of 6 or above. However, at this stage, the findings from the partners survey suggest there is a lack of clarity around referral pathways (Figure 27). People tended to disagree that it is easy to refer people experiencing multiple disadvantage to the service they need – half of respondents (50 per cent) reported a score of below 5 and eight funded areas had an average score of below 5. People also tended to disagree that pathways for referral in their local area are clearly communicated to people experiencing multiple disadvantage – over half of respondents (54 per cent) gave a score of below 5 and 12 funded areas had a mean score below 5. There was general disagreement with the statement that, in respondents’ local areas, people experiencing multiple disadvantage can access services when they need to – half of respondents (50 per cent) gave a score of lower than 5 and 9 funded areas had a mean score of below 5.

Figure 27: On a scale of 0-10, to what extent do you agree or disagree with the following (where 0=strongly disagree and 10=strongly agree)?



Intended outcome: Improved offer for people from ethnic minority backgrounds
In some areas, systems mapping workshop participants identified groups that are under-represented amongst people using local services compared to the local population. This most frequently relates to people from ethnic minority backgrounds, but some local partners also identified LGBTQ+ people and women as being under-represented.

To date, it has not been possible to identify whether there are any significant differences between ethnic minority participants and White British participants in terms of baseline levels of disadvantage or in key indicators of well-being, such as the ReQoL and NDTA, due to low numbers of observations from ethnic minority participants.

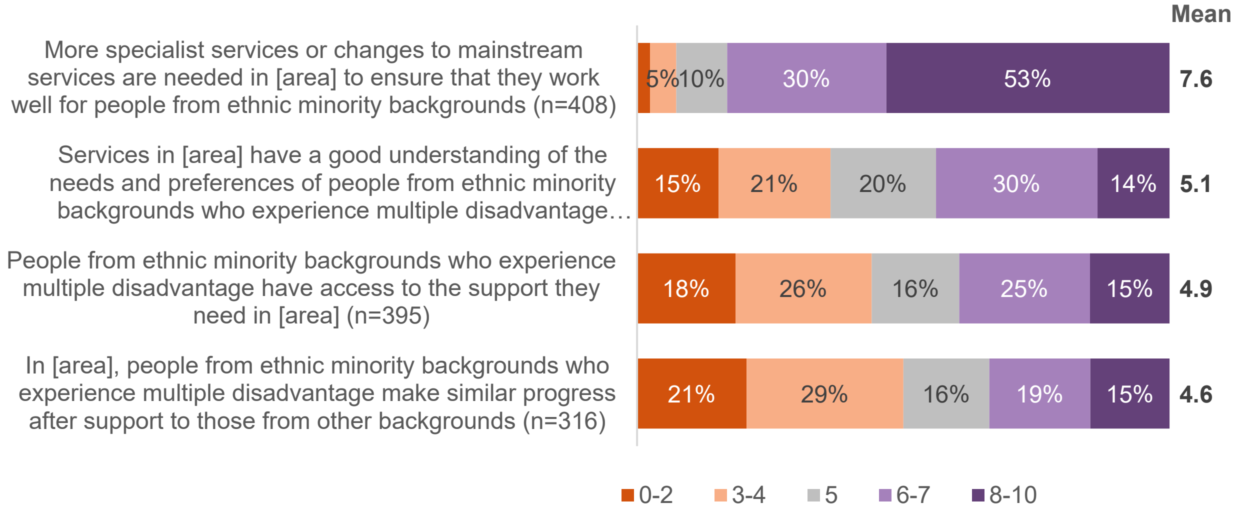
Services tend to be universal rather than aimed at specific groups – people can be under-served when these services are not culturally-sensitive and/or they do not fully understand the needs of particular groups. This is likely to be compounded by another barrier identified by workshop participants in some areas, where there is low representation of people from ethnic minority backgrounds in the workforce supporting people experiencing multiple disadvantage, outside of entry-level and night roles.

Findings from the partners survey provide further evidence of the need for greater understanding of the needs of people from ethnic minority backgrounds (see Figure 28). Fewer than half of respondents (44 per cent) overall tended to agree that services in respondents' funded areas have a good understanding of the needs and preferences of people from ethnic minority backgrounds who experience multiple disadvantage. Answers to this question varied greatly by area, with five funded areas generally tending to disagree, (mean average score of below 5), whereas one area had an average score of 7.8, indicating broad agreement.

Respondents also generally disagreed that people from ethnic minority backgrounds who experience multiple disadvantage have access to the support they need in their local area and that they make similar progress, after support, to that made by people from other backgrounds. Again, there was a large difference between areas on the latter question, with one area showing a greater tendency to agree (the same area that felt staff had a good understanding of people's needs).

There was broad agreement across all areas that more specialist services are needed to ensure that they work well for people from minority ethnic backgrounds. Over four-fifths of respondents (83 per cent) had a score of 6 or more. The most common response was 10 (24 per cent).

Figure 28: On a scale of 0-10, to what extent do you agree or disagree with the following (where 0=strongly disagree and 10=strongly agree?



3.5 Sharing data and information

Key findings

- People with lived experience participating in systems mapping workshops highlighted that repeatedly being asked for lots of information about themselves can create a barrier to accessing support and reduce trust in services.
- The partners survey results indicate that services are sharing client records, thus reducing the need for people to provide the same information multiple times. The results also indicate that services are using data to better understand multiple disadvantage and improve service design, planning and delivery.
- Despite this, systems mapping workshops found that funded areas still experience many challenges around data and information sharing.
- Organisations supporting people tend not to have shared case management systems and we found limited evidence of other mechanisms for accessing live information on people's interactions with services. This can restrict the extent to which services offer joined-up support and means it is more difficult to get a full picture of population needs and pathways through services.
- Along with the absence of common assessment frameworks, this also increases the risk that people accessing services will need to repeat their story and/or complete several assessments.

Intended outcome: Data shared appropriately
Intended outcome: Data shared and used effectively to better understand multiple disadvantage and respond appropriately
Intended outcome: Co-ordinated information sharing
Effective data sharing is an important part of providing joined-up support for people. Data from across services and sectors is necessary when it comes to building an understanding of the prevalence of multiple disadvantage and planning how best to meet people's needs. People with lived experience of multiple disadvantage who took part in the systems change workshops made it clear they were frustrated when asked to repeat their stories multiple times. This creates a further barrier to accessing support: people may have less trust in services and be reluctant to engage if they are asked for lots of information about themselves on multiple occasions.

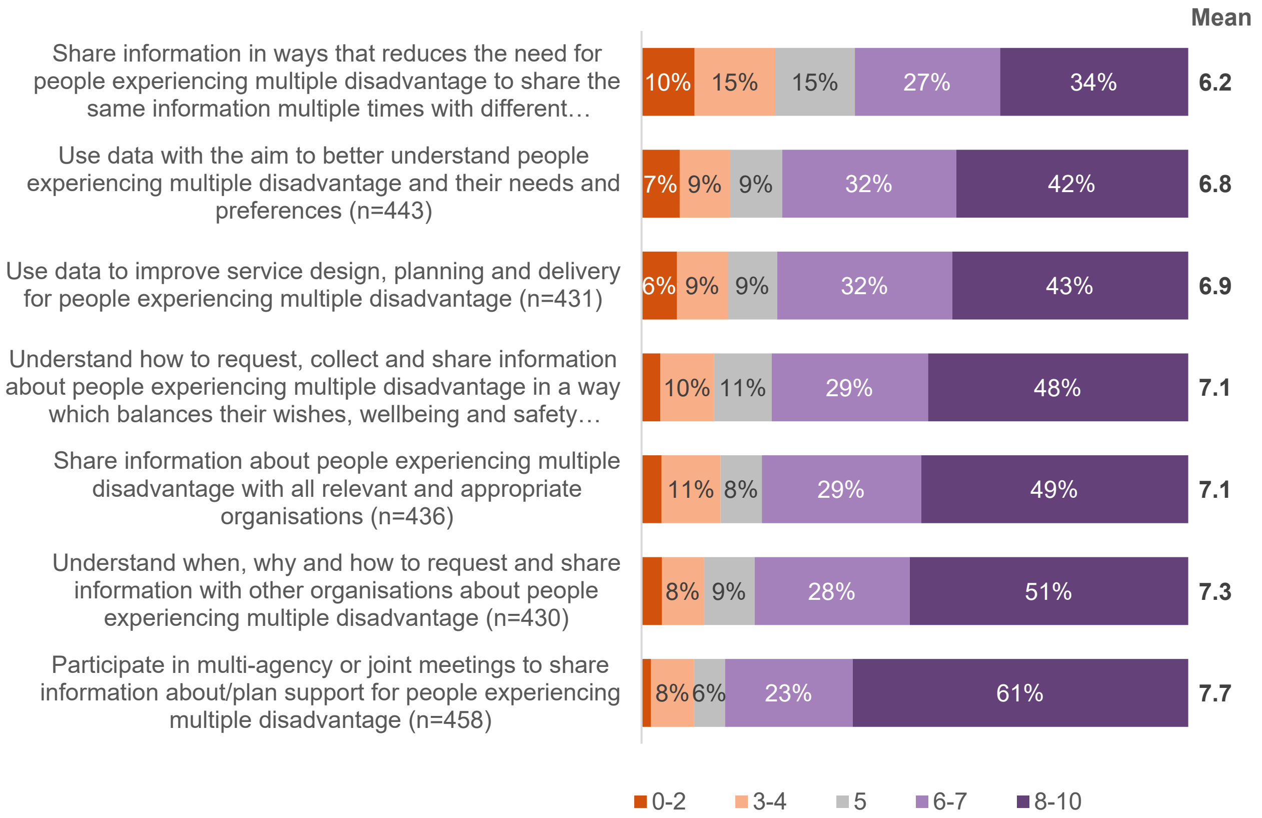
As with other aspects of the system, there are sometimes conflicting findings on this topic, with the partners survey results more positive than the systems mapping exercise. Again, this may be due to the differing groups taking part in each activity.

Responses from the partners survey provide evidence that stakeholders are sharing client records. Over half of respondents (55 per cent) stated that they share client records, data management or information systems with multiple organisations involved in the local system, whilst a further 9 per cent of respondents said they share data with one organisation. This was largely consistent across sectors, apart from domestic abuse and sexual violence services; half of respondents (50 per cent) from this sector reported that they never share client records, data management or information systems.

The partners survey also provides evidence that data is used effectively to better understand multiple disadvantage and respond appropriately, and that staff are following good practice in sharing information about people experiencing multiple disadvantage (Figure 29). People reported that their organisation understands when, why and how to request and share information with other organisations about people experiencing multiple disadvantage at least some of the time – over three-quarters of respondents (79 per cent) gave a score of 6 or above and only one funded area had a mean score of below 5.

Further, respondents generally agreed that their organisations also share information in ways that reduce the need for people experiencing multiple advantage to provide the same information multiple times with different organisations – over half of respondents (61 per cent) reported a score of 6 or above. However, the mean score was 6.2, indicating that there is room for improvement. Respondents were more positive about organisations' use of data to improve service design, planning and delivery for people experiencing multiple disadvantage – the most common score was 7 (21 per cent) and three-quarters of respondents (75 per cent) gave a score of 6 or above.

Figure 29: On a scale of 0-10, to what extent does your organisation do the following (where 0=never and 10=always)?



Evidence from the partners survey suggests that respondents participate in multi-agency meetings to share information and plan support. People generally agreed that their organisation always participates in multi-agency or joint meetings to share information/plan support for people experiencing multiple disadvantage – one-quarter of respondents (25 per cent) strongly agree (score of 10) and over four-fifths (85 per cent) rated their agreement at 6 or above.

As mentioned in Section 3.1, the systems mapping workshops highlighted that there are examples in nearly all funded areas of well-developed multi-agency work. Local partners are enabled to work together through multi-agency structures to plan and coordinate care and share client information on a case-by-case basis, which can help reduce the impact of the lack of a shared case management system.

Nevertheless, despite generally positive findings from the partners survey, systems mapping workshops indicated that funded areas still experience numerous challenges around data and information sharing. One central finding was that different organisations and services involved in supporting people experiencing multiple disadvantage tend not to have shared case management systems. This restricts the extent to which information about people is shared. Firstly, data must be shared on a case-by-case basis, which is time consuming and means that data may not be available immediately to, for example, a first responder. Secondly, staff can be uncertain about whether it is appropriate to share data about a person because of the complexity and variety of different organisations' approaches to information governance. This means that, in some circumstances, the data is just not shared at all, thus restricting the extent to which services can offer joined-up support.

The lack of shared case management systems, combined with the absence of a common assessment framework, also increases the risk that people accessing services will need to repeat their story and/or complete several assessments. For example, even if information has been successfully shared between organisations, it may be that the data collected by one service does not provide the information required by another.

From a strategic perspective, the lack of a shared case management system means it can be challenging to get a full picture of a population's needs and people's pathways. Information about people accessing services is held on separate service- or organisation-level systems, which makes it difficult to understand the extent to which there is overlap in the population of people being supported by services. It also means there is no centralised understanding of what data is available on this group of people across the local system.

4 Conclusions and recommendations

4.1 Changing Futures participants

Despite delays experienced by some areas, by June 2022 the Changing Futures programme (less than a year since the programme started) had already engaged over 1,400 people. Changing Futures targets people with experience of three or more severe forms of disadvantage. Baseline data shows that 77 per cent are indeed in this category, with at least half experiencing four or five forms of disadvantage. This leaves 23 per cent who report experiencing fewer than three types of disadvantage. This could be due to people outside the target group being accepted onto the programme or a result of underreporting of disadvantage due to missing data and people choosing not to answer certain questions in the questionnaires. Further analysis and work with funded areas is underway to better understand this.

Mental health problems are particularly prevalent amongst current programme participants; many experience high levels of anxiety and are unable to manage their conditions. There is also a high degree of overlap between mental ill health and drug and alcohol problems. This is a long-standing barrier when it comes to people getting support.

Beyond the core forms of disadvantage targeted by the programme, participants are also affected by poor physical health, neurodivergence, financial exclusion, social isolation, and are amongst those furthest from the labour market. Most participants are also affected by debt or are behind on their bills. This situation may well escalate given inflationary pressures on the cost of living.

Whilst the majority of participants are male, the programme has rapidly reached a substantial number of women experiencing multiple disadvantage. Their experiences of disadvantage, in particular contact with the criminal justice system, homelessness and domestic abuse, are distinct from those of men. High levels of domestic abuse experienced by women highlight the importance of tailored support to address this. It is important the programme continues to explore and highlight gender differences and showcase effective gender-informed interventions.

People with an Asian background are under-represented amongst programme participants compared to the general population. This may be due to lower prevalence of multiple disadvantage among this community or lower levels of service engagement.

4.2 Public service systems

The variety of disadvantages experienced by participants highlights the range of services people need and helps explain the view that some services perceive people as being ‘too complex’ or ‘too high risk’ to accept on their caseload. Baseline qualitative and quantitative information indicates that access to services and support for people experiencing multiple disadvantage is variable. When seeking to access services that are already over-subscribed (such as GP services or an NHS dentist), people experiencing multiple disadvantage are likely to face additional barriers to the wider population.

Given the range of services, sectors and organisations that people experiencing multiple disadvantage need, siloed and competitive commissioning – both locally and nationally – presents a key barrier to the development of more joined-up services. Short-term funding is also contributing to high levels of staff turnover and inconsistent support for people. Respondents described a lack of clarity around referral pathways; such pathways are not always well communicated and it is not easy to refer people to the support they need. These factors along with high eligibility criteria can drive use of emergency and crisis services: just under half the cohort had visited A&E in the last three months. Some areas are successfully addressing these issues in places, but this does not appear to be widespread or the default approach across systems.

Resolving accommodation issues – whether that be finding a home or moving to more appropriate housing – is a goal for many participants. Systems mapping highlighted that a particular problem is a lack of appropriate housing stock. As highlighted above, people facing multiple disadvantage are likely to find it harder to access in-demand services such as housing. There is a risk that changes to the system delivered through the Changing Futures programme will not be sustainable, or will achieve minimal impact, if issues such as a lack of appropriate accommodation are not addressed.

A frequently mentioned theme in systems mapping workshops was the existence and impact of stigma, prejudice and discrimination surrounding multiple disadvantage. It was suggested that this is sometimes the underlying reason why people do not get access to the support they need. We have therefore added reduced stigma and discrimination surrounding multiple disadvantage as an outcome for the evaluation to explore. Experience of Fulfilling Lives shows this is an area of systems change where progress can be achieved.[54]

Partners survey respondents indicated that services lack understanding of the needs of people with ethnic minority backgrounds experiencing multiple disadvantage. There was also a perception that people with ethnic minority backgrounds are unlikely to make the same progress as others because support is not culturally sensitive and tailored to the needs of this community. Systems mapping workshop participants highlighted the lack of diversity within the sector's workforce, with people of ethnic minority backgrounds predominantly working in entry-level and night roles without the same level of influence on service design.

One of DLUHC's principles underpinning the Changing Futures programme is the adoption of trauma-informed approaches. There appears to be varied levels of understanding of what the term means, as well as differing levels of willingness and capacity to adopt these ways of working, with some staff not feeling like they have the necessary resources and support to work in a trauma-informed way.

Involving people with lived experience at all levels of service design and delivery is also a key programme principle. This is an important way to address stigma, develop understanding about how best to work with people experiencing multiple disadvantage, and provide role models who can demonstrate that recovery is possible. Partners in funded areas are positive about lived experience and the extent to which people with lived experience are involved in decision-making and improving services. However, there is still room for improvement, and it is important that a range of people with different experiences and perspectives are involved in the service design process.

4.3 Data and evaluation issues and priorities

Gathering data from people experiencing multiple disadvantage can be challenging and funded areas are encouraged to adopt a trauma-informed approach to completing questionnaires with people. As a result, there is a substantial amount of missing data, which may mean an under-reporting of experience of disadvantage.

The evaluation team will continue to monitor the profile of participants. DLUHC should continue to engage with funded areas to determine the reasons for the current profile of disadvantage – whether it is due to missing data, mistargeting, or that participants are affected by other forms of disadvantage that are not part of the programme's core definition of multiple disadvantage. Whilst the ReQoL measure indicates high levels of mental ill health, the NDTA scores, in contrast, suggest lower overall levels of need and risk when compared to other similar programmes targeting people experiencing multiple disadvantage. DLUHC and funded areas should check that programme staff are completing the NDTA correctly and organise additional training if necessary.

It is not clear whether low levels of Asian representation among Changing Futures participants is due to lower prevalence of multiple disadvantage or lower levels of engagement with services. This may be a useful topic to explore in greater depth. A different conceptualisation of multiple disadvantage may be required for this community.

Recovery means different things to different people. Helping people to set and work towards individual goals can be an important part of providing personalised support. It is important that the programme, at local and national level, continues to focus on assessing progress against people's individual goals and include this as a source of evaluation evidence.

4.4 Recommended focus for future programme delivery

Funded areas should focus on ensuring ways to access services are clear and well communicated across local partnerships. DLUHC and the programme evaluation should identify effective approaches to improving access to services and communicate these widely across funded areas.

In particular the programme should prioritise identifying and addressing local- and national-level barriers that prevent people with problems with drugs and alcohol from getting personalised and flexible support with mental health issues.

Particular groups of people experiencing multiple disadvantage can be seen as too high risk for some services to support. The programme should explore service-level understanding of and approach to management of risk further. Authoritative, clear and practical guidance for statutory services on how best to support people who are (perceived as) high risk, such as people with a history of arson or violence, could be helpful here.

The programme should harness and build on evidence-based good practice (such as Housing First) in supporting people to sustain tenancies. Funded areas should also consider how they can contribute evidence and learning on the needs of people experiencing multiple disadvantage to local housing strategies.

Siloed and competitive commissioning practice presents a challenge. This will be a focus of future evaluation reports. The programme should prioritise identifying and testing ways to join up commissioning, both locally and nationally, including innovative approaches. Learning on what is effective and what the barriers are should be widely shared.

The programme should explore reasons for differential experiences of services and outcomes for people from minority ethnic backgrounds and investigate ways to improve understanding of culturally specific needs. Good practice on culturally inclusive support should be shared across the funded areas. A lack of diversity in the workforce may be a contributing factor and the barriers for progression for people from minority ethnic backgrounds should be explored further.

Funded areas should take steps to widen the diversity of the lived experience perspectives on which they draw. This should include people who are currently accessing services and those who may struggle to engage through current/traditional user groups or have less positive relationships with services. It should also include the family, friends and support networks of people as well as frontline staff.

DLUHC should continue to help to increase understanding and application of trauma-informed approaches by providing support for funded areas and others to share resources and training that has been co-produced and found to be effective. Training partners and funded areas may wish to consider how training sessions and materials can be tailored to specific roles and sectors so that there are directly applicable and relevant resources for a wide range of people.

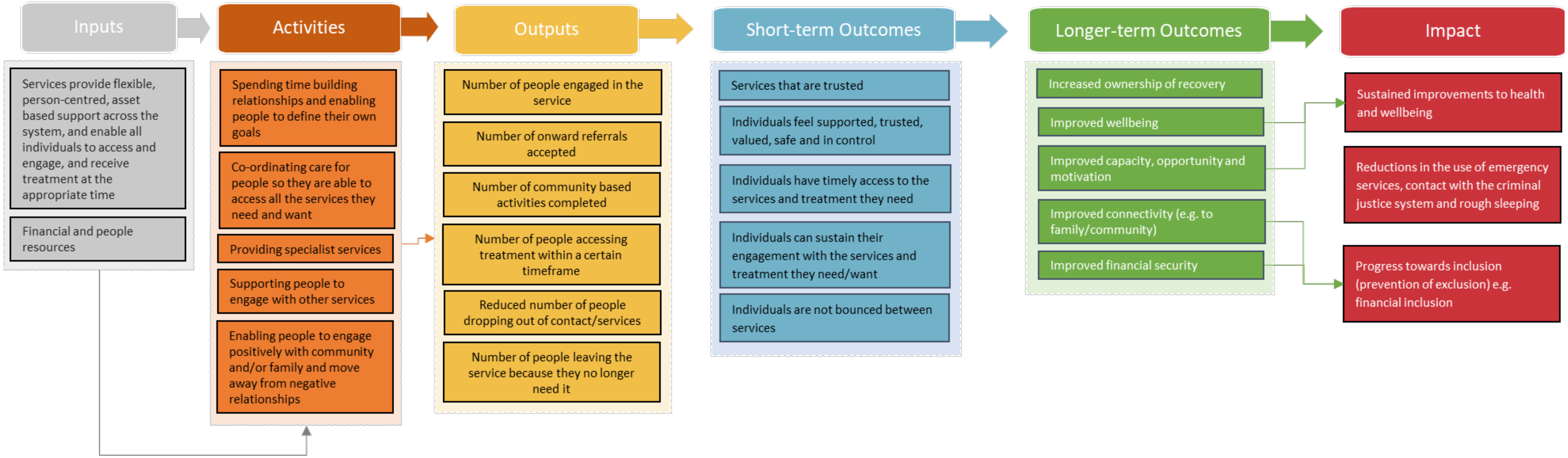
Appendix 1: Programme theory of change

The diagrams below set out the theory of change behind the programme as we understand it so far. This covers three levels – individual, service and local (which might be a regional or local authority level). A text version is provided in Table 15.

The Changing Futures theory of change presents a framework for undertaking a theory-based approach which will be used to evaluate the programme. This is also the basis for the evaluation framework set out in Table 1. The theory of change will be kept under review as part of and throughout the evaluation of the programme.

INDIVIDUAL LEVEL

Context/rationale: Experience of trauma/negative life events or poor health and poor previous experiences of services can lead to mistrust; services are not accessible or co-ordinated and/or do not meet needs appropriately; multiple disadvantage and high levels of needs that are not easily addressed by a single service/disjointed system; services focus on issue rather than the person; lack of support for people at key transition points (e.g. leaving care or prison); services do not always meet the needs of people with protected characteristics.



Inputs

- Services provide flexible, person-centred, asset based support across the system, and enable all individuals to access and engage, and receive treatment at the appropriate time
- Financial and people resources

Activities

- Spending time building relationships and enabling people to define their own goals
- Co-ordinating care for people so they are able to access all the services they need and want
- Providing specialist services
- Supporting people to engage with other services
- Enabling people to engage positively with community and/or family and move away from negative relationships

Outputs

- Number of people engaged in the service
- Number of onward referrals accepted
- Number of community based activities completed
- Number of people accessing treatment within a certain timeframe
- Reduced number of people dropping out of contact/services
- Number of people leaving the service because they no longer need it

Short-term Outcomes

- Services that are trusted
- Individuals feel supported, trusted, valued, safe and in control
- Individuals have timely access to the services and treatment they need
- Individuals can sustain their engagement with the services and treatment they need/want
- Individuals are not bounced between services

Longer-term Outcomes

- Increased ownership of recovery
- Improved wellbeing
- Improved capacity, opportunity and motivation
- Improved connectivity (e.g. to family/community)
- Improved financial security

Impact

- Sustained improvements to health and wellbeing
- Reductions in the use of emergency services, contact with the criminal justice system and rough sleeping
- Progress towards inclusion (prevention of exclusion) e.g. financial inclusion

External influencing factors:
Personal relationships are likely to play a very important role (both positive and negative), but may be largely beyond the control of services
The economic climate is likely to make the achievement of any goals around employment more difficult.

Unintended consequences:
People choosing to move away from negative influences may feel lonely and isolated, with a negative impact on their wellbeing

Key considerations:
Progress through short-term outcomes, to longer-term outcomes, to impact is unlikely to be linear for individuals. What are the implications of this for the length of support provided and for the evaluation?

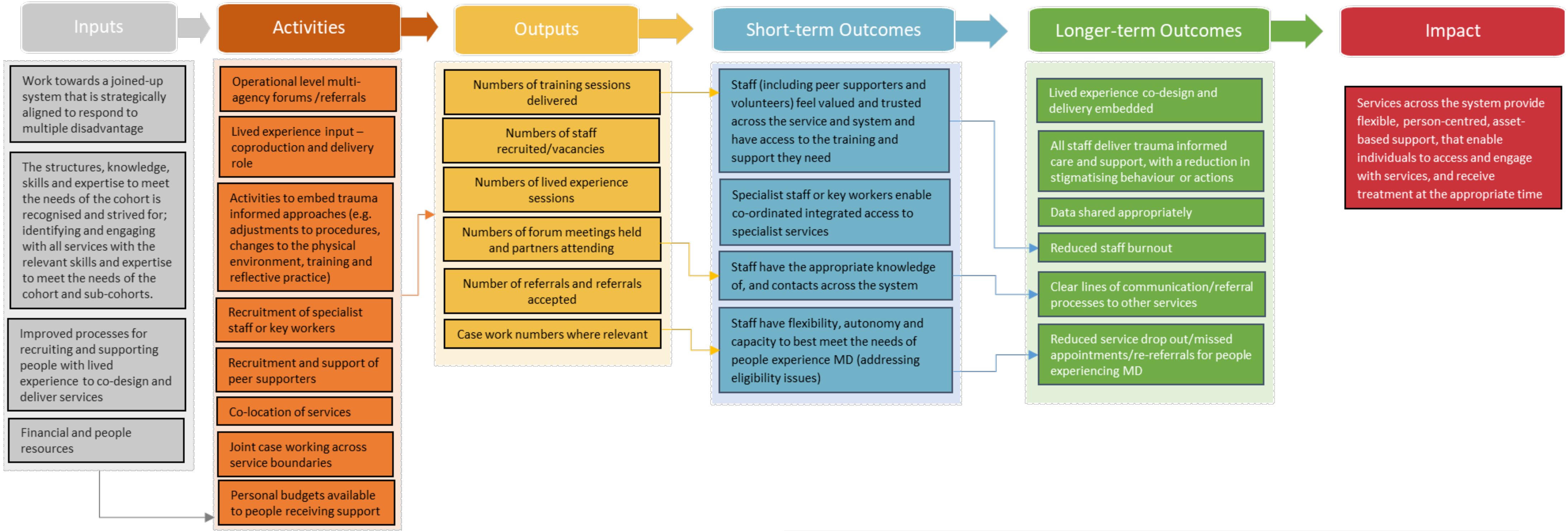
Key assumptions:
A key assumption is that services can play a large enough role in someone's life to make a difference to their overall wellbeing and ability to make changes.

There is also a significant assumption about how the longer-term outcomes will lead to 'harder' impacts such as decreased use of emergency services and reduced contact with the criminal justice system. It is assumed that the goals of individuals will correspond with the intended impacts of the programme. Some assumptions made about the speed with which people's wellbeing and other outcomes can improve. If someone has experienced multiple disadvantage over a long period of time, improvements may not materialise for some time or outside of the evaluation/programme timeframes.

There are assumptions made that access to services and treatment can be improved through better co-ordination, support and flexibility and issues of capacity are outside the scope.

SERVICE LEVEL

Context/rationale: Majority of services have single/restricted issue objectives; specialist services with short term funding and high staff turnover/insufficient workforce; resource pressures leading to increased gatekeeping; poor experience of prior engagement with cohort; focus on deficit-based approaches, instead of instead of relational, trauma-informed and person-centred approaches; stigma surrounding people experiencing multiple disadvantage; underdeveloped co-production with people with lived experience, including reliance on a small number of people



Inputs

- Work towards a joined-up system that is strategically aligned to respond to multiple disadvantage
- The structures, knowledge, skills and expertise to meet the needs of the cohort is recognised and strived for; identifying and engaging with all services with the relevant skills and expertise to meet the needs of the cohort and sub-cohorts.
- Improved processes for recruiting and supporting people with lived experience to co-design and deliver services
- Financial and people resources

Activities

- Operational level multi-agency forums /referrals
- Lived experience input – coproduction and delivery role
- Activities to embed trauma informed approaches (e.g. adjustments to procedures, changes to the physical environment, training and reflective practice)
- Recruitment of specialist staff or key workers
- Recruitment and support of peer supporters
- Co-location of services
- Joint case working across service boundaries
- Personal budgets available to people receiving support

Outputs

- Numbers of training sessions delivered
- Numbers of staff recruited/vacancies
- Numbers of lived experience sessions
- Numbers of forum meetings held and partners attending
- Number of referrals and referrals accepted
- Case work numbers where relevant

Short-term Outcomes

- Staff (including peer supporters and volunteers) feel valued and trusted across the service and system and have access to the training and support they need
- Specialist staff or key workers enable co-ordinated integrated access to specialist services
- Staff have the appropriate knowledge of, and contacts across the system
- Staff have flexibility, autonomy and capacity to best meet the needs of people experience MD (addressing eligibility issues)

Longer-term Outcomes

- Lived experience co-design and delivery embedded
- All staff deliver trauma informed care and support, with a reduction in stigmatising behaviour or actions
- Data shared appropriately
- Reduced staff burnout
- Clear lines of communication/referral processes to other services
- Reduced service drop out/missed appointments/re-referrals for people experiencing MD

Impact

- Services across the system provide flexible, person-centred, asset-based support, that enable individuals to access and engage with services, and receive treatment at the appropriate time

External influencing factors:

The pandemic and the consequences of the pandemic will add significant pressures in the system, but have also revealed the possibilities for new ways of working, focusing on flexibility and innovation.

Staff burnout/wellbeing and turnover will be subject to aspects that are beyond the control of the Local Programme, even when they are work-related - e.g. pay and conditions. The ability of all staff across the system to delivery trauma informed support will be dependent on capacity, and nationally set priorities within those services

Key assumptions:

It is assumed there is sufficient capacity in core specialist services (such as substance misuse) to enable the additional services delivered by the programme to enable people to access to those services. It also assumes core service provision is effective, but timely access and sustainment can be enhanced through additional services/new approaches. It is assumed that high re-referral rates are a negative outcome, but it is possible to interpret it positively, e.g. people returning to a service they previously dropped out of.

Co-production between professionals and people with lived experience is an effective way of overcoming the stigmatisation of people who experience multiple disadvantage

Unintended consequences:

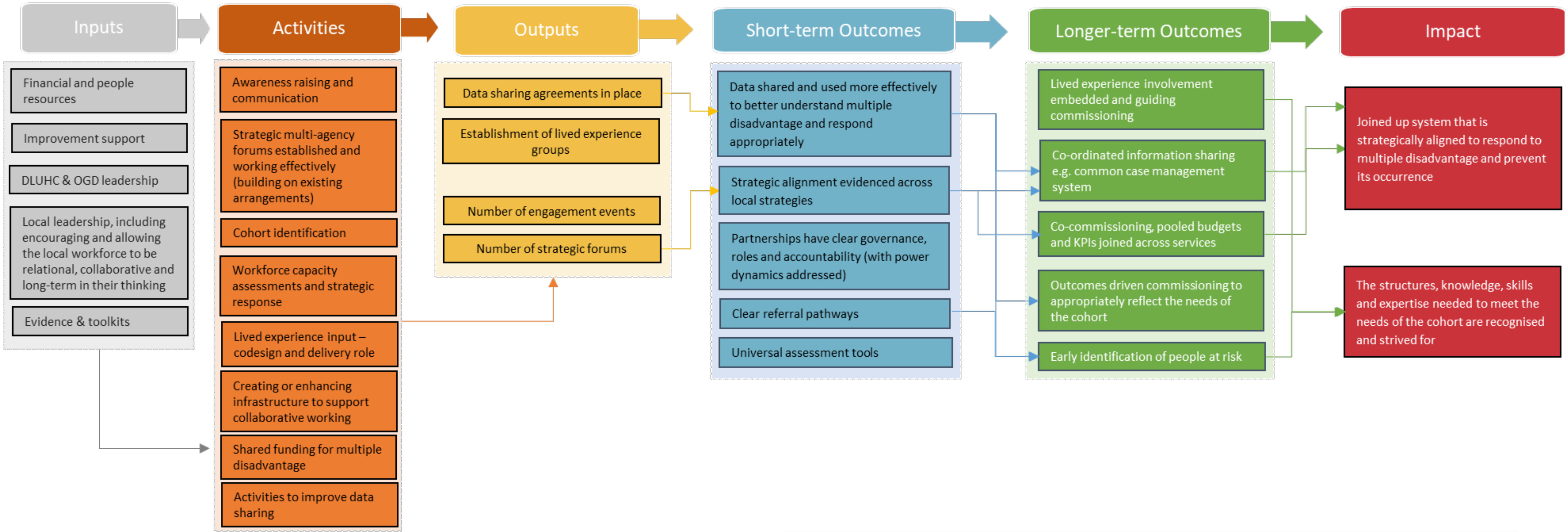
It is possible that more staff time will be used by trying to co-ordinate with other services to start with, until referral processes etc are embedded, so that they actually have less time available for direct work with individuals. Recruitment of additional key workers leads to staff shortages in other services

Key considerations:

Which services are in scope and at what point? For example, consideration is needed about which services are included in the expansion of trauma informed delivery and whether/how community services are regarded as equal partners.

LOCAL SYSTEM LEVEL

Context/rationale: Siloed funding/commissioning at national and local level, contributing to uncoordinated support, few incentives for services to support people experiencing multiple disadvantage and services overly focussed on KPIs. Lack of capacity in some areas (e.g. mental health and housing) and inadequate resources in the system to fund services. Inadequate knowledge and/or consideration of the holistic needs of people experiencing multiple disadvantage exacerbated by absence/ineffectiveness of systems for sharing data. Lack of strategic leadership, incentives or shared will to address this.



Inputs
- Financial and people resources
- Improvement support
- DLUHC & OGD leadership
- Local leadership, including encouraging and allowing the local workforce to be relational, collaborative and long-term in their thinking
- Evidence & toolkits

Activities
- Awareness raising and communication
- Strategic multi-agency forums established and working effectively (building on existing arrangements)
- Cohort identification
- Workforce capacity assessments and strategic response
- Lived experience input – codesign and delivery role
- Creating or enhancing infrastructure to support collaborative working
- Shared funding for multiple disadvantage
- Activities to improve data sharing

Outputs
- Data sharing agreements in place
- Establishment of lived experience groups
- Number of engagement events
- Number of strategic forums

Short-term Outcomes
- Data shared and used more effectively to better understand multiple disadvantage and respond appropriately
- Strategic alignment evidenced across local strategies
- Partnerships have clear governance, roles and accountability (with power dynamics addressed)
- Clear referral pathways
- Universal assessment tools

Longer-term Outcomes
- Lived experience involvement embedded and guiding commissioning
- Co-ordinated information sharing e.g. common case management system
- Co-commissioning, pooled budgets and KPIs joined across services
- Outcomes driven commissioning to appropriately reflect the needs of the cohort
- Early identification of people at risk

Impact
- Joined up system that is strategically aligned to respond to multiple disadvantage and prevent its occurrence
- The structures, knowledge, skills and expertise needed to meet the needs of the cohort are recognised and strived for

External influencing factors:

The pandemic and its consequences will add significant pressures in the system, but have also revealed the possibilities for new ways of working, focusing on flexibility and innovation.

The funding environment (particularly tight finances and short-term settlements) will affect the extent to which strategic commitments can be made to change things and is also likely to impact on the demand for services and the need for a crisis response, with a knock on effect on the capacity for system change and early intervention The intersection of different geographies (and administrative boundaries) may facilitate or create barriers for partnerships or data sharing.

Key assumptions:

It is assumed that a strategically aligned system will positively impact by creating conditions that incentivise, enable and support improvement at service level delivery and partnership work at an operational level

It is assumed that better sharing and access to data will mean that there is better understanding and that people will know how to use it effectively, but this might require additional activities

Unintended consequences:

The focus on identifying people who experience multiple disadvantage reveals the need is greater than expected, putting more pressure on services that might already be stretched.

Key considerations:

To what extent can local actors affect change at a system level, within national constraints?

Which governance structures are most effective and what is the inter-relationship?

What are the geographical boundaries of 'the system' and how do they effect the delivery of the programme?

Table 15 - Programme Theory of Change (text version)

Level 1	Individual level
Context/ problem	Experience of trauma/negative life events or poor health and poor previous experiences of services can lead to mistrust Services are not accessible or co-ordinated and/or do not meet needs appropriately Multiple disadvantage and high levels of needs that are not easily addressed by a single service/disjointed system Services focus on issue rather than the person Lack of support for people at key transition points, e.g. leaving care or prison Services do not always meet the needs of people with protected characteristics, e.g. women, LGBT people, people from ethnic minority backgrounds
Inputs	Services provide flexible, person-centred, asset based support across the system, and enable all individuals to access and engage, and receive treatment at the appropriate time Financial and people resources
Activities	Spending time building relationships and enabling people to define their own goals Co-ordinating care for people so they are able to access all the services they need and want Providing specialist services Supporting people to engage with other services Enabling people to engage positively with community and/or family and move away from negative relationships
Outputs	Number of people engaged in the service Number of onward referrals accepted Number of community based activities completed Number of people accessing treatment within a certain timeframe Reduced number of people dropping out of contact/services Number of people leaving the service because they no longer need it
Short-term outcomes	Services that are trusted Individuals feel supported, trusted, valued, safe and in control Individuals have timely access to the services and treatment they need Individuals can sustain their engagement with the services and treatment they need/want Individuals are not bounced between services
Longer-term outcomes	Increased ownership of recovery Improved wellbeing; Improved financial security

Level 1	Individual level
	Improved capacity, opportunity and motivation; Improved connectivity (e.g. to family/community)
Impacts	Sustained improvements to health and wellbeing, Reductions in the use of emergency services, contact with the criminal justice system and rough sleeping; Progress towards inclusion (prevention of exclusion) e.g. financial inclusion
Key assumptions	A key assumption is that services play a large enough role in someone's life to make a difference to their overall wellbeing and ability to make changes, over and above external factors. There is also a significant assumption about how the longer-term outcomes e.g. of improved wellbeing or ownership of recovery will lead to 'harder' impacts around decreased use of emergency services and reduced contact with the criminal justice system. It is assumed that the goals of individuals will correspond with the intended impacts of the programme. Some assumptions made about the speed with which people's wellbeing and other outcomes can improve. If someone has experienced multiple disadvantage over a long period of time, it may be that improvements will not materialise for some time or even outside of the evaluation/programme timeframes. There are assumptions made that access to services and treatment can be improved through better co-ordination, support and flexibility and issues of capacity are outside the scope.
External factors	Personal relationships are likely to play a very important role (both positive and negative), but may be largely beyond the control of services The economic climate is likely to make the achievement of any goals around employment more difficult.
Unintended consequences	People choosing to move away from negative influences may feel lonely and isolated, with a negative impact on their wellbeing
Key considerations	Progress through short-term outcomes, to longer-term outcomes, to impact is unlikely to be linear for individuals. What are the implications of this for the length of support provided and for the evaluation?

Level 2	Service level
Context/ problem	Majority of services have single / restricted issue objectives Specialist services with short term funding and high staff turnover/insufficient workforce Funding cuts leading to increased gatekeeping Thresholds/criteria for eligibility Possible poor experience of prior engagement with cohort Focus on deficit-based approaches, instead of instead of relational, trauma-informed and person-centred approaches Stigma surrounding people experiencing multiple disadvantage Underdeveloped co-production with people with lived experience, including reliance on a small number of people
Inputs	Work towards a joined-up system that is strategically aligned to respond to multiple disadvantage The structures, knowledge, skills and expertise to meet the needs of the cohort is recognised and strived for; identifying and engaging with all services with the relevant skills and expertise to meet the needs of the cohort and sub-cohorts. Improved processes for recruiting and supporting people with lived experience to co-design and deliver services Financial and people resources
Activities	Operational level multi-agency forums /referrals Lived experience input – coproduction and delivery role Activities to embed trauma informed approaches, including but not limited to adjustments to procedures, changes to the physical environment, training and reflective practice Recruitment of specialist staff or key workers Recruitment and support of peer supporters Co-location of services Joint case working across service boundaries Personal budgets available to people receiving support
Outputs	Numbers of training sessions delivered Numbers of staff recruited/vacancies Numbers of lived experience sessions Numbers of forum meetings held and partners attending

Level 2	Service level
	Number of referrals and referrals accepted Case work numbers where relevant
Short-term outcomes	Staff (including peer supporters and volunteers) feel valued and trusted across the service and system and have access to the training and support they need Specialist staff or key workers enable co-ordinated integrated access to specialist services Staff have the appropriate knowledge of, and contacts across the system Staff have flexibility, autonomy and capacity to best meet the needs of people experience MD (addressing eligibility issues)
Longer-term outcomes	Lived experience co-design and delivery embedded All staff deliver trauma informed care and support, with a reduction in stigmatising behaviour or actions Data shared appropriately Reduced staff burnout Reduced service drop out/missed appointments/re-referrals for people experiencing MD Clear lines of communication/referral processes to other services
Impacts	Services across the system provide flexible, person-centred, asset-based support, that enable individuals to access and engage with services, and receive treatment at the appropriate time
Key assumptions	It is assumed there is sufficient capacity in core specialist services (such as substance misuse) to enable the additional services delivered by the programme to enable people to access to those services. The ToC also largely assumes that the core service provision is effective, but timely access and sustainment can be enhanced through additional services/new approaches It is assumed that high re-referral rates are a negative outcome, but it is possible to interpret it positively, in terms of people returning to a service they have previously dropped out of (particularly if self-referring) Co-production between professionals and people with lived experience is an effective way of overcoming the stigmatisation of people who experience multiple disadvantage
External factors	The pandemic and the consequences of the pandemic will add significant pressures in the system, but have also revealed the possibilities for new ways of working, focusing on flexibility and innovation.

Level 2	**Service level**
	Staff burnout/wellbeing and turnover will be subject to aspects that are beyond the control of the Local Programme, even when they are work-related - e.g. pay and conditions The ability of all staff across the system to delivery trauma informed support will be dependent on capacity, and nationally set priorities within those services
Unintended consequences	It is possible that more staff time will be used by trying to co-ordinate with other services to start with, until referral processes etc are embedded, so that they actually have less time available for direct work with individuals Recruitment of additional key workers leads to staff shortages in other services
Key considerations	Which services are in scope and at what point? For example, consideration is needed about which services are included in the expansion of trauma informed delivery and whether/how community services are regarded as equal partners.

Level 3	**Local system level**
Context/ problem	Siloed funding/commissioning at national and local level - this contributes to issues such as support that is not joined up, a lack of incentive for services to support people experiencing multiple disadvantage and services focussed on KPIs rather than providing the best support for people Lack of capacity in some areas (e.g. mental health) Inadequate knowledge and/or consideration of the holistic needs of people experiencing multiple disadvantage exacerbated by absence or ineffectiveness of systems for sharing data about individuals Lack of strategic leadership, incentive or shared will to address this Inadequate resources in the system to fund services and support for people experiencing multiple disadvantage
Inputs	Financial and people resources Improvement support DLUHC/OGD leadership Local leadership, including encouraging and allowing the local workforce to be relational, collaborative and long-term in their thinking

Level 3	Local system level
	Evidence and Toolkits
Activities	Awareness raising and communication Strategic multi-agency forums established (including the VCS) and working effectively (building on existing arrangements) Identification of the cohort Workforce capacity assessments and strategic response Lived experience input – codesign and delivery role Creating or enhancing infrastructure to support collaborative working such as generating or furthering existing partnership structures and forums at both a strategic and operational level Pooled budgets/shared funding for multiple disadvantage and/or reviews of service commissioning Activities to improve information and data sharing between partners
Outputs	Data sharing agreements in place Establishment of lived experience group Number of engagement events Number of strategic forums
Short-term outcomes	Data shared and used effectively to better understand multiple disadvantage and respond appropriately Strategic alignment evidenced across local strategies Partnerships have clear governance, roles and accountability (with power dynamics addressed) Clear referral pathways Universal assessment tools
Longer-term outcomes	Lived experience involvement embedded and guiding commissioning Co-ordinated information sharing e.g. common case management system Co-commissioning, pooled budgets and KPIs joined across services Outcomes driven commissioning to appropriately reflect the needs of the cohort Early identification of people at risk
Impacts	Joined up system that is strategically aligned to respond to multiple disadvantage and prevent its occurrence

Level 3	**Local system level**
	The structures, knowledge, skills and expertise needed to meet the needs of the cohort are recognised and strived for
Key assumptions	It is assumed that a strategically aligned system will positively impact by creating conditions that incentivise, enable and support improvement at service level delivery and partnership work at an operational level. It is assumed that better sharing and access to data will mean that there is better understanding and that people will know how to use it effectively, but this might require additional activities.
External factors	The pandemic and the consequences of the pandemic will add significant pressures in the system, but have also revealed the possibilities for new ways of working, focusing on flexibility and innovation. The funding environment (particularly tight finances and short-term settlements) will affect the extent to which strategic commitments can be made to change things. The financial climate is also likely to impact on the demand for services and the need for a crisis response, with a knock on effect on the capacity for system change and early intervention. The intersection of different geographies (and administrative boundaries) may facilitate or create barriers for partnerships or data sharing.
Unintended consequences	The focus on identifying people who experience multiple disadvantage reveals the need is greater than expected, putting more pressure on services that might already be stretched.
Key considerations	To what extent can local actors affect change at a system level, within national constraints? Which governance structures are most effective and what is the inter-relationship? What are the geographical boundaries of ‘the system’ and how do they effect the delivery of the programme?

Appendix 2: Funded areas and summary approaches

Essex

Administrative area	Two-tier county
Strategic oversight	Wellbeing, Public Health & Communities (Essex County Council) feeds into Reducing Reoffending Board and in turn Safer Essex Board.
Front line service design	• Front line support provided by specialist voluntary sector organisation, Phoenix Futures. • Team provides intensive, consistent wrap-around support, with a rolling caseload of a maximum of approximately 20 clients per support worker; and co ordinates partnership working between agencies to form a multi agency/MDT approach to address individual needs • Funded projects in districts responding to local need, such as dedicated housing support to sustain tenancies for people experiencing multiple disadvantage. • Dedicated Mental Health and Wellbeing Team to support clients with mental ill health • Development of a wide variety of enjoyable and meaningful activities /pursuits for clients to engage in
Cohort Identification approach	Cohort is agreed through multi-agency consensus. If a person receives multiple referrals from different organisations, they are prioritised.
System level approach	• Further expansion/adaption of the model to support different combinations of multiple and complex needs, according to local need • Strengthen links with the three Integrated Care Partnerships which cover different parts of Essex • Establish a strategic alliance which brings together commissioners /service leads to drive system change, eg opportunities for joint commissioning of services

	- Enhance existing data platform and improve data analysis, including expanding partner access. - Increase involvement of people with lived experience of multiple disadvantage and genuine co production becomes embedded within services

South Tees

Administrative area	Two Unitary Authorities
Strategic oversight	Joint Health and Wellbeing Board
Front line service design	- Key worker service offering intensive one-to-one support and guidance with 15 clients per key worker and 12 where cases are complex via Enhanced Caseload Workers. - Complemented by multi-agency “team around the individual” for coordinated support.
Cohort Identification approach	Building on existing referral processes, with the initial cohort drawn from those already known to multiple services. Self referrals are also accepted and assessed.
System level approach	- Build the case to mainstream a Key Worker approach - Establish system for ongoing learning from front line delivery about systemic barriers to effective care and support, and process to address them. - Improve collaboration with relevant voluntary and community sector organisations at strategic and operational levels to enable more access to community support and activity. - Embed trauma-informed practice across the system.

Leicester

Administrative area	Unitary Authority
Strategic oversight	Led by Leicester Council Social Care & Early Help team, and accountable to the Leicester Community Safety (Safer Leicester) Partnership
Front line service design	• Multi-disciplinary team with intensive support workers and specialist workers, some seconded from specialist agencies such as the police. • Regular multi-agency meetings to review referrals and agree action plans based around individual needs. • Supported by a data warehouse to improve system-wide knowledge of individuals and overall need. • Partnership learning reviews of closed cases to identify areas of improvement and drive change for individuals, service, and system.
Cohort Identification approach	Transfer of appropriate cases from aligned work focussing on anti-social behaviour associated with rough sleeping, and referral from partner agencies.
System level approach	• Expand strategic partnership on multiple disadvantage, including establishing Multiple Disadvantage Strategic Board • Improve cohort identification with a particular focus on those with mental health issues and sex workers • Develop a ‘no wrong door’ approach for service access • Sustain a multi-disciplinary intensive support service.

Surrey

Administrative area	Two-tier county (with eleven districts and boroughs)
Strategic oversight	Health and Wellbeing Board
Front line service design	• A delivery provider consortium of ten local VCSE organisations called “Bridge the Gap”, delivers specialist assertive Trauma Outreach services, supported by a cloud-based referral and case management system. A consultant clinical psychologist leads the referrals panel into Bridge the Gap and provides clinical supervision and support to the specialist VCSE Trauma Workforce. Specialist Trauma outreach workers intensively case work with average caseloads of 3 or 4:1 and a maximum caseload of 8:1. • Mapping out prototype pathways identifying system “bouncing” including Dual Diagnosis. Co-designing and producing integrated solutions with Lived Experience networks, VCSE and other professionals and incorporating these into Bridge the Gap Trauma Outreach Referrals and Service. Piloting a Bridge the Gap /Social Prescription partnership in North West Surrey. • A Lived Experience network for multiple disadvantage co-designs all Changing Futures initiatives and a peer mentoring system is being developed.
Cohort Identification approach	Open referral to the programme and targeted identification through existing case load of “Bridge the Gap” partners.
System level approach	• Multiple disadvantage addressed in Health & Wellbeing strategy. • Develop a trauma informed MD strategy and common skills and performance frameworks, aiming to embed trauma informed working across Surrey • Goal to fund sustainable delivery through “business as usual” funding streams through joint commissioning forums.

Sussex

Administrative area	2x Two-tier county & 1 Unitary Authority
Strategic oversight	Strategic Sponsors Group – a bespoke oversight forum for Sussex Changing Futures
Front line service design	• Each upper-tier council has scaled-up multi-disciplinary teams, with varying roles depending on identified local need. • In Brighton & Hove, the team is based within Adult Social Care. • In West Sussex, teams are based within three voluntary sector touchpoints. • In East Sussex, a phased approach responsive to changes within existing service provision. • Teams establish multi agency care plans and pathways based on individual need. • Peer Support is a key element in each team.
Cohort Identification approach	Assertive outreach and engagement service with a particular focus on people moving and falling between the upper-tier council areas, and women experiencing domestic abuse and child removals. Strong links with safeguarding and multi-agency risk management processes.
System level approach	• Alignment with key strategies across Sussex, such as the Integrated Care Strategy. • Pan-Sussex data transformation project. • Pan Sussex Commissioners network. • Trauma informed workforce development. • Establishment of multi-disciplinary partnerships within each upper-tier authority area. • Lived experience involvement in all governance and decision-making structures.

Greater Manchester

Administrative area	Combined Authority, with four innovation sites delivering (Manchester, Oldham, Rochdale, Wigan)
Strategic oversight	Greater Manchester Combined Authority (GMCA)
Front line service design	Varied across the 4 sites: • Manchester – support team linked to Multi-Agency Prevention & Support meetings (adult social care-led) and wider place-based work bringing services for vulnerable adults together. • Oldham – support team with peer support and focus on women experiencing multiple disadvantage. • Rochdale – multi-disciplinary team, with emphasis on improved collaboration across health, homelessness & VCSE partners on multiple disadvantage. • Wigan – complex dependency navigator team, working in outreach settings aligned to Wigan's neighbourhood delivery approach and mainstreaming inot Adult Social Care.
Cohort Identification approach	• Manchester: Referral, primarily through Multi-Agency Prevention & Support meetings & Street Engagement Hub • Oldham: Case nomination agreed between partners, plus range of informal pathways • Rochdale: Flexible approach, including case nomination agreed between partners • Wigan: Combined outreach & referral.
System level approach	Aligned with GMCAs wider reform approach, the programme includes • Shared learning structures across innovation sites and beyond, including 2 new localities • Multi-agency workforce collaborative driving trauma-informed working and understanding of multiple disadvantage in mainstream services • data accelerator working to improve cross-sector data and analytics.

	• Lived experience involvement embedded in the innovation sites and regional level work, including through traineeships supporting lived experience in the workforce. • A regulation experiment exploring how a ‘whole system’ approach to regulation could work better for multiple disadvantage.

Northumbria

Administrative area	Police and Crime Commissioner area covering six Unitary Authorities
Strategic oversight	Gateshead Public Service Reform team, newly created CFN Reference Group.
Front line service design	• Intensive support from case workers based in ‘touch points’ services, such as homelessness and substance misuse which serve high proportions of people experiencing multiple disadvantage. • ‘Liberated method’ approach to support, highly tailored to what is important to each beneficiary and bounded by two rules – do no harm and comply with the law. • Drawing in specialist services around the person as far as possible, rather than referring them. • Regular debriefs to share learning with an evidence team to identify and act on systemic challenges.
Cohort Identification approach	Through agreement with the touch point service hosting each Changing Futures service.
System level approach	• Iterative approach to system priorities, unearthing barriers to effective care and support though in-depth observation and analysis of patterns in the front-line work. • Governance experiment – the Regional Enablers Network of local leaders - designed to have continuous learning focus and build commitment to wider reform through the process of surfacing, highlighting and addressing system barriers.

Plymouth

Administrative area	Unitary Authority
Strategic oversight	Plymouth Complex Needs Alliance commissioners in city council, accountable to Homelessness Prevention Executive and feeding into multiple partnership boards.
Front line service design	Changing Futures funding focused on system change and targeted enhancements to existing Plymouth Alliance[1], rather than a new client-facing service. This includes: • Testing targeted pilots with view to mainstreaming within Alliance, including personal budgets pilot for women involved in sex work & support for domestic abuse perpetrators with complex needs; • Improvements to Multi-Agency Risk Assessment Conference (MARAC) case management • Peer Research Network, working across Plymouth to co-produce improvements in service • A volunteering offer, and 'learning exchange' for people with experience of multiple disadvantage to develop skills • Housing accreditation scheme to improve quality and availability of temporary accommodation for people experiencing multiple disadvantage.
Cohort Identification approach	Varied, linked to existing Plymouth Complex Needs Alliance.
System level approach	• Leading Plymouth System Optimisation project, focused on driving better join up at frontline level between the Alliance & wider homelessness support. • Revised monitoring, learning and evaluation framework for Alliance. • Criminal Justice system priority, to improve alignment with criminal justice partners • Developing and testing new 'data passport' approach, and improving data sharing & case management

	- Establish new System Innovation Forum and coordinate trauma-informed Plymouth network.

Nottingham

Administrative area	Unitary Authority
Strategic oversight	Nottingham City Place Based Partnership which feeds into Health and Wellbeing Board and Nottingham & Nottinghamshire Integrated Care Partnership
Front line service design	• Navigator service of case workers providing intensive support with low caseloads (7-8 people) • Targeted case workers to enhance support for women and people from ethnic minority backgrounds • Embedded workers in primary care, housing, mental health and probation settings, unblocking access issues and creating multi-disciplinary team. • Peer mentors
Cohort Identification approach	Open referral process, assessed against modified New Directions Team Assessment/ "Chaos" Index tool.[‡‡]
System level approach	• Severe & Multiple Disadvantage now identified as a priority in the Health & Wellbeing Board strategy and Nottingham & Nottinghamshire Integrated Care Strategy. • Links across Nottinghamshire to proote development of SMD approaches beyond the City • Workforce development across the system through Practice Development Unit [§§] • Developing joint commissioning and service planning for multiple disadvantage

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[‡‡] South West London and St George's Mental Health NHS Trust (2008) *The New Directions Team Assessment (Chaos Index)* http://www.meam.org.uk/wp-content/uploads/2010/05/NDT-Assessment-process-summary-April-2008.pdf

[§§] Changing Futures and Nottingham Community and Voluntary Service, *Nottingham Practice Development Unit (PDU) Online Platform* https://www.pdunottingham.org/

	• Developing more effective use of data through dashboards and system-wide metrics, with embedded data role in Integrated Care System • Lived Experience Team to promote involvement in design and delivery of help provided across the system.

Sheffield

Administrative area	Unitary Authority
Strategic oversight	Vulnerable adults commissioning team in council, feeding in to bespoke Changing Futures partnership board and multiple statutory boards
Front line service design	• Core team of keyworkers providing intensive support, with low caseloads (7-8 people). • Additional specialist roles, including psychologist, social worker, housing specialist, and domestic violence support. • Peer support service • Positive activity fund
Cohort Identification approach	Data matching exercise with partners to identify 81 most vulnerable people in the city experiencing multiple disadvantage.
System level approach	• Agreed eight targeted priority system workstreams, including improved approaches to risk management; responding to cuckooing; and improved mental health support and access to physical health services. • Regular learning reports to build evidence and local case for change. • New lived experience service supporting new service design and developing new quality assurance offer for mainstream services.

Stoke

Administrative area	Unitary Authority
Strategic oversight	A Changing Futures Board chaired by the CEO of Expert Citizens and consisting of senior strategic and operational leaders across the city provides system leadership and decision making, overview and scrutiny. The Board reports into Health & Wellbeing Board, Community Safety Partnership and Homelessness Reduction Board.
Front line service design	• Multi-agency case coordination team employed by key service providers who work for and with the wider system (homelessness, domestic abuse, women, hospital discharge, prison release and young people) organisations supporting people of MD. • Each case coordinator coordinates the development and delivery of a coordination plan with all key stakeholders involved in the person's care (e.g. fact finding, case analysis, advocacy and coordination of services using person-centred, trauma-informed, and strengths-based approaches) for up to 12 people experiencing multiple disadvantage.
Cohort Identification approach	Referral process from agencies mainly located at transition points, e.g., hospital, prison discharge, probation, social care or police as well as other agencies across the city. The Multi Agency Resolution Group (MARG) facilities decision and planning of care and support for the most complex cases with direct referrals coming through similar routes.
System level approach	• Develop and embed a system-wide model of co-ordinated care • Project Board continues transition to System Change Decision Making approvals linking into wider Staffordshire and Stoke on Trent Integration Plans with reporting fully integrated into Health and Wellbeing Board/ICB Board by 2025. • Improving workforce skills, recruitment and retention • Ensure lived experience expertise is embedded within commissioning, procurement and planning of service provision. • Model a single approach for data and information sharing.

Lancashire

Administrative area	Integrated Care System area covering two-tier county plus 2 Unitary Authorities
Strategic oversight	Lancashire Changing Futures Board overseeing programme delivery, with links to various statutory partnership boards. Plan to bring multiple disadvantage into the remit of the Lancashire Levelling Up to Advantage board and growing that membership to include Integrated Care Board leads
Front line service design	• Multi-agency team co-ordinated through specialist voluntary sector organisations Red Rose Recovery, The Well & Empowerment. • These organisations provide intensive, wrap around support through a paid lived experience team (LET) who advocate on behalf of beneficiaries and connect to service provisions. • Caseloads of around 20 to meet increased demands
Cohort Identification approach	Referral and outreach working. Eligibility is determined by a multiagency consensus with referrals from across the system.
System level approach	• Four localities which reflect different local government boundaries and ecosystems of commissioned and voluntary services. • Engagement with leads for all new footprints alongside the 5 Integrated Care Board places. • Identify and embed changes across the whole area. • Improve consistency of service offer • Improve responses to trauma and workforce development

Westminster

Administrative area	London Borough
Strategic oversight	Changing Futures Board have accountability. A separate Multiple Disadvantage Partnership Board provide governance and assurance.
Front line service design	• Multiagency teams with multiskilled practitioners providing wraparound service with trauma informed and clinical interventions with a compassioned focused therapeutic approach • Taking an assertive outreach and place-based approach to support. • Multiple specialist pilots including, young adults, change resistant and victims of domestic abuse.
Cohort Identification approach	Utilise a service promotion approach across partners, accepting referrals from multiple sources (including self-referrals).
System level approach	• Test new ways of working with people; experiment to discover what models of service and interventions are most powerful • Identifying the most wicked systemic problems, which can only be solved through radical collaboration • Build a system that can more routinely and effectively respond to complex social needs (such as multiple disadvantage) • Create Lasting System-wide Change by using learning from across the programme, including learning from the new front-line services and delivery models, to identify recommendations & ‘demands’, for longer-term change & legacy

Bristol

Administrative area	Unitary Authority
Strategic oversight	Health & Wellbeing board
Front line service design	• Focus on specific cohorts (young adults from ethnic minority backgrounds, chronic homelessness and women experiencing domestic abuse). • Three lens approach brought into the delivery of the work; o Co-production o EDI o Trauma informed • My Team Around Me (MTAM) – a virtual flexible, client-led multi-disciplinary team model which acknowledges trauma and EDI factors on the experiences of those experiencing multiple disadvantage. • Small caseloads of up to 10 shared between two lead professionals • Single support plan for each person.
Cohort Identification approach	Nominations to a multiagency panel
System level approach	• My Team Around Me blueprint embedded as a way of supporting people facing multiple disadvantage to live a life beyond services • Collective & shared safety planning and considered risk taking is embedded in multiple disadvantage support • Integrated commissioning processes for multiple disadvantage support and early intervention • The conditions are created for lasting cultural, and system change for people facing multiple disadvantage to live a life beyond services

Hull

Administrative area	Unitary Authority
Strategic oversight	Health and Wellbeing Board
Front line service design	• Co-ordinated multi-disciplinary team • Taking an ‘Make Every Adult Matter’ approach • Navigator service offering support and guidance • ‘No wrong-door' approach to services
Cohort Identification approach	Referrals to multi-agency panel who sit weekly to agree appropriate agency. Focus on Adult Social Care, sex workers and neurological conditions.
System level approach	• Transform the system through integrating services & implementing new models of accommodation and support • Establish and embed coproduction to address barriers and system gaps and implement longer-term strategies • Trauma Informed City work to embed across Hull City Council • System thinking across all services to remove silo working

Appendix 3: Summary systems map

The most common and significant strengths and barriers identified throught the system mapping exercises across the areas are represented in the system map in Figure 30 (see the guidance below). The map also reflects the most important relationships between the strengths and barriers, although there are many more ways in which these are related to each other than are feasible to depict in the map. A list of these strengths and barries is provided on Table 16.

Several of the barriers identified are key underpinning factors in other barriers, and perhaps, therefore, the most important to address where possible. These are: complex geographies; siloed and competitive commissioning; short-term funding; the stigma related to multiple disadvantage; and, more broadly, the limited (and insufficient) resourcing available.

All of the identified strengths offer potential ways to address system barriers (leverage points). These vary by area, and not all local systems experiencing a particular barrier will also have the corresponding strength that can help to address the barrier. However, the Changing Futures programme offers an opportunity for areas to learn from one another, share evidence of what works, and share, to some extent, these strengths across locality boundaries.

Reading and using the systems map

The system map has been developed using the systems mapping software Kumu. You can access an interactive version of the map via your web browser.

- The barriers are represented by orange squares; the strengths are represented by green circles.
- The solid arrows indicate the causal connections between barriers that were judged to be most important by participants; the dotted arrows indicate the potential for strengths to positively influence barriers.
- The darker borders indicate the barriers that are also key underpinning barriers in other factors (as described above) and the strengths that have the potential to help address most, if not all, barriers.

If viewing the interactive online version, you can isolate a strength or barrier and view only the other related factors by hovering your cursor over your chosen strength or barrier.

Figure 30: Overarching system map of key strengths and barriers across the Changing Futures areas

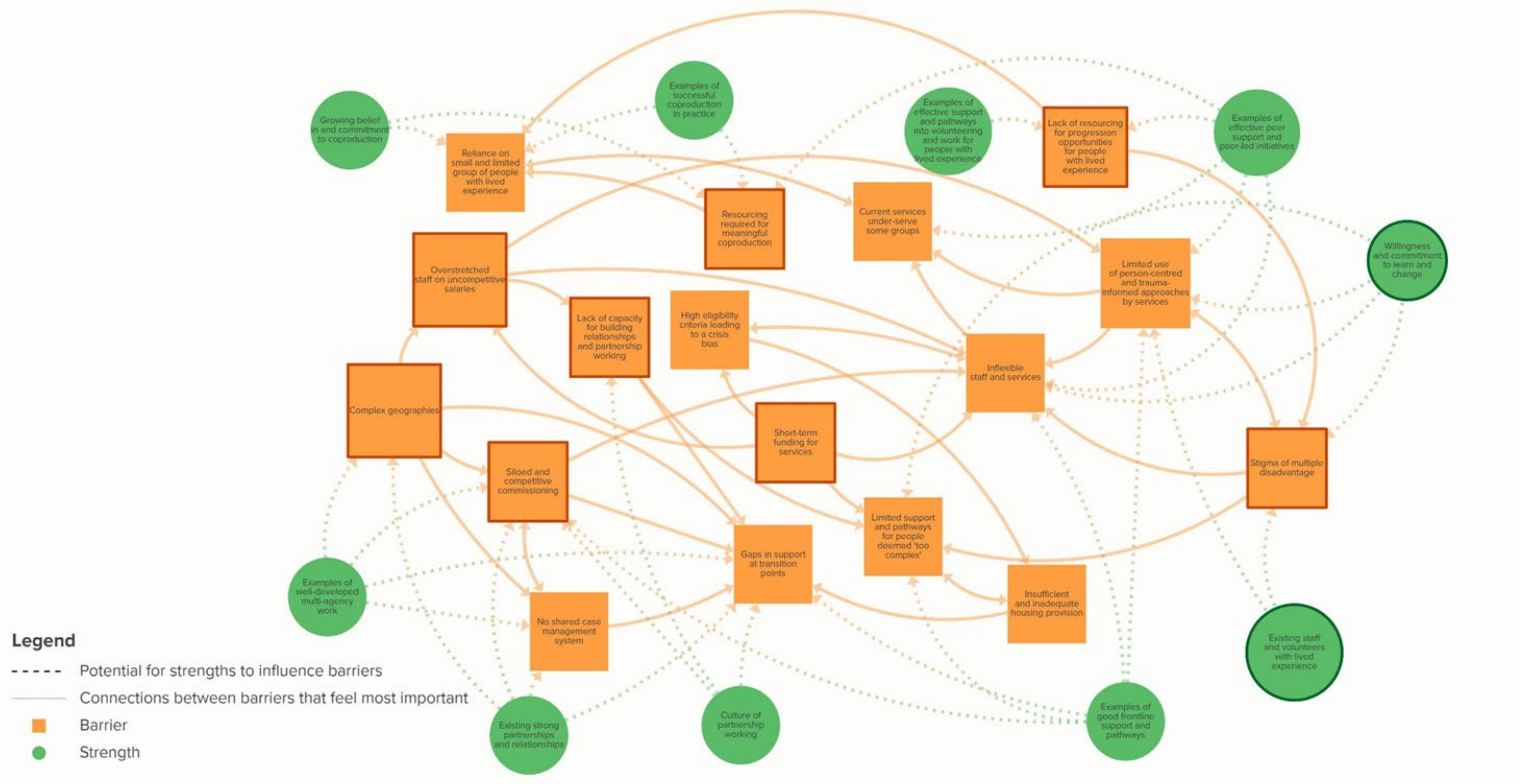

Table 16 – List of overarching strengths and barriers across the Changing Futures areas

Barriers

Category	Barrier
Limited resources	• Overstretched staff on uncompetitive salaries • Short-term funding for services • Lack of capacity for building relationships and partnership working • Resourcing required for meaningful coproduction
Culture	• Stigma of multiple disadvantage
Structures, systems, processes	• Siloed and competitive commissioning • Complex geographies • No shared case management system
Involving people with lived experience	• Reliance on small and limited group of people with lived experience • Lack of resourcing for progression opportunities for people with lived experience
Limited and inflexible provision and pathways	• High eligibility criteria leading to a crisis bias • Limited support and pathways for people deemed “too complex” • Insufficient and inadequate housing provision • Inflexible staff and services • Gaps in support at transition points • Limited use of person-centred and trauma-informed approaches by services • Current services under-serve some groups

Strengths

Category	Strength
Existing relationships and expertise	• Existing staff and volunteers with lived experience • Existing strong partnerships and relationships
Existing examples from which the system can learn	• Examples of well-developed multi-agency work • Examples of good frontline support and pathways • Examples of effective peer support and peer-led initiatives • Examples of successful coproduction in practice • Examples of effective support and pathways into volunteering and work for people with lived experience
Cultures that support change	• Willingness and commitment to learn and change • Culture of partnership working • Growing belief in and commitment to lived experience engagement activities

Appendix 4: Data tables

Participant data

Table 17: Engagement status with the Changing Futures programme July 2022 (base=844)

	Count	Per cent
Actively engaged on the programme	677	80
Disengaged from the programme	97	11
Moved on from the programme	46	5
Not known	24	3

Table 18: Reason for disengaging or moving on from the programme (base=134)

	Count	Per cent
Cannot be reached/No response to engagement efforts	48	36
Cannot be reached due to interaction with the criminal justice system	24	18
Receiving appropriate support outside of the programme	17	13
Support no longer required	13	10
Left the area	9	7
Deceased	3	2
Cannot be reached due to interaction with the mental health system	2	1
Consent withdrawn from the programme	2	1
Cannot be reached due to poor health or hospitalisation	1	1
Other	15	11

Table 19: In the last 12 months before you began getting support from the Changing Futures programme, did you had a service working with you to support you across all the different parts of your life? (base=325)

	Number of responses	Per cent
Yes	144	44
No	155	48
Don’t know	20	6
Don’t want to say	6	2

Table 20: Ever experienced mental health problems (base=613)

	Count	Per cent
Yes	510	83
No	0	0
Don’t know/Don’t want to say	0	0
Missing information	103	17

Table 21: Ever experienced drug or alcohol problems (base=613)

	Count	Per cent
Yes	484	79
No	30	5
Don’t know/Don’t want to say	19	3
Missing information	80	13

Table 22: Ever experienced homelessness (base=613)

	Count	Per cent
Yes	369	60
No	39	6
Don’t know/Don’t want to say	20	3
Missing information	185	30

Table 23: Ever experienced domestic abuse (base=613)

	Count	Per cent
Yes	195	32
No	14	2
Don’t know/Don’t want to say	0	0
Missing information	404	66

Table 24: Ever experienced contact with the criminal justice system (base=613)

	Count	Per cent
Yes	407	66
No	40	7
Don’t know/Don’t want to say	37	6
Missing information	129	21

Table 25: Experience ever of multiple forms of disadvantage for those with complete data only (base=135)

Number of forms of disadvantage	Count	Per cent
2	6	4
3	5	4
4	24	18
5	100	74

Table 26: Experience of other forms of disadvantage (ever) among those with experience of domestic abuse (base=195)

	Count	Per cent
Mental ill health	180	92
Drug or alcohol problems	167	86
Homelessness	131	67
Contact with the criminal justice system	153	78

Table 27: Number of forms of disadvantage experienced by those with experience of domestic abuse (base=195)

	Count	Per cent
1	0	0
2	12	6
3	30	15
4	53	27
5	100	51

Table 28: Experience of violent crime and non-violent crime in the last 3 months by gender (base males=183, females=123) * indicates significant differences between men and women

	Male	Male	Female	Female
	Count	Per cent	Count	Per cent
Victim of violent crime	61	33	57	46
Victim of non-violent crime*	48	26	50	41

Table 29: Contact with the criminal justice system in the last 3 months by gender (base males=183, females=123) * indicates significant differences between men and women

	Male	Male	Female	Female
	Count	Per cent	Count	Per cent
Received a caution	14	8	4	3
Received an injunction or criminal behaviour order	12	7	5	4
Been arrested*	39	21	15	12
Been convicted of a crime*	20	11	4	3
Spent time in prison	17	9	7	6
None of these	98	54	81	66
Don’t know	15	8	8	7
Don’t want to say	9	5	6	5

Table 30: Experience of multiple forms of disadvantage based on reasons for referral to the programme (base=843)

Number of forms of disadvantage	Count	Per cent
1	55	7
2	120	14
3	225	27
4	317	38
5	124	15

Table 31: Experience of multiple forms of disadvantage ever by funded area. Areas with more than 30 per cent of participants with experience of 2 or fewer forms of disadvantage are highlighted.

Number of forms of disadvantage	1 (per cent)	2 (per cent)	3 (per cent)	4 (per cent)	5 (per cent)
Bristol	0	17	33	50	0
Essex	2	7	18	44	29
Greater Manchester	5	18	32	34	11
Hull	0	0	10	75	15
Lancashire	6	1	33	31	12
Leicester	17	17	28	28	11
Northumberland	0	0	25	75	0
Nottingham	0	22	11	44	22
Plymouth	0	0	50	50	0
Sheffield	6	10	13	30	40
South Tees	6	29	28	22	15
Stoke	0	9	27	55	9
Surrey	8	25	8	25	33
Sussex	0	0	0	0	0
Westminster	30	25	40	0	5

Table 32: Mental ill-health and drug or alcohol problems (base=613)

	Count	Per cent
Yes	424	69
No	24	4
Missing information	165	27

Table 33: Experience of mental ill health among those with drug or alcohol problems (base=457)

	Count	Per cent
Yes	408	89
No	14	3
Don’t know	23	5
Don’t want to say	12	3

Table 34: How would you describe your gender? (base=324)

	Count	Per cent
Male	191	59
Female	128	40
Non-binary	2	1
Prefer not to say	3	1

Table 35: Which of the following best describes how you think of yourself? (base=302)

	Count	Per cent
Heterosexual or straight	278	92
Gay or lesbian	6	2
Bisexual	13	4
Other	5	2

Table 36: Do you have any children? (base=324)

	Count	Per cent
Yes	165	51
No	116	36
Currently pregnant/partner is pregnant	4	1
Don't know	22	7
Don't want to say	17	5

Table 37: Do you have children by gender (base males=183, females=123) * indicates significant differences between men and women

	Male	Male	Female	Female
	Count	Per cent	Count	Per cent
Yes*	75	41	80	65
No*	79	43	33	27
Don't know	17	9	3	2
Don't want to say	10	5	6	5

Table 38: Do you have any physical or mental health conditions or illnesses lasting or expected to last 12 months or more? (base=325)

	Count	Per cent
Yes	276	85
No	31	10
Don’t know	9	3
Don’t want to say	9	3

Table 39: Do you have any of the following conditions: acquired brain injury (ABI), ADHD, Autistic Spectrum Disorder, learning disability? (base=325)

	Count	Per cent
Yes	106	33
None of these	176	54
Don’t want to say	43	13

Table 40: Contact with services in the past 3 months by gender (base males=183, females=123) * indicates significant differences between men and women

	Male	Male	Female	Female
	Count	Per cent	Count	Per cent
Domestic abuse services*	3	2	39	32
Mental health services	72	39	43	35
Drug and alcohol services	87	48	61	50
Homelessness services*	65	36	20	16
Probation services	73	40	61	50

Table 41: Experience of homelessness in the past 3 months by gender (base males=183, females=123)

Recent experience of homelessness	Male	Male	Female	Female
	Count	Per cent	Count	Per cent
Yes	101	55	67	54
No	82	45	56	46

Table 42: Are you currently receiving treatment for drug or alcohol problems? (only asked of those who report recent problems with drugs and/or alcohol) (base=458)

	Count	Per cent
Yes, drug problems	124	27
Yes, alcohol problems	50	11
Yes, both	69	15
No	191	42
Don’t know	12	3
Don’t want to say	12	3

Table 43: Contact with mental health services in the past 3 months for those reporting recent mental health problems (base=510)

	Count	Per cent
Yes	245	48
No	265	52

Table 44: In the past 3 months has the participant been referred to a local housing authority for a homelessness assessment? (base=751)

	Count	Per cent
Yes	200	27
No, have already had homelessness assessment, no referral needed	111	15
No in contact with other housing services already	82	11
Not applicable, not homeless	276	37
Don’t know	77	10
No waiting the outcome of a referral made in the previous quarter	5	1

Table 45: In the past 3 months, has the participant been referred to a specialist service for drug and alcohol treatment? (base=749)

	Count	Per cent
Yes	202	27
No, awaiting the outcome of a referral made in the previous quarter	3	0
No, in contact with other specialist drug treatment service	211	28
No, sufficient programme support	25	3
No	173	23
Not applicable, no drug/alcohol need	62	8
Don’t know	73	10

Table 46: In the past 3 months has the beneficiary been referred to a specialist service for mental health treatment? (base=747)

	Count	Per cent
Yes	210	28
No, in contact with other specialist mental health service already	142	19
No, programme support being provided (judged as sufficient)	199	27
Not applicable, no mental health need	57	8
Don’t know	125	17
No, awaiting the outcome of a referral made in a previous quarter	14	2

Table 47: In the past 3 months has the participant been referred to a specialist service for domestic abuse? (base=740)

	Count	Per cent
Yes	53	7
No, in contact with domestic abuse service already	39	5
No, programme support already being provided	73	10
Not applicable, no domestic abuse	481	65
Don’t know	84	11
No, awaiting the outcome of a referral made in a previous quarter	10	1

Table 48: Which of the following types of support have been very important to you? Please select up to 3 (base=527)

	Count	Per cent
Addressing housing problems (including problems with rent)	181	34
Being supported to find or move into accommodation	179	34
Attending appointments, including transport to appointments	98	19
Thinking about your well-being and/or goals	94	18
Benefits applications	85	16
Helping make your accommodation safer (including moving into safe accommodation)	74	14
Accessing a GP	53	10
Help or advice with money problems	40	8
Budgeting	38	7
Setting up a bank account	30	6
Introducing/telling you about services in the area	29	6
Helping you to keep to any probation requirements	24	5
Cleaning/maintaining your accommodation	24	5
Introducing you to people or groups in the local community	19	4
Connecting or reconnecting with family members	19	4
Accessing adult social care	19	4
Accessing employment or training	18	3
Understanding your rights and helping you to take action	16	3
Obtaining ID	15	3
Support from the police with violence or abuse from a partner or family member	15	3
Accessing a dentist	10	2
Legal aid	2	<1
None of these	8	2
Other	10	2
Don’t know	84	16
Don’t want to say	15	3

Table 49: Mean average NDTA scores for those who had and had not received holistic support from a service in the 12 months before getting support from Changing Futures.

	Received support	Not received support
NDTA score	22.26	18.97
Number of responses	94	90

Table 50: Mean average total NDTA score by gender

	Male	Female
NDTA score	20.6	20.8
Number of responses	122	69

Table 51: Mean average total NDTA score by age group

	16-19	20-29	30-39	40-49	50-59	60 or older
NDTA score	Insufficient data	18.8	20.4	23.3	20.9	Insufficient data
Number of responses	4	36	51	59	32	11

Table 52: Mean average total NDTA score by disability/long-term health condition. * indicates significant differences between people who are disabled and those who are not disabled.

Disability	Yes	No
NDTA score*	21.7	14.2
Number of responses	161	23

Table 53: Mean average total NDTA score by experience of disadvantage. * indicates significant differences between people with and without experience of particular forms of disadvantage.

	Disadvantages experienced	Disadvantages experienced	Disadvantages not experienced	Disadvantages not experienced
	NDTA score	Count	NDTA score	Count
Mental ill-health	23	313	-	-
Drug or Alcohol problems*	24.1	288	13.7	24
Domestic abuse	22.4	111	17.5	13
Homelessness*	23.5	214	14.3	32
Contact with Criminal justice system*	23.9	248	14.2	31
Rough sleeping*	14.7	181	14.7	50

Table 54: Mean average ReQoL score by gender

	Male	Female
ReQoL score	14.7	12.7
Count	183	123

Table 55: Mean average ReQoL score by experience of disadvantage, * indicates significant differences between people with and without experience of particular forms of disadvantage.

	Disadvantages experienced	Disadvantages experienced	Disadvantages not experienced	Disadvantages not experienced
	ReQoL score	Count	ReQoL score	Count
Mental ill-health	12.2	510	-	-
Drug or alcohol problems*	12.7	484	13.9	30
Domestic abuse	12.5	195	11.6	14
Homelessness*	13.1	369	13.6	39
Contact with CJS*	12.5	407	13.1	40
Rough sleeping*	13.1	325	13.6	64

Table 56: Mean average ReQoL score by number of forms of disadvantage experienced

Number of forms of disadvantage	1	2	3	4	5
ReQoL score	13.8	13.5	13.4	12.1	12.4
Count	35	100	154	192	100

Table 57: Mean average ReQoL score for those who had received holistic support in the 12 months prior to joining Changing Futures and for those who had not.

	Support received	Support not received
ReQoL score	15	13.2
Count	141	145

Table 58: Overall, how anxious did you feel yesterday? Scale: 0 is 'not at all' and 10 is 'completely' (base=460)

	Count	Per cent
0	24	5
1	2	0
2	11	2
3	12	3
4	24	5
5	53	12
6	62	13
7	71	15
8	97	21
9	43	9
10	61	13

Table 59: Please describe your physical health over the last week by age group (per cent) * indicates significant differences between 20–29-year-olds and 40-49 and 50-59 year-olds (Bases:20-29=38,30-39=74,40-49=73,50-59=39 – insufficient data for under 20s and over 60s)

	20-29 Per cent	30-39 Per cent	40-49 Per cent	50-59 Per cent
No problems	47*	27	14*	10*
Slight problems	21	28	15	15
Moderate problems	16	22	41	28
Severe problems	13	20	23	36
Very severe problems	3	3	7	10

Table 60: In the last 3 months have you been a victim of violent crime, such as being physically assaulted, verbally abused or threatened? (base=610)

	Count	Per cent
Yes	211	35
No	252	41
Don’t know	92	15
Don’t want to say	55	9

Table 61: In the last 3 months have you been a victim of other crime, such as your belongings being stolen or damaged? (base=609)

	Count	Per cent
Yes	185	30
No	273	45
Don’t know	106	17
Don’t want to say	45	7

Table 62: in the last 3 months, have you spent any time living in homeless accommodation or sofa surfing? (only asked for those who spent most time during the last month either rough sleeping or in more stable accommodation, base=321)

	Count	Per cent
Yes	88	27
No	226	70
Don’t know	4	1
Don’t want to say	3	1

Table 63: How confident do you feel that you will be in this [stable] accommodation or other stable accommodation in 6 months’ time?

	Count	Per cent
Very confident	47	26
Fairly confident	58	32
Not very confident	37	21
Not at all confident	27	15
Don’t know	9	5
Don’t want to say	1	1
Total	179	100

Table 64: How confident do you feel that you will be in this [temporary] accommodation or other stable accommodation in 6 months’ time?

	Count	Per cent
Very confident	15	6
Fairly confident	61	24
Not very confident	82	33
Not at all confident	70	28
Don’t know	23	9
Don’t want to say	1	<1

Table 65: Have you slept rough in the past 3 months? (only asked of those not mainly rough sleeping in the past month, base=528)

	Count	Per cent
Yes	132	25
No	349	66
Don’t know	31	6
Don’t want to say	16	3

Table 66: Slept rough in the past 3 months by gender (base males=183, females=123)

	Male	Male	Female	Female
	Count	Per cent	Count	Per cent
Yes	114	62	86	70
No	69	38	37	30

Table 67: Have you ever had a job, and if so how many hours did you work in your most recent job? This includes any paid work you may currently be doing (base=324)

	Count	Per cent
Yes, 15 hours or less per week	13	4
Yes, between 16 and 36 hours per week	42	13
Yes, 37 hours or more per week	58	18
Yes, on a zero hours contract	8	2
No	102	31
Can’t remember	60	19
Don’t want to say	41	13

Table 68: When did you last have a job? (base=119)

	Count	Per cent
In the last year	13	11
Longer than a year ago	99	83
Don’t know	2	2
Don’t want to say	5	4

Table 69: In the past 3 months, what have you been getting support with? Base=613

	Count	Per cent
Addressing housing problems (including problems with rent)	269	44
Being supported to find or move into accommodation	213	35
Thinking about your well-being and/or goals	200	33
Attending appointments, including transport to appointments	193	31
Accessing a GP	143	23
Benefits applications	133	22
Helping make your accommodation safer (including moving into safe accommodation)	129	21
Introducing/telling you about services in the area	128	21
Help or advice with money problems	107	17
Budgeting	85	14
Accessing adult social care	77	13
Cleaning/maintaining your accommodation	66	11
Understanding your rights and helping you to take action	61	10
Introducing you to people or groups in the local community	59	10
Helping you to keep to any probation requirements	54	9
Support from the police with violence or abuse from a partner or family member	37	6
Setting up a bank account	34	6
Accessing a dentist	30	5
Obtaining ID	28	5
Accessing employment or training	22	4
Connecting or reconnecting with family members	22	4
Legal aid	13	2
None of these	91	15
Other	14	2
Don’t know	65	11
Don’t want to say	13	2

Table 70: Is the beneficiary receiving the benefits they are entitled to? (base=745)

	Count	Per cent
Yes	511	69
No, in the benefits system and working to address issues	50	7
No, not in the benefits system but working to address this	7	1
No	38	5
Don't know	125	17
Not applicable	14	2

Table 71: Do you have access to your own bank account? (base=613)

	Count	Per cent
Yes	460	75
No	72	12
Don't know	66	11
Don't want to say	15	2

Table 72: If you are currently in debt or behind on your bills, how much do you agree or disagree that you are able to manage paying these off? (base=460)

	Count	Per cent
Strongly agree	17	4
Agree	54	12
Neither agree nor disagree	56	12
Disagree	63	14
Strongly disagree	84	18
Don't know	68	15
Don't want to say	15	3
Does not apply	103	22

Table 73: In the past 3 months has the beneficiary attended an appointment with a work coach? (base=742)

	Count	Per cent
Yes	50	7
No	301	41
Not applicable, in employment	8	1
Not applicable, receiving support elsewhere	2	0
Not applicable, not work ready	256	35
Unable to attend due to illness or disability	30	4
Don’t know	95	13

Table 74: Do you feel you are making progress towards your personal goals?

	Count	Per cent
Yes	110	42
No	97	37
Don’t know	52	20
Don’t want to say	4	2
Does not apply	1	0

Table 75: If you needed someone to talk to, who would you turn to first (not including your support worker)?

	Count	Per cent
Family	125	27
Friends	108	23
Peer support	32	7
Community group	14	3
A faith organisation	6	1
Other	33	7
No one	96	21
Don’t know	42	9
Don’t want to say	4	1
Total	460	100

Partners survey respondent profile

Table 76: Partners survey responses by Changing Futures area

Area	Number of responses	Per cent
Bristol	7	1
Essex	40	8
Greater Manchester	99	21
Hull	17	4
Lancashire	36	8
Leicester	15	3
Northumbria	2	<1
Nottingham	37	8
Plymouth	67	14
Sheffield	61	13
South Tees	1	<1
Stoke-on-Trent	27	6
Surrey	15	3
Sussex	39	8
Westminster	16	3
Unknown	1	<1
TOTAL	**480**	**100**

Table 77: Partners survey responses by sector

Sector	Number of responses	Per cent
Housing and homelessness	103	21
Multiple disadvantage	84	18
Criminal justice and/or community safety	66	14
Mental health and well-being	59	12
Drug and alcohol services	39	8
Public health	31	6
Physical health and well-being	27	6
Social care (adult or child)	20	4
Education, skills and training	18	4
Domestic abuse and/or sexual violence	18	4
All/mixture	11	2
Benefits	4	1
TOTAL	**480**	**100**

Table 78: Partners survey responses by respondent role

Role	Number of responses	Per cent
Frontline service delivery	155	32
Senior management	132	28
Service management	104	22
Strategy/commissioning	65	14
Lived experience involvement/co-production lead	24	5
TOTAL	**480**	**100**

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