RESOURCE FOR SMALL STEPS BIG CHANGES
A BETTER START NOTTINGHAM
DECEMBER 2020

DESIGNING A SERVICE
A TOOLKIT

DARTINGTON SERVICE DESIGN LAB

SSBC small steps big changes City Care

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ABOUT DARTINGTON SERVICE DESIGN LAB

The Dartington Service Design Lab is a research charity working across England and Scotland, and focused on improving outcomes for children and young people. We support services and systems to improve by bringing the best evidence and research together with users and practitioners. We have many years experience supporting organisations to improve their design, delivery and monitoring – including working with the A Better Start programme since inception.

ABOUT SMALL STEPS BIG CHANGES

The Small Steps Big Changes transformation programme is a partnership of parents and professionals - including Nottingham City Council, health partners, commissioners, voluntary and community groups, parents and local communities - coming together to help give the best start for Nottingham's babies and children.

The SSBC programme covers four key wards across the city (Aspley, Bulwell, Hyson Green and Arboretum, and St Ann's) and is now in its 5th year of operation. SSBC seeks to deliver successful outcomes for children in communication and language, social and emotional development, and nutrition; helping Nottingham's children to grow up happy, healthy and confident.

Throughout this guide, we've used project examples that clearly demonstrate good practice of service design.

In section one, we use references from Father Inclusive Practice, set up to improve children's long-term wellbeing through the strengthening of paternal support during and after pregnancy.

The second section will focus on the development of the Oral Health project, redesigned according to the Theory of Change to improve the effectiveness of the interventions and ultimately, strengthen oral health across the city.

Our final section will embed examples from the Small Steps at Home programme, a free mentoring system to help new mums and dads in the community.

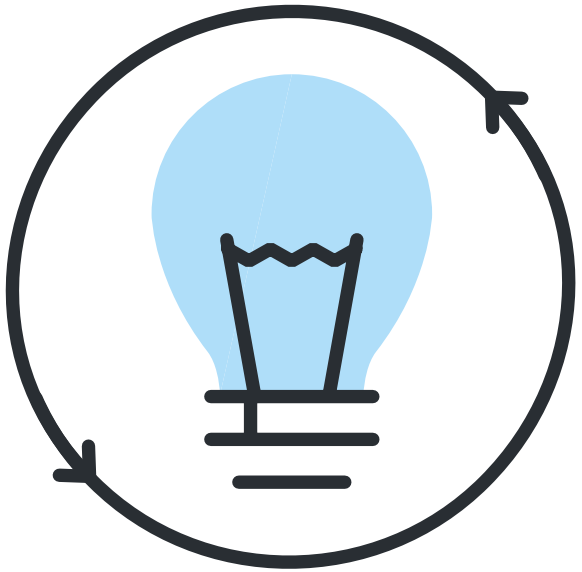
ABOUT THIS GUIDE

In 2019 the Dartington Service Design Lab delivered training to Small Steps Big Changes on how to develop a Theory of Change to guide service design, delivery, and monitoring. This guide captures the content of that training in a format which can be used and adapted by Small Steps Big Changes to develop and adapt Theories of Change in the future.

This guide explains the decisions we believe add up to a useful Theory of Change, and the things you should consider when making these decisions. We don't think they need to be made in exactly the order we set out - but they are all necessary. Throughout the guide we pose questions that you should consider as you develop your Theory of Change – we encourage readers to build in collaborative working from the start, and discuss these questions with colleagues and collaborators as they move though this guide.

PART 1

DEFINING YOUR THEORY OF CHANGE



1. Understanding the Theory of Change – *What's it for? Do I need one now?*

A Theory of Change is an essential part of any strategy, whether you're planning for your whole organisation, or for single programmes. You can visualise it as a map, allowing you to set your goals, a route to reach those goals and a compass to keep you on the right track. A theory of change is:

A practical tool for designing and evaluating your service:
It will help you to decide and describe the changes you wish to make through your work, articulate why you expect the change to happen and set out what you need to do to achieve it.

A creative process of reverse thinking:
A Theory of Change should start with a focus on the desired outcome before it looks at the necessary conditions for achieving the change and how to make these conditions a reality.

An organic and flexible tool – a Theory of Change is a theory:
Delivery in the real world will give you new information which you can use to update and improve it.

A Theory of Change is like the "scaffold" of a service that should be routinely checked and evolved as data is gathered, and learning emerges.

Not all theories of change look the same, but it's essential to go through the process and find a way that works for you so that you and your stakeholders use it well. We find that a full Theory of Change process can take up to three months – including the preparatory work to ensure you're ready, workshop over two or more days to bring together key stakeholders to make key decisions, and the follow-up work to add the necessary detail to these decisions.

CASE STUDY

FATHER INCLUSIVE PRACTICE

Positive father-child relationships have a wide range of long-term, positive impacts on children's wellbeing, which contribute directly to SSBC's three priority outcome areas of; social and emotional development; communication and language and nutrition.

Below is an example of consultation documented on fathers' experiences of services. Although this survey is not specific to Nottingham's SSBC ward areas, it is likely that local experiences will be similar (CSJ/Survation poll of 1,011 fathers, 16–30 May 2018).

- Almost seven out of ten (69 per cent) of new fathers said they thought "fathers were made to feel like a 'spare part' during the pregnancy period".
- Six in ten fathers told us that they had no conversations at all with a midwife about their role.
- When it comes to Health Visitors, nearly half (44 per cent) of all fathers told us they received little or no advice from them on their role as a dad.
- Only half (49 per cent) of new and expectant fathers said the NHS "caters well" for them, with 40 per cent saying that it doesn't.
- It appeared 41 per cent of fathers had never been invited to, or attended, any Children's Centre activity at all despite a legal requirement for Children's Centres to engage with fathers as a "hard to reach group".

Do we need this now?

To improve outcomes for children, fathers need to be recognised as important to their child's health and wellbeing, they must be treated as equal parents in regards to the care of their child and they should be supported by services in order to manage challenges and realise their potential.

The "A Better Start Nottingham" strategy (2014) sets out SSBC's goal for "father inclusive practice to be embedded across services and all relevant local agencies work together to systematically engage with fathers". Implementing and embedding father-inclusive practice will require system change across the entirety of the SSBC partnership and at all levels.

2. *Who needs to be involved?*

Having the right people in the room is vital to making your Theory of Change a success. These should include practitioners, service users, managers and volunteers – as well as people who can talk about the evidence of 'what works' in your field.

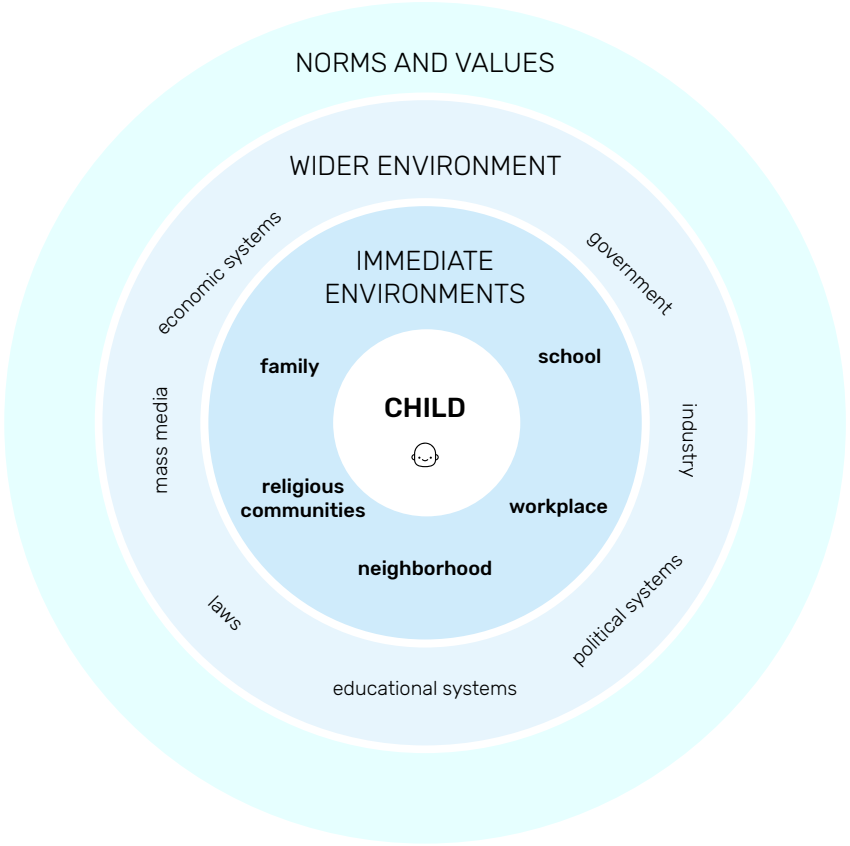
These people will help inform your Theory of Change by bringing their knowledge and experience to bear. If the process goes well they should feel free to challenge and question both what is ambitious, and what is realistic for you to achieve – you need to get the balance right!

By building your Theory of Change with the people that matter, you can establish and maintain a shared understanding – you and you stakeholders can be aligned and motivated around what you're trying to achieve, and how you're going to do it.

CASE STUDY

To support this work, a Father Inclusive Practice (FIP) Group has been set up to meet every two months. Its members include **partners from health, community services, and children's services**. They are working towards father inclusive practice within their organisations and as a group, they have a clear appetite to create a father inclusive environment. In addition to the FIP group, SSBC intend to recruit fathers in Nottingham as a 'dads interest group'. The intention is that dads will be engaged with SSBC and will coproduce services and service developments. They will also be supporting services by engaging more men as parent champions and with quality assurance by providing on-going feedback on FIP.

3. The Dartington Service Design Lab Theory of Change framework



To develop a framework for a Theory of Change we use the 1, 3, 5 Rule – that is the one system we exist in, the three key decisions you need to think about before developing your framework, and finally, the five core principles that underpin those decisions.

THE ONE SYSTEM

Services exist in a wider system – and this system affects how your service operates and whether it succeeds.

Your service could also contribute to a change in outcomes which, in turn, could change the wider system.

Some of the wider system influences and assumptions you should consider are:

- the general and local influences on early childhood development
- the positioning of your own service among the existing others in the system
- how your service will influence others via shared users, staff, or resources

3. The Dartington Service Design Lab Theory of Change framework

THE THREE KEY DECISIONS

Developing a robust Theory of Change requires making some key decisions over:

WHAT changes you want to achieve and what outcomes are expected at the end of the service.

WHO you wish to target with the services and who will most likely benefit from it.

HOW you will bring the change about and what you will design and deliver within your service in order to achieve that outcome.

It's not essential that you work through them in precisely this order – we find people go back and forth between them during a Theory of Change process. But each of these decisions needs to be made.

CASE STUDY

WHAT?
The intended outcome for SSBC aims to implement and embed father-inclusive practice across all services and relevant agencies.

WHO?
- Strategic leaders including strategic boards/partnerships, commissioners and heads of services.
- Local service providers including maternity services, health visiting, early help and SSBC-commissioned services.
- All levels of the workforce including colleagues within maternity services, children's health services, local authority children's services, SSBC-commissioned services and activities, and relevant community and voluntary services.

HOW?
- SSBC have commissioned a consultation to capture local dads' voices on their current experience of services.
- "Think Dads!" workforce training has been developed by SSBC to raise awareness of the importance of fathers and act as a call to action for the children's workforce of Nottingham City.
- Maturity Matrix – a tiered award system will be developed to allow organisations to assess their services and provide a benchmark for father inclusive practice.

3. The Dartington Service Design Lab Theory of Change framework

THE FIVE CORE PRINCIPLES

To produce a Theory of Change that is robust, you must make it well-informed. Considering these five principles before making your decisions will help do this:

'WHAT MATTERS' – understanding the evidence about what influences child development will increase the likelihood of designing and delivering a service that makes a difference.

'WHAT WORKS' – understanding what's proven to work (or not) elsewhere helps us make better decisions about the design of services.

PARTICIPATION AND CO-PRODUCTION - Involving the right stakeholders – including commissioners, staff and service users – is essential to increase buy-in and the chances of creating a service that is feasible and one that people want to use.

PRECISION – A Theory of Change should be specific and detailed, reducing the chance of ambiguity and misunderstanding that can undermine implementation.

ALIGNMENT – Each decision you make constrains the others – this is a good thing.

BEFORE YOU MOVE ON

Are you ready for a Theory of Change?

Are you committed to designing and delivering a service and do you have the senior backing and resources you need to go ahead?

Have you got the right people involved – can you identify and engage the individuals across, and sometimes outside, your organisation who will be able to help you make good decisions?

Can they commit the time you need – perhaps up to three months?

Do you understand your local system – can you explain where your proposed service will sit within it, and what the implications of that are?

4. Making Decisions on 'What': *Defining the outcomes of your service*

Outcomes are what you want to achieve, with, and for the people you serve. They're usually achieved over time and may result in big changes in people's circumstances, skills, or knowledge. Identifying smaller changes that add up to the big changes are an excellent way to understand whether your users are making progress. Your Theory of Change needs to include different 'types' of outcomes, and you'll need to reflect on and show how they relate to each other to monitor your progress. Here's how we define them:

Long-term outcomes or ultimate outcomes refer to the enduring changes you want your service to make and can take some time to occur. Depending on the type of service you're providing, they may include improvements in relationships, mental or physical health, educational attainment, or employment. These are the changes you really care about making so they should be ambitious, but also related to how, and how long, you are able to work with people.

Intermediate outcomes refer to the smaller changes for individuals, families, or communities that need to happen to make the long-term outcomes happen. These are the things your services will directly affect. These can include changes in knowledge, attitudes, skills and behaviours. They allow you to monitor whether users are progressing along the right track, and to respond if they are not.

Sometimes you may define **end of service outcomes**. These are the changes you want to see before someone leaves your service. They should be enough of a change that you feel confident someone can go forward without the support of your service.

You should always consider what each goal or outcome means for every individual affected by your decisions – including how it addresses the needs of your target population and whether it's relevant to the outcomes.

CASE STUDY

Alongside the activities with the workforce to improve father inclusivity, SSBC also developed activities to directly encourage fathers to be more engaged with their role as a parent. One example includes the 'Fathers Reading Every Day' (FRED) challenge. This encourages dads to read with their children on a daily basis for four weeks.

What will be delivered?

1. The FRED programme begins with a launch, where dads are given statistics about the impact their involvement can have on their children and are shown techniques on how to share books with their child.
2. For the self-directed activity, dads commit to read/share books with their children for 5 minutes a day for the first two weeks and 10 minutes a day for the second two weeks. They receive a reading log to record their reading sessions.
3. At the end of the challenge, the dads take part in a celebration which encourages them to reflect on their successes. They are also encouraged to keep this habit going and become more involved long-term, in their child's educational development.

Who will deliver it?
FRED can be delivered by any practitioners who have received the training.

How long/often will people engage with it?
Dads are encouraged to take on the challenge of reading/sharing books with their child every day, for four weeks.

Where will it be delivered?
The launch and celebration components can be delivered in the home or as group activities.

What else needs to happen for the programme to have the best chance of success?
FRED needs to be advertised or recommended by the workforce that mums or dads have contact with. Dads need to complete a questionnaire so that the impact of FRED can be assessed. The trained facilitators need to record the parent's details, attendance and outcomes securely.

BEFORE YOU MOVE ON

Have you defined meaningful long-term outcomes for individuals experiencing your service? Are they things which will make a difference?

Are you able to link your outcomes to what we know matters for early childhood development? If not, why not?

Have you drawn on practitioner experience and research to define the intermediate outcomes which describe someone's journey to long-term outcomes?

5. Making decisions on 'Who': *Defining the target population for your service*

When we serve people who don't need us, we can waste resources. When we serve people who have greater needs than we can meet, we can waste their time. For your service to be effective, it should be targeted at those who are at risk of not achieving the outcomes you're aiming for.

It can be helpful to create a picture of an individual person who can benefit from your service. What stage of life are they at, where do they live, what's going on for them in terms of work, relationships, and health? Again, having practitioner research, but also research about people in your area helps.

From this you develop 'inclusion' and 'exclusion' characteristics which staff will be able to use to determine who is enrolled. These could be based on criteria like these:

- Demographics e.g. their age, sex, ethnicity
- Behavioural patterns e.g. smoking, dietary practice
- Psychological state e.g. stress levels, mental health status
- Physiological state e.g. pregnant, disabled
- Environmental state e.g. housing, employment status, income level

By being specific about who your service can help, you can develop a service that's more responsive to their needs.

FRED challenge

- ✔ Must be a father or a male carer with responsibility for the child
- ✔ Must have child aged 2-3 years and parental responsibility over child
- ✔ Child must live in one of the four SSBC wards
- ✔ Father/male caregiver must have capacity to commit to FRED for at least four weeks
- ✔ Fathers must have basic-level of English to engage with reading log and service questionnaires

BEFORE YOU MOVE ON

Have you created an inclusion and exclusion criteria so that you are more likely to only serve those who need you, and who you can help?

Are your decisions on target population suitable for the type of service you're running – e.g. a drop-in clinic vs a home-visiting programme?

How will you attract the right people to find you, or how will staff know if someone is right for the service?

What will you do about people who need help but don't meet your target population definition? Are there other services you can refer them to, or will you make some exceptions?

6. Making decisions on 'How': *Designing your activities*

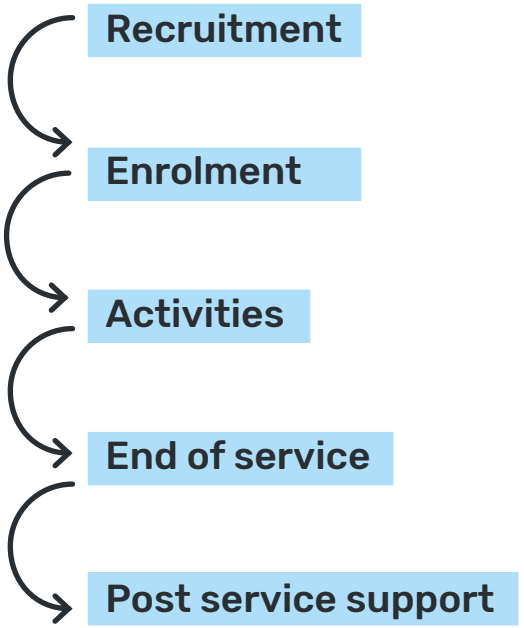
When you know the changes you want to make, and who you need to work with, you then need to decide the activities that you believe will make the difference. What are the experiences each individual need, to help them reach the intermediate outcomes that will lead to long-term outcomes?

It is helpful to think about a programme as lasting from the moment a person first hears about you (how do they hear about you?) to any post-programme contact you might offer. Designing this in detail will support quality implementation.

But it's also important to be clear about which elements are 'core' (because either practitioners or external research point to them being essential for outcomes) and which are flexible (that is to say, they can be adapted, extended, or skipped depending on what's right for specific individuals, or in specific contexts). These decisions form the basis of your programme handbook, or guidance for practitioners.

It can be helpful to think about your "How" decisions in terms of:

- What will be delivered?
- Who will deliver it?
- How long will people engage with it?
- How often will they engage with it?
- Where will it be delivered?
- What else needs to happen for the programme to have the best chance of success?



BEFORE YOU MOVE ON

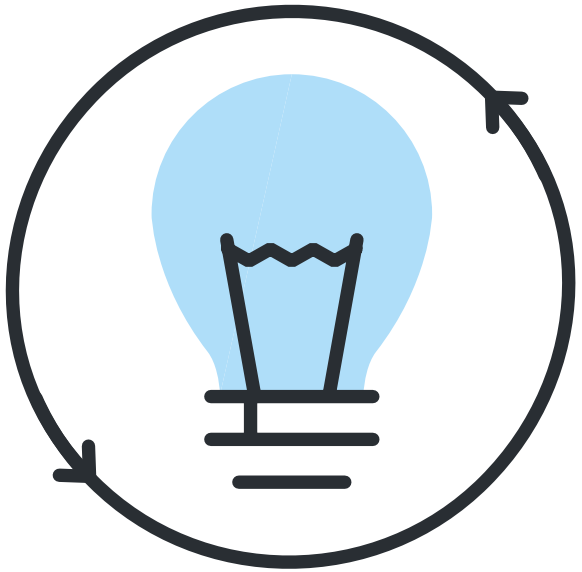
Have you made high-level decisions across all the questions above, and end-to-end for your programme?

Do you and your stakeholders agree on what is 'core' to the programme, and what can be flexible?

Do you feel confident that these activities can get your target populations to your outcomes?

PART 2

DEVELOPING YOUR PROGRAMME FURTHER



1. What strengthens your programme?

Once your high-level decisions have been made, there is more work to do to design the programme in the detail needed for staff to deliver it. This is where you can take more time to consider whether your programme is:

Evidence-informed - and whether the 'core' elements of your service are based on evidence of 'what works'?

Co-produced – in particular, have the 'flexible' elements been created with others to make them as person-centred as possible?

Feasible/Replicable - can staff and/or volunteers deliver both the core and flexible elements with quality across different contexts?

Sustainable – can this service be supported and sustained within your local ecosystem?

This second part of the toolkit will feature examples of the Oral Health project, to demonstrate how these terms can be used in reality.

Now let's explore those terms in greater depth…

CASE STUDY
ORAL HEALTH PROJECT

Tooth decay is the most common oral disease affecting children, but it is preventable (Public Health England 2014). Nottingham has a higher rate of five-year-olds with dental decay experience (approximately 35.6%) in comparison with the national average of 24.7%, with the local areas of Aboretum, Bulwell and Aspley showing the highest levels in the city (Nottingham City Council 2017).

The SSBC partnership has begun the Oral Health project, which aims to:

- Provide a clear signposting pathway from Midwives, Health Visitors, Family Mentors and Early Help to local dental practices.
- Increase knowledge and good dental hygiene skills in parents and children in the local community.
- Increase the number of children taken to the dentist before the age of one year.
- Provide families with consistent and universal messaging from the workforce about good dental health.
- Increase the number of children living in SSBC wards to have good oral health.

2. Making your programme evidence-informed

Evidence rarely provides a clear-cut answer on what you should do, or how you should do it. But, over time, evaluations have produced conclusions both about what matters in early child development, and the elements of common practice that are likely to work in supporting these outcomes.

Useful sources of information include the:

- Harvard Center on the Developing Child
- The Early Intervention Foundation
- The Save The Children Early Learning Communities Evidence Review

CASE STUDY

The Oral Health project was developed using evidence gathered from local parents, practitioners and stakeholders to identify where practice was falling short according to Public Health England guidance. This led to the following core components being designed:

1. Training the workforce: Early Help practitioners, Midwives and Health Visitor and Family Mentor teams were all given four standardised face to face training sessions.
2. Providing resources: Packs of toothbrushes and toothpaste for practitioners to hand out to children aged one and under, alongside additional materials for pregnant women.
3. Supervised Brushing: SSBC funded the Brushing Buddies scheme, a workshop-led programme for nursery staff, to get children brushing on-site once a day and provide them and parents with resources on oral health.
4. Campaigning: The SSBC will use materials from a national campaign and localise it to support parents' understanding of the importance of oral health.

3. Making your programme co-produced

Good co-production means service users and providers working in partnership to design and develop flexible services. By doing this, it can make services more relevant, appealing and valuable to service users, increasing the chances that services will be accessed while preventing a waste of resources.

Co-production exists in many forms and it's important to discover what is right for your service by planning properly and supporting it with adequate resources.

Co-production is **not consultation**, in which you invite existing users of a service to freely share their views about what the service should look like. Co-production is also **not participation**, in which participants experience a service and feed back their experience.

EXAMPLE OF INVOLVING USERS

Providers want to offer some Oral Health session for parents. They invite families to give feedback after the session have run.

No this is not co-production. This is consultation.

EXAMPLE OF INVOLVING USERS

Nurseries intend to offer supervised brushing schemes.

This is piloted with a handful of nurseries in SSBC ward areas.

Feedback from nursery staff and the oral health promotion team is used to refine the programme before rolling out to other nurseries in the community.

No this is not co-prodution. This is user participation.

3. Making your programme co-produced

Equity and diversity is key to good co-production Service users come with a large range of backgrounds, skills and experience which can be invaluable in helping to enrich your overall programme. A successful co-production of a programme is achieved by:

Co-planning – where those with lived experience can review and support the service.

Co-designing – where participants and co-planners help design the look and content of materials and activities for a service.

Co-implementing – Some of the participants are trained to become facilitators or leaders in the implementation of a service.

Co-evaluating – all stakeholders involved help service providers and evaluators understand and agree to how to use the learning from delivery to improve and refine.

CASE STUDY

The Oral Health project has been co-produced with the formation of a parent obsession group (POG). This is a group of Parent Champions representing the communities SSBC work within. POG's interest in the poor oral health of children living in Nottingham City initially began during a community meeting where they became aware of some startling data; in Nottingham, 17% of three-year-olds have dental decay affecting three or more of their teeth (2013/14) and three of the wards that SSBC works in have the highest percentage of children with decay in the city. The findings reinforced POG's enthusiasm to raise awareness in their local community.

"Oral health is so bad across the city, we felt it was a reasonable outcome for parent champions to try to improve" – Rachel, Parent Champion.

In order to support co-production, the Oral Health promotion specialist team provided training, offering an opportunity for the Parent Champions to build their knowledge of key oral health messages, building their sense of motivation and empowerment. This equipped them with the skills and information they needed to begin to plan their own local projects.

4. Making your programme feasible and replicable

Service implementation is a process. Like other processes, it requires a clear description of the service design, including **what** should be done, **why**, **how**, **where**, **when**, **how often** and **by whom**.

These must be spelt out or **codified** in a resource that is accessible to all staff involved in delivering the service. The simplest way to do this can be through producing checklists, electronic and mobile-friendly documents and secure online-sharing tools. These must be updated as new learning emerges, and Theories of Change are revised.

The best-designed resources state clearly what are **core elements** and what can be **flexed**, making your service readily replicable across different contexts.

CASE STUDY

After starting delivery of the core components of the Oral Health project, it became clear what could be flexed to increase impact.

1. Training the workforce: Alongside the face to face training sessions, six additional sessions of support and guidance could be offered on how to include oral health messages across the staff's existing work and activities with families. This could be delivered by e-learning.
2. Supervised Brushing: Local dental practitioners could offer fluoride varnishing in nursery settings alongside the one-hour training session for nursery staff.
3. Campaigning: One local initiative was to introduce the Brush, Book and Bed workshop, to promote effective tooth brushing at night.

5. Making your programme sustainable

Most new services can survive in the short-term, especially if they are well-funded. But to reach their full potential and achieve desired changes in the long-term, services also need to pay attention to the wider contexts and systems in which they operate.

This means asking from the design stage how your service may interact with and depend on other services and structures in the local system.

To do this, it's worth identifying the range of stakeholders and institutions across it. These may be any or all of the following:

- Commissioning
- Statutory services
- Political leadership
- Voluntary and Community Sector
- Families and Carers

We recommend you consider the following:

Priorities – to understand what they're trying to achieve and its relationship to your own impact.

Structures and Processes – how do these stakeholders operate, and how successful is this?

Synergies – How can your service leverage the successes elsewhere in the system e.g. via referral partnerships, linking up services, or avoiding duplication?

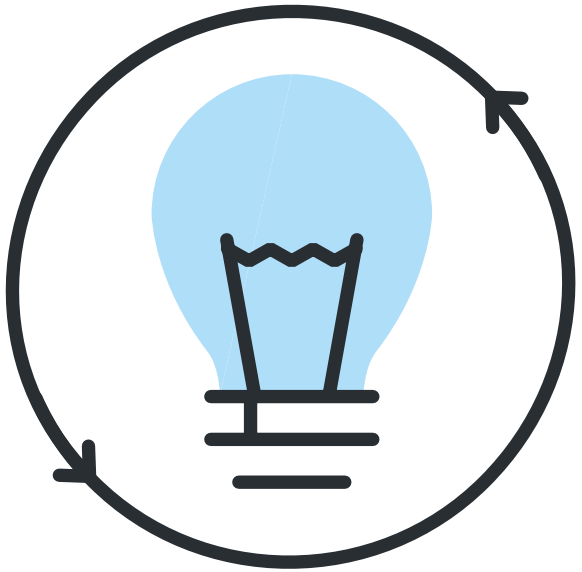
CASE STUDY

SSBC have developed the Oral Health project with sustainability in mind. The work of SSBC will end in 2025 and therefore any projects that are being set up need to be able to stand alone. Therefore, the Oral Health project work has been designed so that it ties in with other national and local initiatives alongside backing and support from the main service providers in the city. Some examples of this alignment include:

1. Flexible commissioning: SSBC has begun to explore ideas of funding dental practitioners to work directly in local early years settings on projects, with initiatives such as painting fluoride varnish on children's teeth as a preventative intervention.
2. Co-ordinating responses: A service level agreement to commission a local Oral Health Promotion Team to provide expertise, support and guidance is being developed. Within this, on-going training can be offered to local workforce.

PART 3

USING DATA FOR UNDERSTANDING & IMPROVEMENT



1. What is data and how do we define it?

When you're delivering your programme, data will help you manage it for impact. But even before delivery, you need to think about which data matters, and how you're going to use it.

Data can come in many forms, but ultimately, it's **information** – specifically information which you can use to answer questions. To get the right data, you need to get these questions right first. This brings us back to the Theory of Change and the 'three key decisions'.

Asking alternate questions around these three decisions can help test the assumptions made in your Theory of Change to give you more accurate data which you can act on:

WHAT – When you know the changes you want to achieve at different stages in your programme you can ask "how much change are we actually seeing in the selected outcomes?"
WHO - When you know who you wish to reach with the services and who you can ask "what proportion of those enrolling in the service are actually from the target group – and are the target group benefitting?"
HOW – Now that you know the service design you think can help your target group reach outcomes, you can ask yourself, "is the service being delivered as designed?"

The data you collect from testing your Theory of Change will help shape an ever more-informed programme and service. This third part of the toolkit will feature an example of a new 'Small Steps' home visiting programme, to demonstrate how SSBC has brought these skills to life.

CASE STUDY
SMALL STEPS AT HOME

Small Steps At Home is a new programme developed by the SSBC partnership to improve child outcomes in language and communication, nutrition, and emotional wellbeing. Across four areas of the city, teams of peer mentors have been trained to support parents, through delivery of manualised programme of activities. These are delivered in the family's home from pregnancy to when the child turns four-years-old.

1. What is data and how do we define it?

There are different ways to collect data to answer these questions. Every service user's experience is different and looking for differences in the data will help you identify what's going well and what isn't - and **for who.**

Quantitative data (for example, enrolment and attendance numbers, and progress against outcomes) helps us see what is happening **Qualitative data** (for example, feedback questionnaires and surveys about the usefulness, accessibility, and quality of the service) help us understand why it's happening.

By collecting data on what's working and what isn't, for who and why, you'll be more informed to know what needs to change and how you need to change it.

WHAT - If you've spotted differences in people's progress during the programme, ask yourself:

"If some people do better than others, why? What's the reason?"

WHO - The differences in data might also show some differences in the target group. If so, you might want to ask:

"Are some people less likely to fully participate in the service – and if so, why?"

HOW - It could be that there are changes to be made in the service design and delivery. You could figure this out by asking:

"Are parts of the programme more or less feasible for practitioners to deliver, or acceptable to people? if so, why?"

CASE STUDY

WHAT – *"how much change are we actually seeing in the selected outcomes?"*

SSBC set a key performance indictor (KPI) of 80% of all eligible families to take up the offer of Small Steps both antenatally and postnatally.

WHO - *"what proportion of those enrolling in the service are actually from the target group – and are the target group benefitting?"*

After two years of delivery, 55% of eligible families had enrolled on Small Steps.

HOW – *"is the service being delivered as designed?"*

SSBC explored when and how families were invited to take part in Small Steps. Was being called at 22 weeks pregnant the best time to engage and enrol expectant mums?

BEFORE YOU MOVE ON

Have you defined the few questions that will help you understand whether your Theory of Change is working?

Have you decided on the data that will allow you to answer those questions?

2. How to collect the data you need

You depend on your staff and the people you serve to get the data you need to answer your questions. It's crucial that the data you ask them to collect, and the tools you ask them to use are acceptable to them. Consider:

Are you asking them to collect data they can see as important and relevant to their work?

Are you asking staff to collect data which could compromise their service delivery e.g. overly intrusive or frequent questions?

Are you minimising the amount of time staff need to spend collecting and entering data – i.e. collecting the minimum you need to get answers to your questions?

Is your data entry system genuinely user-friendly and do you provide ongoing training and support to staff on how to use it?

Can you commit to sharing the results of data analysis with the people who provide it, both to get their opinion on what the data is telling you, but also how these answers can help them in their job?

3. How to present the data you need

Once you have your findings, the form you present the data in can depend on the **audience** and the questions they are interested in.

Try to imagine the audiences that you might need to present information to. Here are a few – can you list the different reasons you would have for sharing data with these audiences?

- Funders and commissioners
- Wider system partners
- Senior management
- Team leaders
- Frontline staff
- Service users

How do your different audiences like to use data, and how does this differ depending on what they're expected to do with the data?

- Report writing and sharing written insights
- Graphs and infographics
- Video content
- Presentations

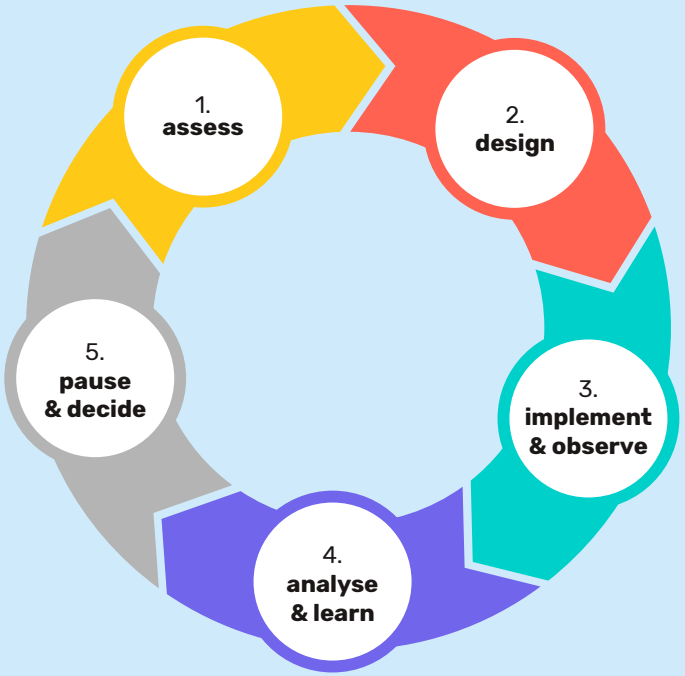
Whichever format you choose to present to your audience, it's always helpful to receive feedback on this too, to evaluate if they were able to understand the answers the data provides, and the implications of these answers.

4. The Rapid Cycle Design and Testing Cycle

At the Dartington Service Design Lab, we apply our Rapid-Cycle Design and Testing method in many of our projects aimed at helping organisations test and improve services in real time.

The Rapid-Cycle Design and Testing method combines the best available evidence of 'what works', with users' own take on what's right for them, and providers' first-hand experience of what can be implemented in practice. It guides services through several fast-paced cycles of designing, delivering, learning and refining, with each cycle divided into five key stages: Assess, Design, Implement and Observe, Analyse and Learn, and Pause and Decide.

Rapid-Cycle Design and Testing draws on implementation science, user-centred research and systems thinking to result in services that are evidence-informed, co-produced, doable, and sustainable within different settings.



4. The Rapid Cycle Design and Testing Cycle

This first **Assess** stage includes putting together your Theory of Change to articulate a causal link from both new and existing activities to end-of-service outcomes.

From there, you can move onto the second phase of your work, the **Design** phase in which you start rethinking your existing activities and design innovations that will help increase the chances of improving your outcomes.

This next phase, which begins to **Implement and Observe** these redesigned activities involves testing and taking notes in a continuous fashion. This is a vital part of the rapid cycle as it not only forms the way in which you implement your service, but it will tell you whether you're reaching the right target group and achieving your outcomes as you set out to do.

The fourth stage, **Analyse and Learn**, looks at the data collected to date and starts to define the criteria needed for assessing what a successful service or programme should look like. As we define these criteria we strive to strike a balance between evidence-informed expectations, experience-based explanations, and what is most meaningful and valuable to the service and its users according to their feedback.

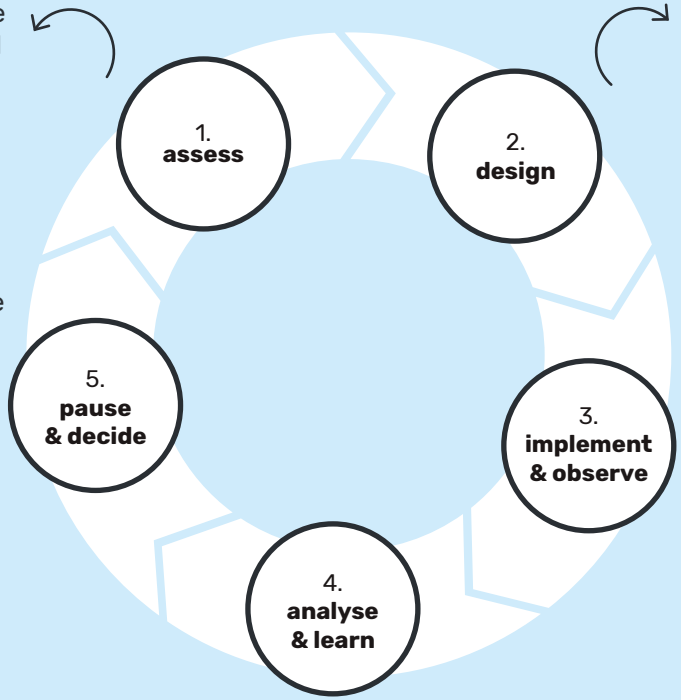
Finally – or rather, before repeating the cycle again – the last phase takes time to **Pause and Decide** around the data and analysis to look at decision-making for the next iteration. Here we explore what needs to be kept, changed or discarded according to all of the information collected.

The cycle will then run again and so on.

The important thing to remember is that 'rapid' does not means days, it means weeks and months. The cycle takes time and requires a lot of thought. The more time invested in each phase, the greater the success of the service.

CASE STUDY
SMALL STEPS AT HOME: RAPID-CYCLE DESIGN AND TESTING

Assess: We saw more eligible families needed to be 'reached' in order to assess impact on the intended child outcomes. The team set out to understand reasons why many families did not take up the offer of Small Steps. By collating the responses from families who declined the service at the 22 week call, it became clear that expectant parents were not able to engage with the offer this early due to continued work commitments and/or other pregnancy related appointments with other service providers.



Design: The team agreed to trial delaying the invitation call until the 32 week marker of pregnancy and assess impact on the KPI and stakeholder satisfaction. Alterations to the processes which flag when to make contact with service users were designed, and data collection methods and time points to measure uptake of the programme were written into the programme.

Implement and observe: The new changes were implemented and after a three-month time period, the impact in the KPI was measured. Reflections and feedback from stakeholders and families were also collected.

Pause and Decide: While delaying the call has increased uptake to Small Steps, there has been a knock-on effect. The time to book in antenatal home visits has been reduced and if a baby arrives early, the antenatal activities may not happen at all. The SSBC partnership is currently deciding on the next iteration to determine what is more or less acceptable for this service.

Analyse and Learn: At the end of the cycle, the delayed invite call resulted in fewer declines, seeing a raise in the KPI to 75% (from the initial 55%) of eligible families taking up the service. Additional benefits following stakeholder feedback included that families were more willing to engage with the service at a later time in the pregnancy as they had started maternity leave and had more availability. An additional benefit observed was the reduction in the rare occasions contact was made with families when a pregnancy was no longer viable.

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