Birmingham City Council's
Adult Social Care Prevention Portfolio –
Review of the Performance Evaluation Framework

Final Report

Dr Rachel Hopley, André Castro Bilbrough, Sophie Wilson, Prof. Laura Caulfield

January 2022

Contents

1. Overview

The aim of this report is to provide a review of Birmingham City Council's (BCC) Adult Social Care Prevention Portfolio evaluation framework, and covers the following commissioning areas:

- Vulnerable Adults 1 – Social Inclusion, Wellbeing and Housing Services
- Vulnerable Adults 2 – Disability and Mental Health
- Carers
- Prevention and Communities
- Neighbourhood Network Schemes
- Refugees and Migration

A series of activities have been completed by the research team in order to understand the reach of the portfolio, the data captured by providers and the data that is reported to BCC. The activities in this work involved the following:

1. Review of strategic context in relation to commissioning and performance
2. Discussions with lead commissioners to understand the objectives and monitoring data
3. Review and evaluation of quarterly monitoring data forms for each commissioning area
4. Review of the monitoring data collected by individual providers
5. Discussions with lead providers within each commissioning area
6. Assessment of the alignment of key outcome variables to evidence impact
7. Recommendations for performance evaluation framework

There is agreement amongst the lead commissioners that their area of commissioning fits with the Prevention First Approach. When discussing priorities of the performance framework, lead commissioners stated that it should be practical, able to justify spending and increase standardisation. In some areas extensive conversations have already taken place in co-designing the format of quarterly data returns (Vulnerable Adults; Prevention and Communities), whereas others are considerably less developed in their monitoring and reporting format (Refugee and Migrants). Following a review of the quarterly reporting forms it became apparent that there is noticeable variance in the quantity and quality of the data being requested in different commissioning areas.

A structured review of the data being collected by individual service providers and subsequent in-depth discussions highlighted the volume of data collected by some providers and the extensive variation between both providers and commissioning areas. Whilst providers were generally content with the current reporting templates, commenting on how these had improved over time and they appreciated inputting into the amended templates, further future amends are required. Most providers collect additional information beyond what is already submitted to BCC and would be happy to provide further data if requested. Indeed, many providers submit additional qualitative information with their returns (where it is not specifically requested) to help demonstrate the impact of the project. The data currently collected and shared by providers relates predominantly to the Citizens Outcome of the Prevention First Framework. Where impact is assessed at an individual level, the measures used vary, but a version of the Outcomes Star is most commonly used. Many providers commented that they were not sure how the data was used by BCC other than assuming they were used to assess contractual obligations and this should be addressed by BCC.

The report concludes with options and recommendations for an evaluation framework that reflects strategic priorities, provides a methodology that evidences services are having an impact on individuals and communities, evidences social value is being sought and delivered, and demonstrates what services are achieving across the whole life course.

2. Strategic Context

2.1 Vision and Strategy

The Vision and Strategy for Adult Social Care (ASC) 2017 outlines the three core aims of commissioned adult social care services across the city. These aims are:

1. Improve outcomes for those with health, care and support needs
2. Improve the quality of commissioned health and care services
3. Improve the resilience and sustainability of our health and social care system[1]

These three aims were initially presented as being underpinned by eight core principles:

1. People require access to high quality information, advice and guidance
2. People require and respond better to personalised support
3. People need to be able to access a wide range of community assets which are local, flexible and responsive
4. People need to be able to access prevention and early intervention services quickly and at any time in their lives
5. People's needs are often complex and require support and interventions from a range of organisations. Therefore, services need to be integrated and built on partnership working utilising multi-disciplinary teams and where feasible single points of access
6. While recognising that for some people there is a need to protect them, it is essential that we ensure we "make safeguarding personal"
7. All services should be co-produced with users and carers as they are directly impacted by services and have first-hand experience of what works well and what doesn't
8. Underpinning all of this is the imperative to use resources effectively[2]

However, following the Covid-19 pandemic - in particular the manner in which it highlighted pre-existing inequalities within the city - a ninth principle was added when the vision was refreshed in 2020:

9. People should expect to be treated equally and fairly and services should not discriminate on any grounds against citizens. Services should seek to improve social justice by tackling the reasons for discrimination and creating opportunities for all citizens[3]

Whilst these principles still highlight the importance of using resources effectively (principle eight), this strategy and these principles as a whole mark a divergence from the previous approach (2010-2017) which was primarily focused on making savings[4]. The broader context however was (and still is) that across the city, the population of older citizens is expanding, the

---

[1] Commissioning_Strategy_for_Adult_Social_Care_2017_accessible_version, p.5

[2] REFRESH OF ADULT SOCIAL CARE VISION AND STRATEGY, p.2

[3] REFRESH OF ADULT SOCIAL CARE VISION AND STRATEGY, p.3

[4] Measuring impact and performance Prevention Commissioning, p. 1

population of citizens with complex needs is expanding[5], substantial numbers of adults (including younger adults) are disabled or suffer from mental illness, and the public want support which enables them to exercise their independence. Given this, as well as the reduction in available resources – and the inevitable pressure that comes alongside that - the council had to adapt by making changes to the type, organisation and delivery of services provided across the directorate, which ultimately led to this new vision of commissioning in ASC.[6]

This new vision is being embedded over two distinct phases - the reshaping phase (2018-2021), and the self-regulation and integration stage (2021+).

The reshaping phase was designed to focus on: stable and structured investment in order to allow all parties to plan adequately; a package of support led by commissioners for the care sector and partners which includes support around delivering social value; incentivising quality by developing a quality rating system for care provision; shaping the market to reduce reliance on the council; developing efficient and integrated systems and processes; and robust, clear and consistent contract management. The final output of this stage will be the development of a performance framework through which to assess effectiveness.[7]

The 'self-regulation' phase will implement further changes across the sector, focussing on: the role of the social care system as it relates to employment and training; selecting and exclusively doing business with the best providers, reducing reliance on commissioned social care services generally; forming strong partnerships with providers; integrating with the health system; and building a more strategic relationship with providers to deliver innovation and enable self-regulation.[8]

Whilst this provides a summary of the strategic context at the level of the whole directorate, commissioning across ASC is enormously diverse. Services within the directorate are grouped into the following six commissioning areas:

- Vulnerable Adults 1, covering social inclusion, wellbeing and housing services
- Vulnerable Adults 2, covering support services for people with disabilities and mental health issues
- Carers
- Prevention and Communities
- The Neighbourhood Networks Scheme
- Refugees and Migration

---

[5] Putting Prevention First: Investing in Communities, p. 3-4

[6] Commissioning_Strategy_for_Adult_Social_Care_2017_accessible_version, p.5

[7] Commissioning_Strategy_for_Adult_Social_Care_2017_accessible_version, p. 10-11

[8] Commissioning_Strategy_for_Adult_Social_Care_2017_accessible_version, p. 11

Given the variation of services provided across the ASC portfolio, as well as the variation across providers and individual clients within each of these commissioning areas, the exact manner in which this framework is embedded is intended to vary widely.

Whilst a full outline of every activity across the whole directorate is beyond the scope of this report, it is worth noting some of the activities which have already been commissioned in support the new vision for ASC since 2017:

- the establishment of the neighbourhood network scheme[9]
- a jointly commissioned all-ages carers pathway
- development of a prevention focused housing and wellbeing support pathway for vulnerable adults[10]

2.2 The Prevention First Framework

At the heart of the new ASC strategy and vision is the Prevention First Framework, which takes at its core the aim that “citizens lead healthy, happy, independent lives within their own homes and communities”.[11] The Prevention First Framework aims to achieve this by investing in three key areas: developing community assets through the Neighbourhood Networks Scheme, investing in communities through Prevention and Communities grants, and supporting vulnerable adults through a focused housing and wellbeing support pathway. Whilst the Prevention First approach has not yet been fully embedded, evaluations which have already taken place of the Neighbourhood Networks Scheme, Prevention and Communities grants, carers’ commitments and within Vulnerable Adults 1 demonstrate the success of a prevention-focused approach.[12]

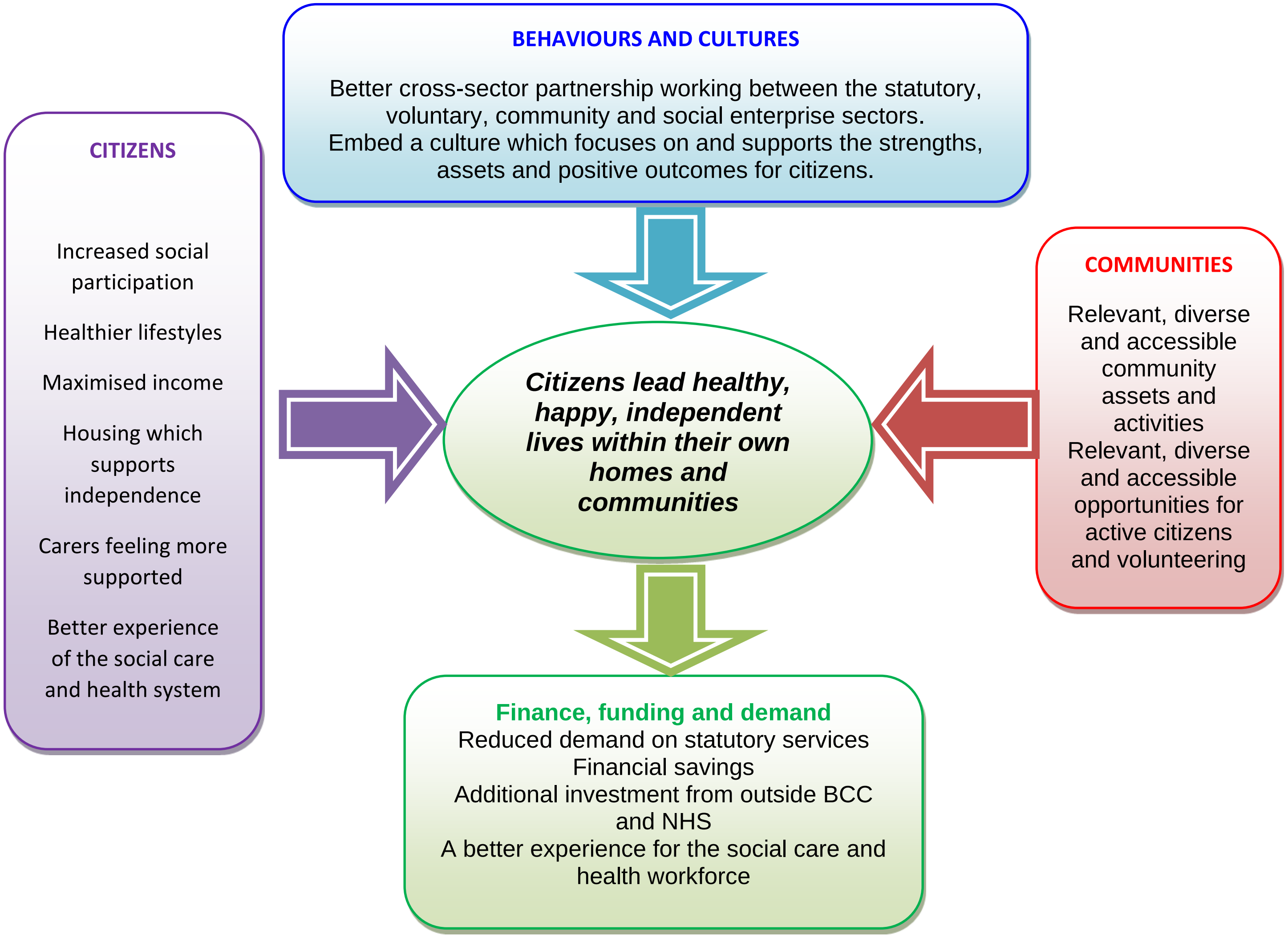
In many areas, specific strategies have been adopted which reinforce the Prevention First agenda. For example, the new strategy taken within VA1 towards homelessness rebalances in favour of preventing homelessness.[13] Similarly, the most recent domestic abuse strategy places a greater emphasis than previously on a proactive prevention strategy.[14] It is expected however that these frameworks will continue to develop and modify as programmes move forward through different stages of their relevant strategies.

The model underlying the Prevention First Framework acknowledges that in order to bring this about effectively whole systems change is required, with changes for individuals, changes for communities, changes in the sector-wide culture and changes in finance and funding all playing a role, as highlighted in Figure 1. Each commissioned service across the ASC Directorate will capture data that together can evidence the combined impact across the directorate.

---

[9] Putting Prevention First: Investing in Communities, p.2
[10] Putting Prevention First: Investing in Communities, p. 2
[11] Prevention First Performance Framework, pg. 2
[12] Birmingham Neighbourhood Network Scheme: Impact Assessment Summary Report
[13] Homelessness Prevention Strategy – Equality Analysis
[14] Domestic Abuse strategy

Figure 1. Prevention First Outcomes Framework[15]



BEHAVIOURS AND CULTURES

Better cross-sector partnership working between the statutory, voluntary, community and social enterprise sectors.
Embed a culture which focuses on and supports the strengths, assets and positive outcomes for citizens.

CITIZENS

Increased social participation

Healthier lifestyles

Maximised income

Housing which supports independence

Carers feeling more supported

Better experience of the social care and health system

Citizens lead healthy, happy, independent lives within their own homes and communities

COMMUNITIES

Relevant, diverse and accessible community assets and activities
Relevant, diverse and accessible opportunities for active citizens and volunteering

Finance, funding and demand
Reduced demand on statutory services
Financial savings
Additional investment from outside BCC and NHS
A better experience for the social care and health workforce

---

[15] Source of image: BCC Prevention First Performance Framework May 2019

3. Methodology

3.1 Information from Lead Commissioners

We received strategic documents from BCC relating to commissioning aims and goals of relevant strategies. We subsequently met with each of the lead commissioners (n = 4) across the ASC portfolio to gather information about their views of the Prevention First framework, current process of collating data from providers, the Council's use of the data, and any gaps or worries they currently identify with regard to performance evaluation. At the end of these meetings commissioners were asked to share blank data monitoring forms with the research team for review. These documents were systematically reviewed to facilitate understanding and the data organised into a spreadsheet to capture the type of information requested.

3.2 Information from Providers

All providers were contacted by email to request information about the data fields they collect in their service, what scales are used to measure variables, and how the data is captured and recorded[16]. The email was sent on behalf of the research team by an individual involved in managing the commissioned areas and therefore in communication with the providers regularly. Upon receiving the email, several providers emailed questions about the purpose of the data gathering exercise to BCC contacts. The objective of the overall performance review was reiterated at the start of each email and any follow up conversations to allay any fears or concerns of providers that they had done anything wrong.

All documents and materials were reviewed for potential sources of data that are currently being collected by the individual interventions. Information around referral processes, service user demographics, intervention delivery, assessments, retention, case closures, and end of intervention feedback were sought and organised into an excel spreadsheet.

All providers that responded to the request to share data agreed to an individual follow up conversation with the research team. The meetings focussed on clearing up any outstanding queries relating to the information received, as well as understanding what additional data service providers routinely collect that is not currently shared with the Council, their understanding of how the data they share is used; and their openness to sharing additional information if it were requested.

Meetings were held with 25 providers over phone or video call (apart from one interviewee who was unable to do a live interview and instead responded to each interview question in written format). Written notes were taken during interviews and interview findings reached using those notes.

---

[16] The details of this report are based on the information providers collected at the time this review was completed (August 2021). It is possible that the information collected and shared with BCC will change over time. For instance, NNS now collect some demographic information which is not captured in this report.

4. Review of Existing Process and Measures (Commissioner Level)

4.1 Meetings with Lead Commissioners

Performance Framework Aims

Lead Commissioners were very positive about Prevention First as a framework for the strategic aims underpinning the overall performance framework. The idea of it bringing together all commissioning areas within Adult Social Care was seen positively, particularly as the lead for one of the areas (Refugees and Migration) felt that their area was not as linked to the other commissioning areas as it might be. One commissioner even suggested that the Prevention First framework should underpin strategy across all of BCC, not just ASC.

In terms of their priorities regarding what the performance framework should be and do, commissioners highlighted three priorities for any performance framework: that it should be practical, that it should be able to justify spending, and it should increase standardisation.

Firstly, area leads were keen that any performance framework be realistic in what it demands of providers to collect, due to an awareness that overly onerous requirements for data collection would be frustrating and impractical for providers and clients. This was particularly highlighted in the case of the Neighbourhood Networks Scheme and (to a lesser degree) the Prevention and Communities grants, where providers are often small voluntary organisations with more fluid relationships to the clients. There was discussion of the previous evaluation standards which had included questions about loneliness and isolation, but providers being resistant to asking clients such sensitive questions.

Secondly, and possibly the most highlighted priority for the performance framework, was that the performance framework should be able to justify spending, particularly in the face of budget cuts. There was a worry that whenever cuts need to be made, prevention services are an easy target. Given this, a robust framework which demonstrates the value of prevention-based services as saving money over the long-term was perceived to be important. This was also mentioned as important when presenting any performance framework to providers, as there was a historical tendency described for data collection to be used only to cut budgets rather than to protect them.

Finally, and as has already been mentioned, the idea that the performance framework would be shared across commissioning areas within the directorate was seen as a positive. However, the idea of having outcome data, and evaluation results, which are comparable to other organisations (such as CCGs) was also seen as tremendously useful, as was the idea of increasing standardisation of outcomes across providers within areas. At every level then, having a performance framework which increased standardisation was seen as important.

The Current State of Evaluation

Descriptions of the current state of evaluation were largely heterogenous, both in process and in content. In some commissioning areas, extensive performance frameworks had already been coproduced with providers, listing large numbers of potential quantitative outcomes and outputs, whereas in other areas there was a strong focus on qualitative data or very limited data collected. Further details are provided in section 4.2.

One of the commissioning leads with a more developed framework said that they felt the existing data collected was reliable and a good “snapshot” but recognised this was useful as a starting point from which to have further discussions with providers as alone it didn’t give a full picture.

Areas of Improvement in Data Quality

Lead commissioners highlighted a number of areas where improvements could be made to current data quality: a lack of equalities data; outcomes which are not sufficiently connected to strategy and assessing impact; inefficient data storage and management; lack of individual level data; and missing data.

Although improving, lead commissioners felt there is currently a lack of equalities data collected. As one lead commissioner pointed out, if demographic information is not collected then it’s impossible to know how accessible the services are. The focus on social justice was added as an additional principle in the strategy for ASC, after the initial principles, and one commissioner explained that the fact it was a later addition may have been one of the factors which had led to it not being included so prominently.

Lead commissioners felt it was inefficient for providers to each collect and submit data in different ways as this meant that extracting and reformatting all the performance data was an unnecessarily difficult task. Ideally, the actual storing and managing of the data could be more uniform and user friendly – both for providers and commissioners. Whilst some providers share data with BCC at the individual level, others do not, and one commissioner said they actually didn’t ask providers for individual level data because it would be too difficult to process.

One interviewee spoke about how providers, in practice, were not measuring against all the outcomes they had committed to when they initially applied for funding. In many cases this was due to the Covid-19 pandemic. Many providers had been forced to adopt very different ways of working or change focus entirely, so some of the initial outcomes they intended to collect were no longer relevant or practical.

Furthermore, the current outcomes that were collected were described as being insufficiently linked to strategy and evaluation. This meant that there was sometimes a need to be “creative” in using what current data already existed to answer the necessary questions. One of the interviewees said that in part this was simply because the collected outcomes did not give enough detail, but more broadly the worry was that they were not asking the right type of questions. In some cases, providers had initially been set more useful outcome measures but providers themselves had moved away from them.

There was an acknowledgment that in many areas providers often collect more data than they provide to BCC, and that much of this data could be tremendously useful. For example, within Prevention and Communities grants awarded, a number of the providers are medium or even large charities who have their internal systems, or may have funding from other sources which requires them to collect additional data. Nevertheless, this information was not provided to BCC – often because it wasn't asked for, or because it would be difficult to extract appropriately from other data which BCC doesn't have permission to access. This was explored further within activities 4 and 5.

4.2 Review of Quarterly Return Monitoring Data

The purpose of collecting monitoring data is to systematically and purposefully examine project activities to ensure they are being implemented as planned. Monitoring project outputs (things produced by the project or programme) allows intervention providers to methodically track the progress of project implementation, execution, and outcomes. It can be particularly useful in detecting areas of success and where improvements are needed.

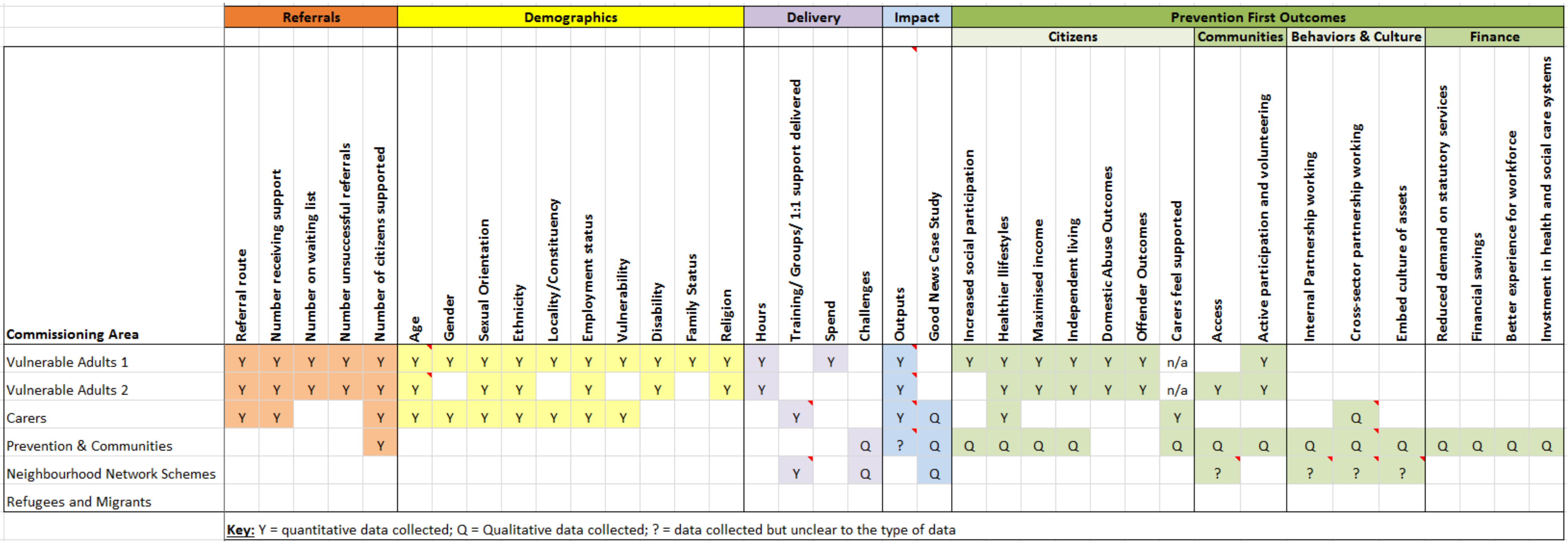
The monitoring data is crucial for BCC to measure the progress toward the Prevention First outcomes and to determine if the commissioned interventions/activities are delivering programmes that work towards actualising those outcomes. Furthermore, it allows BCC to demonstrate the benefit and value of preventative approaches and secure future funding.

Routine monitoring forms were received for five out of six commissioning areas. The design and content of current quarterly monitoring forms varied quite considerably between the commissioned areas: an excel spreadsheet, designed to collect quantitative information from providers for Vulnerable Adults; quantitative and qualitative data for Carers; an open-ended response form of qualitative information for Prevention and Communities; and a short list of headings for Neighbourhood Network Schemes. The commissioning area for Refugees and Migrants do not have a standard reporting template that all providers complete but have each co-designed their reporting template with the commissioners at BCC to fit the scope of their delivery.

Given the wide-ranging services and activities commissioned across the Adult Social Care portfolio, we appreciate that some degree of flexibility in reporting is important. In the case of the more developed performance frameworks this provider-level and client-level variation was managed by having very large lists of potential outcomes which providers selected the relevant subset from, whereas for others – for example, the Neighbourhood Networks Scheme where most of the collected information is qualitative, it was up to providers to decide what information they wanted to provide. However, whilst allowing providers the freedom to include information they feel relevant in the qualitative forms this poses challenges when aggregating the data across multiple providers, and reporting against Prevention First KPI’s, as it is anticipated response depth and content will differ between providers.

A map of the various data collated by BCC for each commissioning area is depicted in Figure 2. A key difference noted between areas, is that currently demographic information is only shared for contracts relating to Vulnerable Adults and Carers.

Figure 2. Mapping data and outcomes collated by lead Commissioners across the Adult Social Care Portfolio



	Referrals					Demographics										Delivery				Impact		Prevention First Outcomes															
																						Citizens							Communities		Behaviors & Culture			Finance			
Commissioning Area	**Referral route**	**Number receiving support**	**Number on waiting list**	**Number unsuccessful referrals**	**Number of citizens supported**	**Age**	**Gender**	**Sexual Orientation**	**Ethnicity**	**Locality/Constituency**	**Employment status**	**Vulnerability**	**Disability**	**Family Status**	**Religion**	**Hours**	**Training/ Groups/ 1:1 support delivered**	**Spend**	**Challenges**	**Outputs**	**Good News Case Study**	**Increased social participation**	**Healthier lifestyles**	**Maximised income**	**Independent living**	**Domestic Abuse Outcomes**	**Offender Outcomes**	**Carers feel supported**	**Access**	**Active participation and volunteering**	**Internal Partnership working**	**Cross-sector partnership working**	**Embed culture of assets**	**Reduced demand on statutory services**	**Financial savings**	**Better experience for workforce**	**Invstment in health and social care systems**
Vulnerable Adults 1	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y		Y		Y	Y	Y	Y	Y	Y	n/a		Y							
Vulnerable Adults 2	Y	Y	Y	Y	Y	Y		Y	Y		Y		Y		Y	Y				Y			Y	Y	Y	Y	Y	n/a	Y	Y							
Carers	Y	Y			Y	Y	Y	Y	Y	Y	Y	Y					Y			Y	Q		Y					Y				Q					
Prevention & Communities					Y														Q	?	Q	Q	Q	Q	Q			Q	Q	Q	Q	Q	Q	Q	Q	Q	Q
Neighbourhood Network Schemes																	Y		Q		Q								?		?	?	?				
Refugees and Migrants																																					

Key: Y = quantitative data collected; Q = Qualitative data collected; ? = data collected but unclear to the type of data

(*N.B. There was no standard reporting template for the Refugees and Migrants commissioning area at the time we spoke to the commissioning manager)

5. Review of Existing Process and Measures (Provider Level)

5.1 Review of Individual Provider Monitoring Data

Information about provider's data collection and monitoring processes were received from 25 providers, and covered the following commissioning areas:

- 12 from Vulnerable Adults 1 – Social Inclusion
- 3 from Vulnerable Adults 2 – Disability and Mental Health
- 1 from Carers
- 8 from Prevention and Communities
- 3 from Refugee and Migrants.

This activity highlighted the volume of data collected by individual providers and includes referral information, demographics, risk assessments, safeguarding referrals, (repeated) needs assessments, and feedback questionnaires. A summary of the various data captured is depicted in Figures 3, 4 and 6 with further insight from providers about the data collection and sharing processes in section 5.2.

The following points must be noted when interpreting the information to follow:

- *The information provided in this section is based on the data that providers shared with the research team and as such may not be fully representative of all data collected.*
- *Some providers deliver multiple contracts within and across commissioning areas, but data collection processes were similar across the contracts and as such only appear as one line in Figures 3 and 4.*
- *Neighbourhood Network Schemes did not share monitoring data forms but their views are captured in section 5.2.*

Client Profile *(see Figure 3).* Nearly all providers (96%) collected demographic information to some extent. There is much consistency for VA1 and VA2 contracts and this fits with the standard reporting template provided by BCC commissioners. A number of additional data fields were also collated less consistently among providers (i.e., education, nationality, immigration status) and these are highlighted in red text in Figure 3. Contracts within Prevention and Communities and Refugees and Migrants do collect demographic data, but for fewer data fields as shown in Figure 3.

All providers kept track of the number of referrals/people accessing their service and 68% recorded the reason they were referred or the support needed. As may be expected given the nature of the services provided, details about referral routes and whether other agencies were involved was collected more consistently for VA1 and VA2 providers.

Figure 3: Overview of demographic and referral information collected by individual providers
(Headings in red text are additional to those currently shared with BCC)

	Client Profile																Referral Information					
	Age	Gender	Sexual Orientation	Employment Status	Economic Status	Vulnerability	Disability	Ethnicity	Religion	Family Status	Constituency	Education/Qualifications	Pregnant	Nationality	Immigration Status	Language (Interpreter Required)	Number of referrals	Number on waiting list	Referral route	Reason for referral/support need	Reason for unsuccessful referral	Other agencies involved
n collected	23	20	15	10	8	11	17	19	11	7	16	4	7	10	7	10	25	8	20	17	6	15
% collected	92%	80%	60%	40%	32%	44%	68%	76%	44%	28%	64%	16%	28%	40%	28%	40%	100%	32%	80%	68%	24%	60%
VA1/VA2	Y	Y	Y		Y	Y	Y	Y			Y			Y	Y	Y	Y	Y	Y	Y	Y	Y
	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y		Y	Y			Y		Y	Y		Y
	Y	Y	Y			Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y		Y				Y		Y		Y	Y
	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y		Y
	Y	Y	Y		Y	Y	Y	Y	Y		Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Y	Y	Y	Y	Y		Y	Y	Y	Y	y		Y	Y			Y		Y	Y		Y
	Y	Y	Y		Y		Y	Y	Y	Y	y		Y	Y		Y	Y		Y	Y	Y	Y
	Y	Y	Y	Y		Y	Y	Y	Y	Y		Y					Y			Y		Y
	Y	Y	Y	Y	Y			Y	Y					Y		Y	Y		Y	Y		Y
	Y	Y	Y					Y							Y	Y	Y	Y	Y	Y		Y
	Y	Y	Y	Y		Y	Y	Y	Y		Y	Y				Y	Y		Y	Y		Y
	Y	Y	Y		Y		Y	Y	Y								Y	Y	Y			
Carers	Y	Y	Y	Y			Y	Y			Y						Y		Y	Y		Y
P&C																	Y	Y				
	Y						Y	Y	Y		Y						Y		Y	Y	Y	
	Y	Y		Y		Y		Y			Y					Y	Y		Y	Y		
						Y	Y										Y		Y			
	Y	Y					Y	Y									Y					
	y					Y	Y				y						Y	Y	Y	Y		
	Y	Y						Y			Y	Y		Y	Y	Y	Y		Y	Y		Y
	Y	Y					Y	Y			Y						Y		Y			
R&M	Y																Y					
	Y	Y		Y								Y					Y		Y			Y
	Y	Y	Y								Y			Y	Y		Y			Y		

Citizen Outcomes: *(see Figures 4 and 5)*. The outcomes data collated varied across all providers according to the service they provide. Figure 4 depicts the different citizen-level outcomes being monitored, and shows that:

- 84% of providers monitored at least one outcome related to economic wellbeing;
- 84% of providers monitored at least one outcome related to health and wellbeing;
- 60% monitored at least one outcome related to accommodation/independent living.

A breakdown by commissioning area is presented in Table 1 below.

Table 1. The number of providers monitoring citizen-level outcomes by commissioning area

	Economic Wellbeing	**Health and Wellbeing**	**Accommodation/ Independent Living**	**Domestic Abuse**	**Offending**
VA1/VA2	100% (13/13)	100% (13/13)	92% (12/13)	58% (7/12)	58% (7/12)
Carers	100% (1/1)	100% (1/1)	0% (0/1)	0% (0/1)	0% (0/1)
P&C	50% (4/8)	63% (5/8)	13% (1/8)	0% (0/8)	0% (0/8)
R&M	100% (3/3)	66% (2/3)	66% (2/3)	0% (0/3)	0% (0/3)

The data captured by Prevention and Communities and Refugee and Migrants contracts appear to be more targeted at capturing data on specific outcomes related to their service or activities. It is important to acknowledge here that some Prevention and Communities projects collate qualitative data from service users about what difference the project has made to their lives, but this not captured in Figure 4.

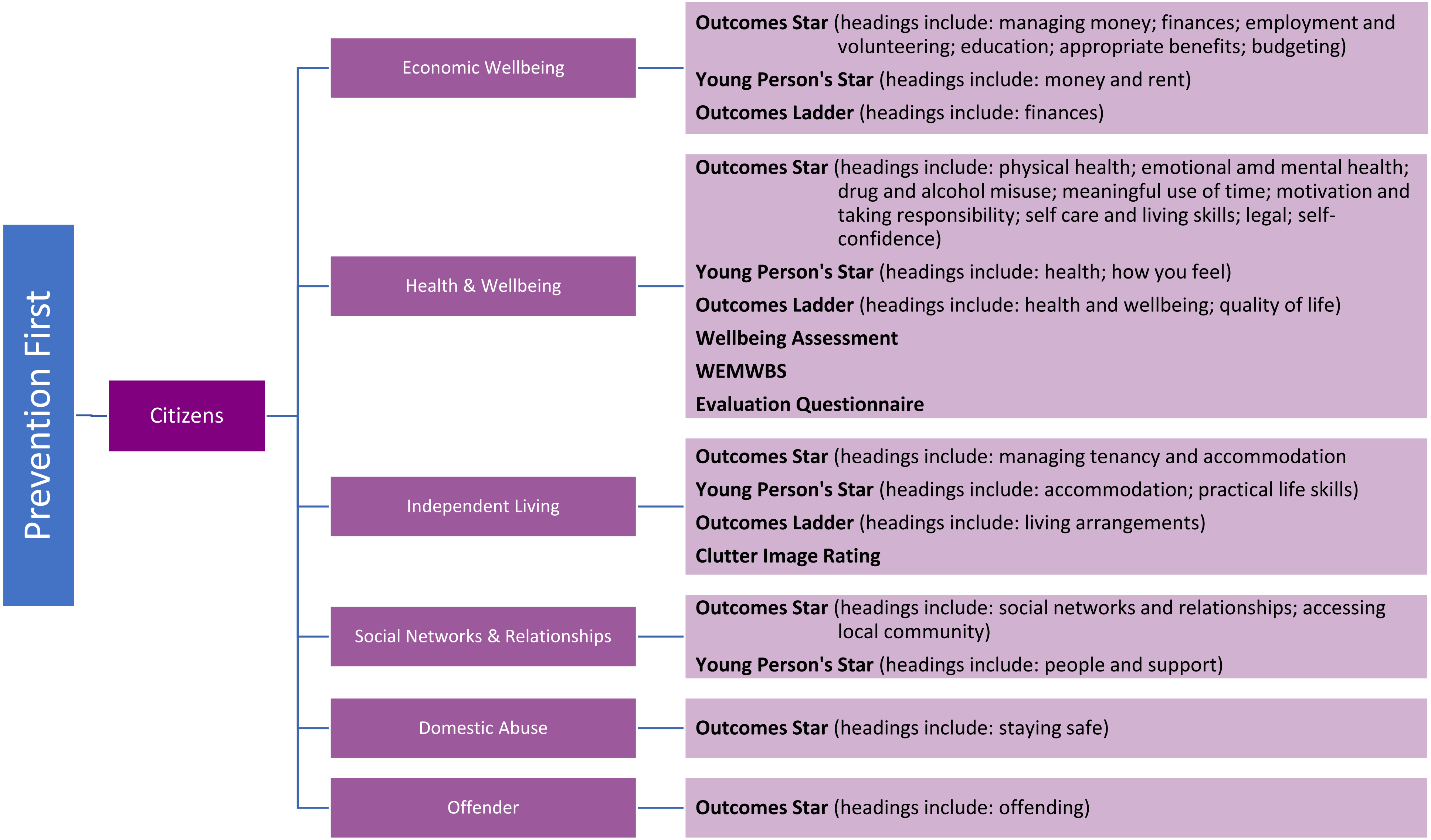
Figure 5 highlights the various tools used by providers to collect and monitor changes in these individual citizen level outcomes. Repeat measures vary considerably from pre and post assessments to routine reviews every 3 or 6 months whilst they are in the service. 67% of the providers that shared information captured repeat assessments of individual needs and progress. Outcomes Star was the most widely used tool to assess and review client needs.

Figure 4: Overview of citizen level outcome data collected by individual providers

(Headings in red text are additional to those currently shared with BCC)

	Citizens																																							
	Economic Wellbeing						Health and Wellbeing																				Accommodation supporting independence							Domestic abuse				Offenders		
	Reduced overall debt	Ensured correct benefits were accessed	Participated or obtained paid work	Participated in education or training	Manages finances and budgets	***Report on an aspect of economic wellbeing***	Better managed or improved physical health	Better managed or improved mental health	Improved (self-reported) wellbeing satisfaction levels	Quality of Life	Vulnerable adult safe and well	Vulnerable adult not self-neglecting	Accessed primary health care	Registered with a GP	Had an annual health check	Participated in leisure, cultural, faith, learning & community activities	Established contact with external services, family and/or friends	Access to specific health programmes such as flu jabs and inoculations	Adopted healthy lifestyle choices through pregnancy	Able to look after their children and keep them safe	Drug and alcohol use	Self care and living skills	Meaningful use of time	Motivation and taking responsibility	Legal support and advice	***Report on an aspect of health and wellbeing***	Managing tenancy and accomodation	Maintained accommodation, including paying rent and bills	Avoided eviction	Secured temporary accommodation for a set period of time e.g. 6 months	Obtained long term accommodation	Managing hoarding	***Report on an aspect of accommodation***	Developed confidence	Felt safer	Understood the nature and cause of domestic abuse	***Report on an aspect of domestic abiuse outcomes***	Offending	Aware of impact of offending	***Report on an aspect of offender outcomes***
n collected	7	13	6	12	14	*21*	14	15	8	1	6	6	7	11	4	9	6	6	5	7	7	10	4	5	3	*21*	14	6	4	3	3	1	*15*	6	6	4	7	7	3	7
% collected	28%	52%	24%	48%	56%	*84%*	56%	60%	32%	4%	24%	24%	28%	44%	16%	36%	24%	24%	20%	28%	28%	40%	16%	20%	12%	*84%*	56%	24%	16%	12%	12%	4%	*60%*	24%	24%	16%	*28%*	28%	12%	*28%*
VA1/VA2					Y	Y	Y	Y						Y							Y	Y	Y	Y		Y	Y						Y					Y		Y
	Y	Y		Y	Y	Y	Y	Y	y			Y	Y	Y	Y	Y		Y	Y	Y						Y	Y	Y	Y		Y		Y	Y	Y	Y	Y			
	Y	Y	Y	Y		Y	Y	Y				Y		Y		Y	Y	Y		Y	Y	Y				Y	Y	Y					Y		Y		Y			
	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y						Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y
		Y	Y	Y	Y	Y	Y	Y	Y			Y		Y		Y	Y	Y	Y	Y	Y	Y		Y		Y	Y	Y					Y	Y	Y		Y			
	Y	Y				Y	Y	Y					Y	Y		Y					Y	Y	Y	Y		Y	Y						Y					Y		Y
					Y	Y	Y															Y				Y	Y						Y							
	Y	Y	Y	Y	Y	Y	Y	Y			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y					Y	Y						Y	Y	Y	Y	Y	Y	Y	Y
	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y		Y		Y	Y	Y	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y
					Y	Y	Y	Y													Y	Y	Y			Y	Y											Y		Y
		Y		Y	Y	Y	Y	Y			Y					Y										Y	Y						Y	Y			Y			
					Y	Y	Y	Y													Y	Y	Y	Y	Y	Y	Y						Y					Y		Y
	Y	Y	Y	Y	Y	Y		Y			Y		Y	Y		Y										Y		Y					Y							
Carers				Y		Y	Y	Y			Y									Y		Y				Y														
P&C									y																							Y	Y							
					Y	Y				Y												Y				Y														
		Y				Y																																		
									Q				Q													Y														
		Y				Y		Y						Y												Y														
					Y	Y			Y																	Y														
									Y																	Y														
R&M		Y		Y	Y	Y	Y	Y																	Y	Y	Y		Y	Y			Y							
				Y		Y																																		
		Y		Y		Y								Y			Y								Y	Y	Y						Y							

Figure 5: Tools used to assess repeat measures of citizen level outcomes. Note that completed Outcomes Stars are supplemented with more detailed qualitative notes and action plans

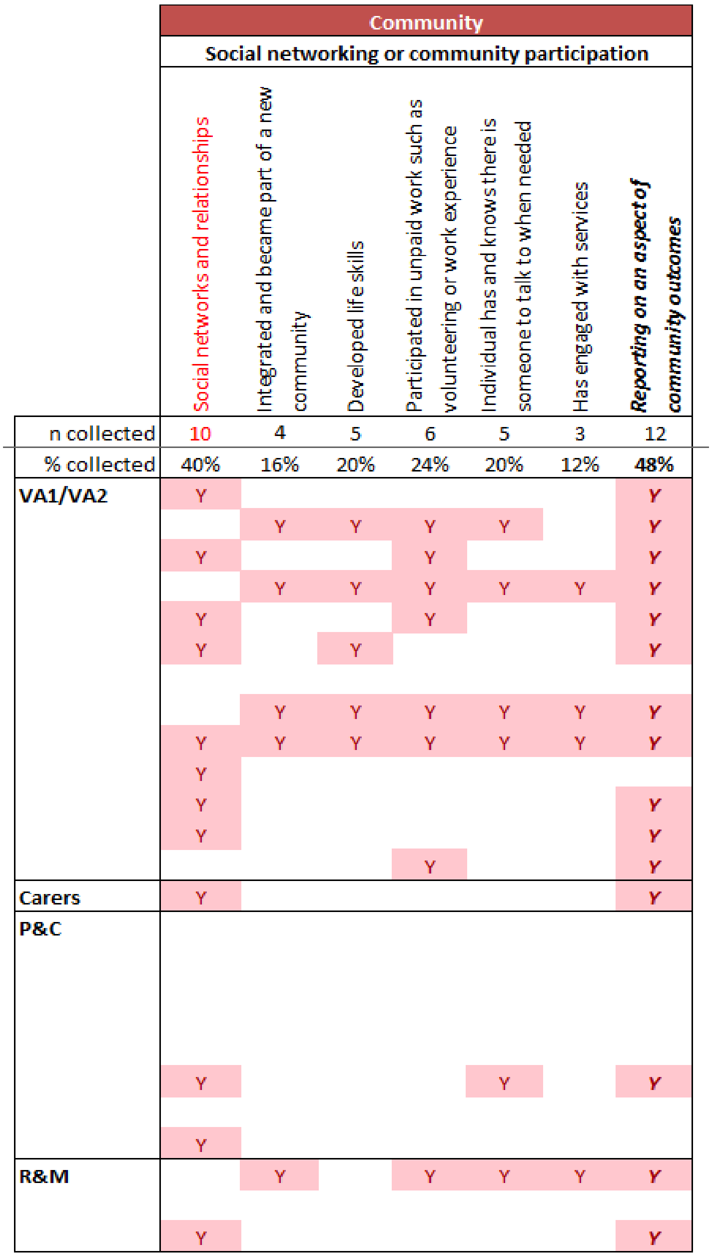


Prevention First

- Citizens
  - Economic Wellbeing
    - **Outcomes Star** (headings include: managing money; finances; employment and volunteering; education; appropriate benefits; budgeting)
    - **Young Person's Star** (headings include: money and rent)
    - **Outcomes Ladder** (headings include: finances)
  - Health & Wellbeing
    - **Outcomes Star** (headings include: physical health; emotional amd mental health; drug and alcohol misuse; meaningful use of time; motivation and taking responsibility; self care and living skills; legal; self-confidence)
    - **Young Person's Star** (headings include: health; how you feel)
    - **Outcomes Ladder** (headings include: health and wellbeing; quality of life)
    - **Wellbeing Assessment**
    - **WEMWBS**
    - **Evaluation Questionnaire**
  - Independent Living
    - **Outcomes Star** (headings include: managing tenancy and accommodation
    - **Young Person's Star** (headings include: accommodation; practical life skills)
    - **Outcomes Ladder** (headings include: living arrangements)
    - **Clutter Image Rating**
  - Social Networks & Relationships
    - **Outcomes Star** (headings include: social networks and relationships; accessing local community)
    - **Young Person's Star** (headings include: people and support)
  - Domestic Abuse
    - **Outcomes Star** (headings include: staying safe)
  - Offender
    - **Outcomes Star** (headings include: offending)

Community Outcomes *(see Figure 6)*.

Figure 6. Overview of community level outcome data collected by individual providers *(Headings in red text are additional to those currently shared with BCC)*



	Community						
	Social networking or community participation						
	Social networks and relationships	Integrated and became part of a new community	Developed life skills	Participated in unpaid work such as volunteering or work experience	Individual has and knows there is someone to talk to when needed	Has engaged with services	***Reporting on an aspect of community outcomes***
n collected	10	4	5	6	5	3	12
% collected	40%	16%	20%	24%	20%	12%	**48%**
VA1/VA2	Y						Y
		Y	Y	Y	Y		Y
	Y			Y			Y
		Y	Y	Y	Y	Y	Y
	Y			Y			Y
	Y		Y				Y
		Y	Y	Y	Y	Y	Y
	Y	Y	Y	Y	Y	Y	Y
	Y						
	Y						Y
	Y						Y
				Y			Y
Carers	Y						Y
P&C							
	Y				Y		Y
	Y						
R&M		Y		Y	Y	Y	Y
	Y						Y

Behaviours and Culture Outcomes: None of the providers shared information to show they specifically collate information relating to behaviour and culture, but this is discussed in section 4.4. It should be noted that VA1 providers were soon to be completing an annual Payment by Outcomes report template which captured details of systems change - working in partnership, joint commissioning, quality standards and joint referral routes.

Finance Outcomes: None of the providers shared information to show they specifically collate information relating to finance other than that attributed to the cost of delivering their own service.

5.2 Meetings with Providers

Findings from interviews conducted with providers are divided into two sections: the first section provides an overview of each commissioning area, and the second section covers additional considerations or themes raised by providers.

5.2.1 Overview by Commissioning Area

Vulnerable Adults 1 and 2

Vulnerable Adults 1 covers social inclusion, wellbeing and housing and Vulnerable Adults 2 (soon to be renamed Prevention and Empowerment Pathway) covers learning disabilities and mental health issues. These are commissioned separately and use distinct reporting templates. Nevertheless, two out of three of the VA2 providers interviewed had contracts in both VA1 and VA2, and this meant that many of their answers – for example on how submitted data should be used by BCC, or on their relationship as an organisation with BCC – didn't distinguish between the two areas. Furthermore, whilst the core reporting templates used in each area are distinct, they are highly similar. For these reasons, their responses are grouped together here.

In both VA1 and VA2 the standard procedure is the submission of a quarterly reporting template (standardised within each of the two areas), which focuses entirely on quantitative outcomes. Alongside these quarterly reports, there are annual submissions which include more information about partnership working and allow providers to give qualitative information and case studies.

For many of the individual outcomes, a question is asked about how many service users presented with a need, how many had this need partially met, and how many had the need fully met. These outcomes are often based on conversations with service users and completing Outcomes Stars. In some instances the outcomes were based on judgement by a project worker (or similar role) rather than the service user. One VA1 provider spoke of disagreements between staff about whether the client had a specific need highlighting the subjectivity of responses.

The VA1 and VA2 workbooks capture quantitative data, and providers largely understand the need for quantitative data to be collected and shared with BCC. Yet, one provider explained that *"they record information from clients about what difference the service has made to them, but it is difficult to capture quantitatively."* Many VA1 and VA2 providers explained that they would be happy to provide additional qualitative data with their returns if requested, and in fact several already do return case studies with either their quarterly returns or annual report to further demonstrate the impact their work is having, as they feel there are sometimes situations whereby *"a person had large positive change but it's not captured by the spreadsheet".* Two providers found it useful for them to be able to add comments to the workbook to explain any changes in trends or discrepancies.

On the whole providers were happy with the current reporting template, and most commented on how it was fairly straight forward to complete and that it had improved from previous versions. In particular, providers like how all quarters are in one document, so it is easier to compare over the year. A number of providers specifically stated they had input into the design of the current reporting template and changes had been made to the form based on their feedback, and we believe this is a large reason as to why there is general satisfaction with the template.

Nevertheless, providers did also raise queries over the current template including gaps in capturing all of the work they have done and that it can be difficult to capture the difference their service makes quantitatively; not being able to capture related problems in the system such as the housing issue and difficulties moving women on from their service; and that it is missing the stories and narrative to explain the figures and contextualise the information provided.

Respondents across VA1 and VA2, broadly reported that the template as it currently exists is not excessive and requires a proportionate amount of effort to the funding received. Many of the respondents in VA1 and VA2 are relatively large organisations, many of whom have dedicated IT systems to collate the required information.

"Doesn't take long to fill in as internal systems are set up so easy to transfer data and all staff are aware of the reporting dates and complete documents ahead of schedule."

Carers

There is only one provider with contracts funded through the Carers commissioning area. The provider works in partnership with twelve organisations across Birmingham to provide information and advice about the caring role and where to access support; and provide support groups and workshops. The quarterly reporting template used for the Carers has been agreed between the provider and BCC and as such the provider is happy with the template. The template is very detailed and captures a mixture of qualitative and quantitative data including number of carer assessments, the number of sessions delivered, demographics and change in wellbeing scores. They deliver the Statutory Carers Assessment under the Care Act 2014 for all adult-to-adult carers and a similar wellbeing assessment for parent carers or young carers. This assessment covers nine domains. The data for quarterly returns is taken from the central database that all partners input into.

Refugees

The three organisations interviewed held contracts which focussed on the housing and resettlement of refugees (in both the short and medium term). Even within a given contract, the responsibilities and activities were described as being varied and two of the organisations interviewed said that, although in theory there is a strict delineation in what types of support they provide to refugees as part of their contract, the practice is much more "blurred". Nevertheless, the types of services provided by the three organisations were described as being complementary and the organisations had strong relationships with each other.

The templates used varied by contract. In each case they had been developed specifically by the organisation in order to match the specific project, meaning that even within the same organisation different contracts were associated with different reporting processes. One of the interviewees said that the measures they were using were the ones mentioned as part of the initial bid for the contract, whereas another organisation said that the development of the reporting template, as it currently existed, happened predominantly after service had started. Relative to some providers in other areas, the organisations interviewed described having fairly advanced architecture to collect and store data, such as an in-house tailored case-management system to log client details and worker actions.

Interviewees were broadly positive around the existing reporting template, and particularly valued the fact that they had been able themselves to direct the structure of the template. For example, one of providers said that from their perspective a key priority of the template was to collect information related to potential safeguarding issues, and they had been able to steer the reporting template in that direction.

A common approach was to have two types of report – one quarterly report which is entirely or predominantly quantitative, detailing for example what percentage of service users had been registered with a GP or found employment, and a separate report which gave qualitative information, either in the form of a narrative report grouped by theme and topic or in the form of case studies. That said, there were exceptions. One of the smaller contracts for example, only provided qualitative reports.

It was broadly seen as a positive feature that there was both quantitative and qualitative features to reporting. One of the interviewees, for example, said that they appreciated the qualitative reporting because it focussed on the service users' own perspective and allowed greater flexibility to report on any issues that may have arisen, but they also appreciated that it was important that the commissioners had the quantitative reporting in order to inform decision-making and have evidence (albeit it at a "lower-level") of how people's lives had been changed.

One interviewee raised the importance of their service user's legal status, not only in its own right but also in preventing other types of issues, and suggested that given this importance, legal status should play a more central role in their reporting template. The interviewee did say however that this was an area they were looking into introducing and were optimistic that this could be done effectively.

Neighbourhood Network Scheme

The Neighbourhood Network Scheme is a programme which currently covers each constituency within Birmingham. In general, the structure is that within each constituency a VCFSE organisation (or group or organisations) is identified and plays the role of an anchor organisation(s) to connect and support the VCFSE sector within the constituency, as well as administer and provide grants, all in line with Prevention First principles, aiming specifically at supporting over 50 year olds. There are however exceptions – in two constituencies the designated anchor organisation sits within BCC, in another two constituencies a pilot is being run which extends the target group to all adults rather than just over 50s.

The grants awarded can be up to £10,000, although in the vast majority of cases the grants awarded are for small amounts given to support the growth and development of very small organisations. Reporting in the NNS therefore happens at two levels – firstly on the anchor organisation for each constituency, but also for all of the smaller groups supported and funded through the NNS.

Interviews were conducted with two NNS anchors, and with one organisation which is not itself an anchor organisation but is responsible for processing and adjudicating grant applications across two constituencies in the city.

The process through which small VCFSE grant awardees are evaluated varies dramatically by constituency, as well as within constituencies to some degree. One of the constituencies uses an Impact App with all of the grant awardees, which collects limited quantitative data on attendance (although many groups use the app with a sample of users, so it doesn't necessarily provide a good estimate of this) and impact but also allows users to provide free-form qualitative information too if they so wish. This was supplemented with further annual evaluation forms from each funded group which also covered attendance, and included a qualitative summary from awardees, as well as an annual get together of all the grant awardees to discuss best practice and learn from each other. In the other constituency interviewed, the anchor requests only qualitative reports from grant awardees, focussing on case studies, and in some cases for very small organisations they would get this type of information from informal conversations. The interviewee said explicitly that, *“we can't answer things like how many people have benefitted, what impact has been made on certain issue, etc”*. The interviewee did suggest that this was an area that they would like to improve on and had been considering alternatives but the difficulty, highlighted by both anchors interviewed, was that evaluation had to be “light touch” given the nature of the grant awardees - typically very small organisations without any of the data architecture, staff availability, or staff skill to engage in extensive data collection.

In terms of evaluating their own role, both anchors said that they held evaluation sessions with the groups that they support to assess their own performance. In one of the constituencies, for example, organisations are rated by the anchor in terms of their internal structure (i.e., whether or not they have all of the appropriate policies and resources). This measure can be used to demonstrate progress both at the level of a small VCFSE organisation (i.e. we have moved from being unconstituted to being constituted as an organisation), but also provides a measure of the anchor’s success in supporting those VCSFE organisations (i.e. we have supported x number of organisations to become constituted). The grant awarding organisation said that they primarily report on quantitative outcomes (such as how many applicants were successful or supported to apply for other sources of funding). These outputs contribute to the Prevention First behaviours and culture outcome.

One of the anchors acknowledged that much of the value which the NNS is achieving is not captured by the current template, but said it was difficult to see how that could be done practically. Both anchors also highlighted potential risks about any changes to the reporting template making it impractical for the groups they support. One of the interviewees in particular, was cautious that a move towards more quantitative measures would provide challenges to the groups they work with and that BCC needed to have an element of trust that the NNS would have the desired preventative effects.

Prevention and Communities

Prevention and Communities grants are awarded to a total of 46 organisations (some of whom hold multiple P&C contracts) aimed at addressing the Prevention First outcomes. Given the open and broad nature of the Prevention First outcomes, the organisations and activities that receive funding through P&C are enormously diverse, which was reflected in the four organisations interviewed.

There is a standardised template used by all providers which asks limited quantitative information (how many people attended, how many of those people were new) and a much larger portion focussing on qualitative responses directly related to the Prevention First framework. Providers had regular meetings with the relevant contract manager from BCC who would RAG rate them based on information submitted in their quarterly reports.

Broadly the organisations interviewed did not have major problems with the existing template, and it was compared very favourably to the previous template which was seen as being excessive. One of the interviewees felt that the emphasis on qualitative reporting was inefficient as the type of support and type of outcomes clients received did not change from quarter to quarter – rather what varied was the number of people who had achieved various outcomes, so focussing on case studies (which were qualitatively similar from report to report) was not providing useful information. One interviewee said that an increased focus on quantitative outcomes would be easier to record and administer, although another said that providing case studies and descriptions was easier to record and maintain.

P&C was one of the most varied areas in terms of the amount of existing infrastructure they held to record data – one of the P&C contracted organisations interviewed was part of a national charity and so had dedicated case management software, whereas another organisation only had one member of staff who entered client information on a Google Sheets, manually counting the number of new participants for each submission.

5.2.2 Other Considerations

Proportionate Effort

Interviewees, across commissioning areas, thought that it was important that the amount of effort required of them to provide the relevant data was proportionate and reasonable. As a number of interviewees pointed out, their key priority was providing the services and programmes for which they had been contracted - not collecting and recording data. One example of where the reporting effort was felt to be disproportionate and not closely related to demonstrating the quality of the service was for payment-by-input (i.e., quantifying the number of hours of delivery).

Broadly respondents thought that the reporting templates they currently used were appropriate. Some organisations (in VA1) said that it was close to the maximum that was practical for them to collect. A few interviewees – particularly within the P&C and Refugees commissioning areas – said that the previous reporting template had been excessive, requiring vastly more information than was proportionate to the size of the contract, but that the current template was much better.

A number of interviewees said that the reporting templates required substantial amounts of effort to use at first but had become much more manageable over time. In some cases, this was due to changes in structure that providers were able to negotiate with BCC, but many interviewees highlighted that staff simply need time to adapt to any new template or reporting procedure.

Some providers had been part of developing the outcomes and framework they reported against, which seemed to lead to a level of buy-in from providers. Where providers hadn't influenced the development of their reporting template, they did seem broadly pleased that they had been (in most cases, relatively easily) able to negotiate changes to reporting templates to be more fit for purpose, although one provider did say that although he appreciated the flexibility, he wished there had been more consultation before its implementation to prevent the need for changes.

Some interviewees also highlighted how external factors (i.e., Covid19) meant that they were under more pressure than they had planned for in the initial contract and this meant that they were finding their reporting responsibilities a challenge, however this wasn't blamed on the structure or nature of the reporting templates particularly.

How Is Data Used

Providers were generally uncertain of how exactly the information they provided – either quantitative or qualitative - was used by BCC. One provider said explicitly, *"We have no idea how the data is used."* Where providers did suggest how it was used, they most commonly mentioned it in one of two ways.

The first and most commonly suggested was its use in ongoing and continuous assessment of the organisation's performance in relation to the details of the contract. In some cases, this related to the payment by outcomes that had been agreed, but it was also mentioned by a number of providers who weren't paid by outcomes.

The second important use that providers mentioned was the idea that BCC aggregated the information they provided and used it to make broader strategic or policy decisions within Adult Social Care. Indeed, this is certainly done in some areas – for example some of the key quantitative outcomes measured in VA1 contribute to a regular dashboard which shows figures across all providers in the area. One interviewee was able to give a concrete example of a time that reporting data from providers was put into a broader picture and used to inform strategy in a way that they were aware of. However, in general, providers did not have a clear idea of how their reporting fits into a broader picture.

Additionally, one provider said that the reporting data was to be used in case there were safeguarding breaches – and the information on the reporting template would be used retrospectively to understand and assess how that situation had been reached. Two providers echoed what many of the lead commissioners saw as the purpose of the reporting template, that they thought the data was used as "ammunition" to protect the service from funding cuts.

How Should Data Be Used

The way BCC currently use the data mentioned above were all cited as important. A few organisations said that it may be useful to see results from other organisations working on related issues or be given more of a picture from across the whole city – particularly as BCC would be well placed to conduct the type of analysis that a given provider wouldn't. Any given provider would only have a small dataset and may lack the relevant technical ability, so may struggle to draw findings from their results but BCC drawing all of the data from across the city together would be much better placed to provide this kind of picture. For example, one provider said that BCC should be trying to understand the relationship and publicising the findings to front line providers between demographic variables and various outcomes - i.e., providers who work on housing in VA1 would want to know whether black citizens get evicted more often than white citizens? Are providers achieving equally good results with black client as white clients? This information, the provider pointed out, would help providers not only in their existing BCC contracts, but would also help providers guide future activity and potentially be more successful in applications for funding.

That said, in some areas, providers already had very close working relationships with all the relevant providers, and many said that it wasn't particularly important that they as a provider see the results as long as they are being used internally to inform policy.

Prevention First Framework

Some interviewees, particularly within the Refugees and Migrants commissioning area, were very positive about the idea of the Prevention First Framework. Unlike in other areas (i.e. P&C), the reporting template in R&M is not currently so tightly based around the Prevention First framework. One interviewee spoke about how the Prevention First framework formalised and fleshed out the existing objectives of what they were already trying to do, and another interviewee spoke about how the outcomes and changes which they were trying to introduce to the reporting template were fundamentally preventative-focused.

There were no interviewees that expressed any hesitancy about the Prevention First framework per se, although one interviewee did say that providers across ASC were simply too diverse and varied in activities and objectives to be “pigeon-holed” into any one framework.

Data Sharing with BCC

Many of the providers interviewed, across all five areas, collected a range of data and information, covering demographic information, social value outcomes, a variety of outputs, which they did not give to BCC. The key areas where additional information is like to be useful to BCC is where providers collect good wellbeing measures (or related measures, such as outcome stars) and demographic information. Providers were generally open to sharing additional information and noted that where dedicated case management systems were in place this may be relatively straightforward. Nevertheless, some large organisations with dedicated case-management systems explained it may not be simple to extract outcomes and information associated with BCC funded contracts from non-BCC funded contracts. Similarly, some of the smaller organisations do not collect additional information to that required by BCC or store the information in such a way that extracting it would be a substantial increase in workload.

A number of organisations also said that they regularly wrote up case studies or other types of qualitative data on their clients for other purposes so it wouldn’t be difficult for them to provide additional qualitative information to BCC. In some cases this may be useful. For example, one organisation said that their contract with BCC is not for a crisis service, but in practice many of the people using the service funded by that contract are in crisis. They said that they could very easily provide additional extensive qualitative data on clients in such a situation which presumably would be useful from a commissioning perspective to gain a better understanding of why people in crisis are using what is ostensibly not a crisis service. In many cases however qualitative data is going to face similar problems as quantitative data. Qualitative data takes a very long time to analyse or even consider fairly, and if it isn’t targeted towards the type of questions that BCC has as priorities then it is unclear whether it would be of value.

There is clearly scope for BCC to be collecting more data from providers, which would be useful to BCC and wouldn’t impose additional burden on providers. However, ethically, it should be ensured that any additional data shared is relevant and will serve a specific purpose.

Provider-Commissioner Relationship

A number of providers praised BCC for their flexibility and adaptability in the reporting template. It was clearly very important to providers that they had a strong relationship with the relevant commissioning manager because that linked them into a wide variety of other types of work and organisations, in the public and third sector.

In the few cases where there was a weaker relationship with a commissioning manager (or similar figure) this was highlighted as important. A couple of interviewees said that BCC had been less responsive in general since the pandemic, and one suspected that the transition from in-person to wholly online meetings may have been a factor.

Unclear Outcomes

A few providers, particularly in VA1, said that they found the reporting template to be too full of outcomes which were not relevant to the kind of work they did. It was suggested that this made the data reporting less clear to understand and slightly more complicated to complete. A few more providers said that, though they had initially found the reporting template complicated, by the time of interview they had accustomed to it, and no longer found it so difficult.

A couple of interviewees also said that there were outcomes which they didn't understand or found confusing, and they were worried that they weren't using the template in the same way as other organisations might be. A further issue is that even when the reporting template was conceptually clear, it was not necessarily obvious if a service user hit the required threshold to be recorded on the template or not. For example, one provider said that though it was not common, there were sometime disagreements between staff whether or not record that a user had a specific need or not.

Gender

Three providers mentioned that more work needed to be done around how their current reporting template recorded gender and gender identity. There was variation in exactly how gender was recorded, but in at least two cases, the question format presented being transgender as an alternative to being a man or woman. One provider described this as confusing. As well as resulting in incoherent data, there are a number of serious problems with a reporting template which fails to recognise that a transgender woman (or man) can simultaneously be transgender and a woman (or man). Furthermore, such a structure does not acknowledge other gender possibilities, such as non-binary identities.

One of the larger providers who raised this issue said that they had started a process of reviewing the gender options across their organisation. Fundamentally though, this issue should not be left to the discretion of providers. Whether or not a person is transgender is separate from their gender, and so if information is required to both questions, these should be presented as separate questions. The guidance given by Stonewall[17] on this issue recommends one question on gender giving four options for a person's self-described gender (man, woman, prefer not to say, and the option to self-describe) and a separate question on gender identity, which either asks people whether they are trans (yes, no, prefer not to answer) or alternatively asks people whether their current gender matches the gender they were assigned at birth (yes, no, prefer not to say). Either of these options would be acceptable, although the latter is probably preferable as it matches the format used in the most recent census.

Social Value

Many providers spoke of the added social value that their service provides but recognised this was not readily captured in their data. One provider said that they were certain they were having an impact on several other statutory services, such as the police but that there was no realistic way for them to capture that impact. A number of areas that didn't currently have measures related to social value said that they were interested in the area and were looking at collecting additional data. Many providers collected some form of individual wellbeing or wellbeing-adjacent measure. Of these, by far the most common was the Outcome Star (in some form) although there were also groups that collected other measures, such as WEMWBS or a visual analogue scale (see Figure 5). There is also a working group and pilot ongoing, looking at the use of ICECAP. Though these scales are used, organisations were not necessarily readily turning these scores into estimates of social value. In the case of Outcome Stars, for example, they are often conceived of as a tool for aiding progress as a measure.

---

[17] https://www.stonewall.org.uk/sites/default/files/do_ask_do_tell_guide_2016.pdf

6. Considerations for the Performance Framework

Three key considerations that have arisen from our discussions and review of the current data collected are discussed in further detail in this section with various options for solutions provided. Our recommended solutions are listed in a summary section (6.4).

6.1 Lack of Individual-Level Data Submissions

Individual level data is not submitted to BCC currently, rather quantitative data is collected at the individual level and then aggregated before being sent to BCC. The information that BCC receives is therefore a count of how many people match various demographics, needs or outcomes. In some areas submissions are entirely qualitative and don't require even the collection of any individual level data.

6.1a The Problem

Lack of individual level data to analyse is associated with a number of potential problems. Most seriously, it constitutes a problem in the context of BCC's equality and diversity responsibilities.

Firstly, BCC should be able to evaluate the breakdown of users by various protected characteristics. For some commissioning areas, there is no way to estimate this at a basic level because there is no corresponding quantitative data submitted (only qualitative information). Even in other areas which do provide some demographic information, the lack of individual-level data means that these features cannot be cross-referenced. Knowing only the count of female service users, and the count of black service users, for example, doesn't tell you how many service users are black women.

Secondly, BCC should be able to evaluate whether people's outcomes vary by protected characteristics. For example, if a large city-wide provider is incredibly successful in supporting White British service users, but fails to achieve any improvement with any service users from any other ethnic group this would certainly merit attention. Unfortunately, with only a count of how many service users are White British and how many service users achieved some outcome, it is impossible to know whether this is the case not.

More broadly, the lack of individual level data severely limits the ability to dig deeper into the data. It inhibits the possibility of conducting a statistical analysis to estimate the impact of provider interventions. If individual-level data was provided with identifying information, it could be associated with information from statutory services. For example, one provider receives nearly all of the service users as referrals from ASC. If results were provided at the individual level, then the impact of the provider could be estimated against ASC outcomes (i.e. are clients who engaged with provider associated with a lower cost to ASC than similar clients who did not have the opportunity to engage with the provider?). Even if identifying information is not given, having basic information on the ward or constituency in which service users live and their outcomes, could be used to predict various other ward- or constituency-level outcomes.

Finally, two providers said that it was more effort on their behalf to provide counts rather than the raw information because it meant that they had to process the data and calculate the counts, although one provider also said that it was much easier to provide the counts than the individual-level data.

6.1b Potential Solutions

Theoretically the EDI responsibilities could be addressed by using much more fine-grained categories – for example asking each provider to give counts of the number of black women, black men, white women, etc. instead of asking separate questions about race and gender. However this would entail a substantial increase in work for providers, particularly if done for every relevant demographic variable, and would not address the other considerations about limiting the usefulness of the dataset.

Ultimately, individual level data will have to be collected and analysed in some form. Broadly, to address the issues raised above the three options are:

1. All demographic information, as well as outcomes and needs are collected and submitted at the individual level across all providers;
2. Some information is provided only at the aggregate level, as is currently done, but some core information, which includes demographic information and some outcome measures, are submitted at the individual level for all users.
3. Some information is provided only at the aggregate level, as is currently done, but some core information, which includes demographic information and some outcome measures, are taken from a random sample of users and submitted at the individual level.

Of course, it is also possible to have a mix and match of these two strategies for different commissioning areas – for example, it may be more reasonable in VA1 where providers are typically larger and have more substantial contracts to expect providers to submit individual level information for all service users, whereas in the NNS where many of the organisations are very small, it is more reasonable to only request individual level information from some grant holders. Where individual level data are collected, it is easier to supply information for all users than obtain a random sample, particularly for those with robust systems in place.

All options come with associated difficulties. Firstly, sharing and processing individual level data, particularly if it is identifying, would require new data sharing and data protection agreements with partners. For some areas (i.e. the NNS) it is possible that people could submit individual level information anonymously which would limit some of these complications, but in the case of other areas (for example, refugees) it is likely that many users would be identifiable merely from basic demographic information combined with the knowledge of the commissioning area that they are in. Secondly, whichever approach is adopted, the storage and analysis of such a large dataset would require some form of investment in staff members with the appropriate technical skills as well as appropriate accompanying software.

6.2 Incomparable Measures

The current situation is that the outcomes vary substantially. Some commissioning areas have very consistent outcomes and measures whereas in other areas the outcomes vary by providers, and in areas which only provide qualitative information the reported outcomes may even vary within the same provider from report to report. Even when the theoretical entity being measured is the same, there is also variation in what measure is used to assess the given outcome.

6.2a The Problem

All of this heterogeneity means that in some cases it is impossible to compare or aggregate the impact even of very similar provider interventions which aim to cause the same outcome due to the lack of shared measures of that outcome, and the practical difficulties associated with translating between different measures of the same outcome. The situation is even more difficult when trying to compare or aggregate the impact of radically different providers who are aiming to cause substantially different outcomes.

Given the aim of being able to evaluate the impact of ASC providers overall, it may be tempting to want to implement a single list of outcomes which would be collected by all providers. This would introduce a number of other problems. The activities engaged in by providers are themselves highly heterogenous – so any single framework would either need to be incredibly large, much larger than any of the existing frameworks (and a couple of providers said that they found the existing VA1 framework about as large as they could practically deal with already), or the framework would simply need to be very shallow and miss much of the detail that is currently captured. Furthermore, providers when interviewed really valued the input that they were able to put into the framework, because it allowed them to capture what they, as the experts in their own activities, felt was most important.

The problem therefore is how to have a framework which is both flexible enough to be relevant and allow substantial provider input whilst still having some kind of comparable outcomes which can be aggregated across providers to give a picture of the impact of ASC providers overall.

6.2b Possible Solutions

In answering this it is worth considering the purpose of the variables which are measured. Fundamentally the measured variables are not all trying to achieve the same outcome. Some of the outcomes, for example those which relate to an individual's Prevention First outcomes, are about evaluating the overall impact. Many of the measured outcomes however are not like this. For example, a number of providers measure how many people they supported to register with a GP. This kind of information is useful when a commissioning manager discusses the performance of the provider relative to the contract. It could be that all of the people who registered with a GP refuse to ever attend a GP, but it is nevertheless useful to know that the provider has been able to complete the task they outlined in the contract. Although lead commissioners in interviews talked about the reporting template primarily in terms of big-picture evaluation, the providers placed a much greater emphasis on that information being used in performance meetings about them as a provider.

In short therefore, we need to make a distinction in the type of measures used between the Primary Outcomes which are about big picture evaluation, and the Outputs which are more focussed on ensuring that everything is currently on track. In implementing, there are two good ways to do this:

1. There is a set of Primary Outcome(s) which are measured using the same or similar measures by all providers, and alongside them a much larger group of Provider Outputs. These Provider Outputs are highly flexible and vary from provider to provider.
2. There is a set of Primary Outcome(s) which are measured using the same or similar measures by all providers, a set of Standardised Outputs which every provider for whom it is relevant collects that information in a standardised way, alongside them a larger group of Provider Outputs. These Provider Outputs are highly flexible and vary from provider to provider.

The first of the options is somewhat simpler – but it means that there can be no comparison of outputs across providers. There would still be the Primary Outcome data, which would mean that ASC could be evaluated by how well it had achieved those, but it wouldn't be possible to say how many people had been supported with gaining employment, for example. All of the Outputs would be measured in a way that is specific to a provider. For example under this option it could be that one provider is measuring how many of the service users have a need to find employment, and how many then found employment, whereas another provider, perhaps in another commissioning area, is measuring how many people they supported to apply for a job, and yet another is measuring whether or not a service user is employed or not at various time points. These measures cannot meaningfully be aggregated, but it does mean that each provider can select the type of measurement most relevant to their activities. In the case of small organisations (for example in the NNS) it could be that they collect no provider outputs.

The second option on the other hand keeps the small amount of Primary Outcomes and flexible Provider Outputs but also has an intermediary category for common outputs which relevant providers should use when engaged in relevant activities. For example, every provider who works in any way on employment would have at least one Standardised Output for employment that they have to collect (in some sense it is arbitrary which one they select), so that aggregated figures for employment could be calculated. Of course, they would be able to additionally collect any Provider specific Outputs they deem relevant (which may include additional employment related measures).

Which outcomes are selected for the Primary Outcomes is also an important question. The current options:

- A measure of wellbeing, such as the short form of the WEMWBS, ICECAP or a single item Life Satisfaction measure. Some of these measures are used by a small number of providers already. Both the SWEMWBS and ICECAP have been validated extensively, although require multiple items to address a single construct. Life Satisfaction is less robust, but is widely measured (i.e. in Understanding Society) and would allow direct comparison with various national statistics.
- A form of Outcomes Star, which is used in one form or another by a very large number of providers. It includes 5-10 questions on various aspects of life. The testing conducted on it for psychometric validity is substantially weaker, and there is variation between different Outcomes Stars.
- Another possibility would be to ask citizens directly about where they would place themselves on a likert item of the various citizen level Prevention First outcomes. This has no psychometric validity but relates most closely to the Prevention First Framework.

The ideal would be to include a wellbeing measure alongside an Outcomes Star as this could address both social value and citizen-level Prevention First Outcomes. The raw data from the Outcomes Star is important to show the scale of change for individuals (such as that currently presented by Carers in their quarterly returns), rather that just whether the need was met or not (as is currently done for VA1).

6.3 Lack of causal identification

In general it is important to understand what the causal impact of a provider’s intervention is and what outcomes merely happened at the same time. Currently, this is done in a highly inconsistent way. For example, one provider said that determining whether or not a client has a need and whether or not they have met that need is done by members of staff, whereas in other cases this is done in the style of an Outcomes Star where both worker and service user discuss this together. In either case, simply reporting that a person achieved some outcome (i.e. employment) or moved score on a scale does not demonstrate that the provider *caused* that change. Perhaps they would have achieved employment, or moved score on that scale, even had they not engaged with the provider's service.

In many areas, as the information submitted is entirely qualitative, there very well may be some causal identification, such as a case study which is described in great detail and where it is implausible that the intervention was not responsible for the change in outcome, but it will be hugely varied and not possible to generalise from the case study to the service users of the provider in general.

Of course, causal identification is not important for outputs (either Provider Outputs or Standardised Outputs). It may be useful to know that providers have helped x number of people send-off x job applications, even if some unknown proportion of those job applications may have been sent even without the support from the providers.

6.3a The Problem

In these cases the most rigorous approach to estimate the causal impact would be to conduct Randomised Controlled Trials which would, in most cases, be highly unethical and impractical. BCC has a number of moral and legal responsibilities (i.e. providing housing for refugees) which it cannot 'randomly' engage in.

Nevertheless, in order to construct an overall picture of impact within a commissioning area, or even across commissioning areas, it is important that some method is used to distinguish causation from merely coinciding, and ideally that a consistent method is used across providers and areas to ensure that, although estimates may be inaccurate relative to the truth, they are at least as unbiased as possible relative to each other.

6.3b Potential Solutions

Given that more rigorous methods is not possible, there are three plausible options:

1. pre-post change scores,
2. causal impact as subjectively estimated by the client,
3. causal impact as subjectively estimated by the worker.

Change scores do not truly reflect the causal impact. It is possible for example, that clients who would engage with certain types of provider would naturally change over time on average, regardless of the impact of the provider. For example, a recently bereaved person might choose to join a local support group, funded through the NNS. They join when they are at their lowest, and over time they very slowly start to feel better. This would yield a positive change score on the relevant measure; however, it is possible that on average they would have had the same improvement without the NNS funded project merely as a function of time since they were bereaved, or maybe they would have accessed another support group not funded through the NNS. In such a case the change score would be an overestimate of the true impact. Equally however it could be that a person joins the bereavement support group and doesn't improve at all over the time – they just stay stable or even deteriorate very slightly. This would yield a negative change score. However, it might be that without the support group they would have had a complete emotional breakdown, so the negative change score is actually an underestimate of the true impact which is positive.

A further issue with change score is that they require measurement to be taken prior to engagement with a provider, however this may be difficult in some cases – particularly where clients who present to providers for the first time may be in crisis or even present to the provider precisely because they are in crisis. In such a scenario, asking clients to fill out a series of outcome measures may not be appropriate. Excluding such clients from the analysis entirely or asking them to fill out the outcome measures after having engaged with the service however is likely to bias (probably downward) the results.

In some contexts, it may be possible to compare change scores to some baseline population to better estimate the causal effect of engaging in a given service. For example, some services may have waiting lists who could be used as a control group. In other cases, the observed changes could be compared to changes observed in nationally available data (i.e. from large panel datasets such as Understanding Society, or through other services such as the DWP Employment Data Lab), using available covariates to do some kind of matching procedure (such as propensity score matching). Unfortunately the application of such methods would have to be highly tailored to each individual service (and in many cases no such process would be possible at all) rather than make up a general framework across Adult Social Care providers.

The other alternative is to use some kind of subjective estimate of causation, given by the client themselves. The client can give a score on the relevant measure for how they have been over some given period, and then estimate what their score would have been had they not received that support. This type of estimate is widely used in SROI analyses, and they have the advantage that they are relatively easy to perform – they can be taken at a single point of time and that time can be selected when clients are least likely to be in crisis. However, these estimates are likely again to be substantially biased. The literature on affective forecasting suggests that people systematically overestimate the impact of most changes. It is also possible that service users are influenced by how much they like or approve of the provider when estimating how badly off they would be without it (although they may be biased in a similar way when deciding on the second score in a change score). An additional issue is that no work has been done psychometrically validating any of the potential core outcomes when asked about how a person imagines themselves to be. If using one of the psychometrically validated measures, for example, it is possible that it would not have similarly properties when used in this way.

Of these three options, the third is by far the weakest. The worker estimating the effect introduces all the same biases as the client themselves doing it, however comes with additional problems. The worker is likely to be less accurate than the client in estimating how the client is, and less accurate in estimating how much of their score is due to the provider intervention. Furthermore, as a worker for the provider that is being evaluated they have the most motivation to be biased.

6.4 Summary

Problem: Lack of Individual level data submissions
Solution: Based on the problems and solutions discussed we recommend that individual level data is collected (**Option 2)** request individual level information on core demographics and primary outcomes from all users where possible. For providers or commissioning areas where this would be impractical (for instance for some NNS grant holders), an explanation detailing why this is impractical should be requested. If the core demographic information that we recommend is collected at an individual level, then analysis can be performed comparing the diversity in service users to the known diversity of the city as a whole, or the diversity of the relevant local area.

Problem: Incomparable measures
Solution: In order to have cohesive measures which can be used to construct a picture of outputs and outcomes achieved across the commissioned services, we recommend **Option 2:** A set of Primary Outcomes which are measured using the same measures by all providers, a set of Standardised Outputs which every provider for whom it is relevant collects that information in a standardised way, alongside a larger group of Provider-Specific Outputs, that are highly flexible and vary from provider to provider.

Problem: Lack of causal identification
Solution: For the purposes and standards for which the data will be used we recommend **Option 1**: repeated measurements of individual level measures would provide sufficient depth, whilst still being practical to collect for providers and easy to interpret for users. We recognise that repeat measures may not be appropriate for some providers who only provide advice or support on one occasion and would not expect this data to be collected for these providers.

7. Suggested Framework

The core responsibilities of the evaluation framework are to give BCC an understanding of the following areas:

- the performance of commissioned services as a whole against the four areas outlined in the Prevention First Outcome Framework, which are:
    - Citizen level outcomes,
    - Behaviour and culture across the sector,
    - Communities,
    - Finance, funding and demand;
- the extent to which people using commissioned services are being treated equitably and provided the same opportunities in a way which is socially just;
- the fulfilment and success of providers (at the level of an individual provider) of their specific aims and contractual obligations;
- the social value of all commissioned services.

The framework provides a proportionate and pragmatic tool to provide oversight of the outcomes and outputs of Prevention First delivery partners. The rationale and justification for our decision making is provided in previous sections of the full report.

A summary of the framework and frequency of information to be collected is outlined below.

- Provider outputs: aggregate data to be reported quarterly.
- Citizen level outcomes: individual level data to be reported annually.
- Behaviour and culture across the sector: reported by providers annually.
- Communities: reported annually (predominantly by NNS and P&C).
- Finance, funding and demand: to be sourced and analysed by BCC annually.

The critical elements for use in the performance evaluation framework are annual reporting of individual level core demographics and primary outcomes (using Outcomes Star and WEMWBS). Standardising the provider outputs will allow further analyses to be conducted on contractual obligations and estimates of social value.

Table 2: Framework summary

Framework Summary, By Collected Measure				
Measure	**Item**	**Level**	**Relevant To**	**Reporting Frequency**
Core demographics	Gender Age Disability Ethnicity Postcode	Individual	Social Justice, Robust Social Impact analysis	Annual
Optional demographics	Immigration Status Sexual Orientation Religion Details about Disability Employment Status Nationality	Preferably individual but provider aggregate may suffice	Robust Social Impact Analysis, Social Justice	Annual
Standardised Output	Taken from HACT database. (example: Number of people moved from unemployed to full-time employment; WEMWBS)	Preferably individual but provider aggregate may suffice	Provider Obligations, Social Justice, Robust Social Impact Analysis	Quarterly
Provider-Specific Output	Example: Decluttered property ESOL Training	Preferably individual but a provider aggregate may suffice	Provider Obligations, (if individual, then Social Justice)	Quarterly
Service Reach	Number citizens engaged - (new and repeat) Referral route Reason for unsuccessful referral	Preferably individual but provider aggregate may suffice	Provider Obligations, Social Justice	Quarterly
Primary Outcomes (Outcome Stars)	Economic Wellbeing Health & Wellbeing Social Participation Independence in Housing	Individual	Prevention First: Citizen Outcomes	Annual
Accessibility	How accessible was this service? (included in end of project feedback form)	Individual	Prevention First: Community Outcome	Annual
Behaviour and Culture	Number of partners (taken from service reach) Staff investment in relevant training Engagement with citizens Referral pathway	Provider level – qualitative	Prevention First: Behaviour and Culture Outcome	Annual

7.1 Demographic Profile

A minimum data set that is consistent across all commissioning areas and providers is required, and a list of optional variables that can be collated where appropriate. This optional list is not exhaustive and individual providers may have additional data fields that they collect relevant to their service and we recommend that collection of these continue. The categories used for all demographic information should match as closely those used in national statistics such as the census and other national surveys[18]. Providers should submit individual level data (for all clients) where possible annually.

- **Required** minimum data set: Age, Gender, Disability, Ethnicity and Postcode (full at best, part at minimum)[19].
- **Optional** additional fields: Sexual Orientation, Religion, Further details about Disability, Employment Status, Nationality, Immigration Status, whether an interpreter is required.

For example, in the context of services that work with a large number of disabled clients or provide a disability-related service, it may be important to collect in substantial detail on the precise type of disability. For other services however, this additional detail would not be required and so they could collect only the required minimum disability information (which is whether a client is disabled or not). In this way the required minimum demographic dataset ensures that there is sufficient data to be used for strategy purposes across all of ASC, whilst still allowing for the flexibility to collect the optional additional fields which would be relevant to specific contracts.

Note: individual data will be anonymised and identifiable information (for instance name and date of birth) will not be shared. For many other organisations however, this would be less relevant and so

7.2 Provider Outputs

Providers will also be able to collect and share information on outputs that pertain to their contractual obligation. Broadly speaking there are three types of relevant output:

- Standardised Measures
- Provider-Specific Measures
- Service Reach Numbers

On the whole, aggregate level outputs are sufficient and should be provided quarterly (as is currently done in many areas to report against provider obligations). For some of the larger providers it may be appropriate to provide individual level outputs which can be cross referenced with demographic information.

7.2.1 Standardised Measures

For the purposes of the framework we recommend that as far as possible, providers use **standardised measures** for individual level outputs, ensuring consistency across organisations who are providing support towards a similar issue. We recommend providers (with the support of commissioners) use the HACT database to identify and select relevant measures. The HACT social value bank provides survey questions for a large number of outputs (employment, health, environment, financial inclusion),

---

[18] *With the exception of gender, which we recommend using the definition and options from Stonewall*

[19] *There are some contracts for which providing a postcode is not appropriate (such as domestic abuse services)*

alongside a financial estimate for the social value of that output. Examples and links for relevant databases are provided below:

Social Value Bank: https://www.hact.org.uk/calculating-your-social-value

- Employment: (example: 1) Record of individuals moving from unemployment into full-time employment; 2) If you have recently moved from unemployment to full-time employment, how satisfied are you with your job security?)
- Local environment: (example: I feel like I belong to this neighbourhood?)
- Financial Inclusion: (example: If you are in debt, how much of a burden is that debt?)

Community led housing: https://hact.org.uk/community-led-housing-social-value-calculator

- Housing: (example: Number of individuals going from temporary to secure housing (no dependent children))

Mental health: https://www.hact.org.uk/mental-health-social-value-calculator

- Wellbeing: Warwick-Edinburgh Mental Wellbeing Scale (7-item)
  (Wellbeing is an important output for Prevention First services and as such using the same measure across services would be highly valuable and may wish to be considered a primary outcome).

There also needs to be some additional standardised measures relating to these topics. In many cases these can be taken directly from the current VA1 standards. The details of the standards should be confirmed and refined during the consultation phase with providers.

7.2.2 Provider-Specific Outputs

A number of outputs are only relevant to a small subset of providers (or even only a single contract in some cases). In order to capture their achievements, there must be space for providers to identify (and agree with the commissioner) ***provider-specific outputs*** which are specific to their service and users. For instance, the number of people accessing ESOL training, or decluttering a property.

7.2.3 Service Reach

In addition to the outputs listed above, the following details should be captured by providers and shared with BCC.

- Number of people referred/accessing service
- Number of new referrals this quarter (where appropriate)
- Number of referrals from statutory organisations and VCSE organisations (this item could be used to demonstrate partnership working for the behaviours and culture outcome if broken down further for instance housing, health, criminal justice, community).
- Reason for unsuccessful referrals (where appropriate): Drop down choices to include: Did not meet eligibility criteria, Did not attend appointments/did not call back or contact, Refused support offered, Unable to manage risk, Needs Too High, No capacity, Exceptions to above.

Referral information should also be requested at the individual level annually so that analyses can explore who is not able/choosing to take up the support, and thus where widening inequalities may become apparent.

7.3 Prevention First Outcomes

The Prevention First framework outlines four distinct areas which contribute to BCC's aim that citizens lead healthy, happy and independent lives within their own homes and communities.

7.3.1 Citizen Outcomes:

Primary Outcomes: Six different individual citizen level outcomes are specified:

- Increased social participation
- Healthier lifestyles
- Maximised income
- Housing which supports independence
- Carers feeling more supported
- Better experience of the social care and health system

Whilst not all these outcomes are relevant to every provider, there is value in providers collecting data on outcomes which are not their primary intended outcome, in order to capture secondary impacts that their users experience.

We recommend that providers collate repeated **Outcomes Stars** with service users and provide the raw data to BCC (where possible and appropriate) annually. The raw data will allow baseline scores to be utilised in further analyses and evidence the distance travelled by service users. It is appropriate that different Outcomes Stars are used accordingly (for instance Homeless Outcomes Star; Empowerment Star; Young Person's Star). Note that the Carers Wellbeing Check is not an Outcomes Star per se, and that other providers not currently using Outcomes Star can use alternative measures so long as they cover at least the four core outcomes (and carer's feeling supported if relevant).

Table 3. How the Outcomes Star items map onto the primary citizen-level outcomes

	Homelessness	**Empowerment**	**Young Person**	**Carers Wellbeing Check**
Economic Well-Being	Managing money & administration	Money	Money & rent	Financial situation
		Work & learning	Work & learning	Work, education & training
Health and Well-Being	Physical Health Mental Health	Health & wellbeing	Health How you feel	Health & wellbeing
Social Participation	Social networks & relationships	Support networks	People & support	Relationships
Independence in Housing	Managing tenancy & accommodation	Accommodation	Accommodation	Home
Carers feeling supported				Time out Other caring commitments

The categories highlighted in Table 3 are those that map directly onto the Prevention First outcomes identified by BCC. Additional categories are captured by various Outcomes Star (such as Offending, Safety, Self-care) and may be important to capture and evidence.

7.3.2 Communities

The Communities outcomes are:

- Relevant, diverse and accessible community assets and activities
- Relevant, diverse and accessible opportunities for active citizens and volunteering

If the core demographic information that we recommend is collected at an individual level, then analysis can be performed comparing the **diversity** in service users to the known diversity of the city as a whole or the diversity of the relevant local area.

In order to assess the **accessibility** of providers, it is recommended that at least annually, users are asked a single item on accessibility (i.e., how accessible did you find the service?). Ideally this would be asked of lapsed members as well as active participants in services. The minimal requirement would be the submission of individual level responses to the accessibility item across commissioning areas, sitting alongside all the other individual level data.

The **relevance** of the service should be assessed qualitatively by discussion between providers and the relevant commissioning manager on an annual basis.

7.3.3 Behaviour and Culture

The current Prevention First framework outlines two objectives under Behaviour and Culture:

- Better cross-sector partnership working between the statutory, voluntary, community and social enterprise sectors.
- Embed a culture which focuses on and supports the strengths, assets and positive outcomes for citizens.

To evidence what providers are achieving in respect of maintaining and improving service delivery we propose all providers report on this outcome annually. It may be appropriate to agree the exact format of this within each commissioning area and with providers but ultimately this would be a qualitative assessment providing details that will seek to capture:

- Partnership working (number and breadth of organisations, including multi-disciplinary working)
- Staff investment in relevant training (such as psychologically informed environments)
- Engagement with citizens
- Robust referral pathway across the ASC portfolio (i.e. between commissioning areas where appropriate)

Details from the service reach data could be used to evidence the above.

7.3.4 Finance

The relevant Finance outcomes within the Prevention First framework are:

- Reduced demand on statutory services
- Financial savings
- Additional investment from outside BCC and NHS
- A better experience for the social care and health workforce

Fundamentally, the nature of these outcomes means that the onus must be on BCC itself to answer these questions rather than providers collecting this data. By gathering the data outlined above, there will be more opportunity for a robust analysis to be undertaken by BCC in order to assess the impact of providers on demand for statutory services, and the associated financial savings.

7.4 Social Value

The social value of an intervention covers the entire value created as experienced by everybody impacted by the intervention, as opposed to only the financial value (a traditional return on investment).

In the short term, an Output-Based Social Value Analysis can be conducted (by BCC) as soon as information on outputs achieved are collected. The HACT database provides average figures for the financial equivalent to the social value of various outputs. In addition, Unit Costs of Health and Social Care (calculated annually by PSSRU[20]) can be utilised to estimate the return on investment through preventing future primary and secondary care admissions. There are a number of problems with this approach, and in the long-term it is imperative that BCC move away from using these average figures and towards using their own collected data, but unfortunately that would not be available until sufficient data has been collected.

Once sufficient data has been collected it is recommended that BCC conduct a further, more robust social value analysis. Unfortunately, the diversity and variation within provider activities means that there is no single analysis method that can be applied across all commissioning areas and providers. Nevertheless, the variety of outcomes, and in particular the collection of a single item on life satisfaction, would mean that analyses of such a type would be possible at least in a number of cases. For example, for a number of providers it would be possible to match citizens on at least a number of dimensions to participants in Understanding Society and compare changes in Life Satisfaction in service users to changes in Life Satisfaction amongst similar people in non-service users within the Understanding Society cohort.

---

[20] Unit Costs of Health and Social Care 2020 | PSSRU

8. Recommendations

Birmingham City Council:

1. BCC to provide clarity to providers about how the data they share is being used, what it is being used for and provide regular feedback. This could be in the form of an overall dashboard highlighting the aggregated outcomes across the City.
2. When commissioning contracts, consider factoring in a budget for monitoring systems (particularly for smaller organisations with less capacity) and training in how to complete outcome measures robustly.
3. Data sharing agreements and secure sharing and storage of data should be completed as part of the provider contracts.
4. Provide training in how to collect robust data to ensure uniformity across providers commissioned within the ASC directorate.
5. Agree a standard format for reporting of individual level raw data by providers (core demographics and primary outcomes).
6. End payment-by-input (payment on the quantity of delivery (i.e. number of hours delivered as this is not a measure of quality).
7. Continue to engage and involve the providers in any changes to reporting templates and acknowledge the time needed to embed and train staff to such changes. This has proven to be successful and appreciated (particularly with VA1 contracts to date).
8. To allocate resource to cleaning and processing of individual level data at each quarterly and annual return.
9. Gender and gender identity to be measured consistently and coherently using the Stonewall definition: one question on gender giving four options for a person’s self-described gender (man, woman, prefer not to say, and the option to self-describe) and a separate question on gender identity, whether their current gender matches the gender they were assigned at birth (yes, no, prefer not to say).
10. That commissioning managers look through the HACT social value bank to see which items may be relevant to their providers.
11. Consider investing in an online portal with dashboard capacity.

Providers:

12. That providers take up opportunities to contribute to discussions and input into the design of reporting templates when available.
13. That providers use an Outcomes Star to collect primary outcomes where possible and appropriate.
14. That repeated measures are collected every 3 months where possible, but this will depend upon the timeframe an individual is involved with the service. If involved for a shorter time frame a pre-post measure should be completed. At a minimum, providers should include details of how regularly the outcomes are repeated.
15. To look at the HACT social value bank to identify which items (if any) would be appropriate for their service.