The Kirklees Better Outcomes Partnership:

The final report of a longitudinal evaluation of a Life Chances Fund outcomes partnership

BLAVATNIK SCHOOL OF GOVERNMENT

UNIVERSITY OF OXFORD

GOVERNMENT OUTCOMES LAB

Department for Culture, Media & Sport

Final evaluation report July 2025
Franziska Rosenbach, Dr Felix-Anselm van Lier, Maria Patouna, Dr Eleanor Carter

Acknowledgements

The authors gratefully acknowledge the support of colleagues at the Department for Culture, Media and Sport. The authors also acknowledge the National Lottery Community Fund, which administered the Life Chances Fund. We are particularly grateful to the KBOP peer researchers and to Michael Peoples, the KBOP peer mentor coordinator who helped to deepen our understanding of the service by bringing together KBOP service users and facilitating the peer-led research. Michael provided support throughout data collection and interpretation and made a crucial contribution by describing the delivery experience from a service user perspective.

We would like to thank KBOP service users who generously shared their experiences of services and enabled their user voices to be taken into account. We are also very thankful to staff in Kirklees who provided access to documents and participated in numerous research activities over the multi-year evaluation period. We are grateful for the ongoing research project support provided by specific Kirklees Council staff who wish to remain anonymous. Equally, we are extremely thankful to the Kirklees Better Outcomes Partnership team for having been so engaged in our research project. Special thanks are due to the partnership's Director, Sarah Cooke, for allowing the authors to observe meetings, access documents, repeatedly participate in shaping the research, build connections with the delivery partners and provide detailed comments on a draft of the report. We thank Bridges Outcomes Partnerships for their continuous support as research participants, granting access to contracts and meetings and providing detailed comments on a draft of the report. Furthermore, the research would not have been possible without the participation of all KBOP delivery partners, who revealed in-depth insights into their delivery experience and were extremely generous with their time.

Contribution statement

Franziska Rosenbach authored this report. She contributed to the research design, developed the conceptual report design and oversaw data collection and analysis. Franziska also led on initial drafting and design of visuals.

Dr Felix-Anselm van Lier co-authored this report. He supported data collection and analysis and drafted section 5.3 of the report. He also co-edited and provided overall oversight for the final version of the report.

Maria Patouna co-authored this report. She conducted data cleaning and analysis of longitudinal survey data and prepared figures 2-4, 7 and 9.

Dr Eleanor Carter co-authored this report. She designed the overall research strategy, supported data collection and analysis and drafted section 5.1 of the report. Eleanor co-edited the report and is responsible for overall research quality.

Jessica Reedy authored the Executive Summary, co-edited the report and co-developed the policy recommendations. She also supported final reviews, formatting, and quality assurance processes.

Michael Gibson co-edited the report and co-developed the policy recommendations.

About the Government Outcomes Lab

The Government Outcomes Lab (GO Lab) is a global centre of expertise based at the Blavatnik School of Government, University of Oxford. Our mission is to enable governments across the world to foster effective partnerships with the non-profit and private sectors for better outcomes.

We are an international team of multi-disciplinary researchers, data specialists & policy experts. We generate actionable knowledge, offering a comprehensive and evidence-based approach to the study of cross-sector partnerships through the three main strands of our work: research, data and engagement.

You can find out more about our work here.

About the Department for Culture, Media and Sport

The Department for Culture, Media and Sport supports culture, arts, media, sport, tourism and civil society across every part of England — recognising the UK's world-leading position in these areas and the importance of these sectors in contributing so much to our economy, way of life and our reputation around the world. The department champions sport for all at every level, supports our world-leading cultural and creative industries, and enhances the cohesiveness of our communities.

DCMS delivered the Life Chances Fund (LCF) between 2016-2025. The LCF aimed to help those people in society who face the most significant barriers to leading happy and productive lives. The £70m Social Outcome Partnership fund contributed to outcome payments for locally commissioned social outcomes contracts which involve socially-minded investors. Projects have helped support tens of thousands of beneficiaries in areas like youth unemployment, mental health and homelessness.

Recommended citation for this report

Rosenbach, F., Carter, E., van Lier, F-A., Patouna, M. (2025) *The Kirklees Better Outcomes Partnership: The final report of a longitudinal evaluation of a Life Chances Fund outcomes partnership*. Government Outcomes Lab, Blavatnik School of Government, University of Oxford.

Table of Contents

List of figures and tables 6

EXECUTIVE SUMMARY 7

THE LIFE CHANCES FUND EVALUATION 12

1.1 THE LIFE CHANCES FUND 12

1.2 THE KBOP EVALUATION 14

RESEARCH METHOD 18

SUMMARY OF RESEARCH METHODS 18

2.1 INTERVIEWS & SURVEY 19
2.1.1 Data collection 19
2.1.2 Data analysis 21
2.1.3 Limitations 21

2.2 SYSTEMS MAPPING 22

2.3 PEER-LED RESEARCH 23
2.3.1 Data collection 24
2.3.2 Data analysis 25
2.3.3 Limitations 26

THE KBOP SOP AND COMPARISON WITH PREVIOUS SERVICE ARRANGEMENTS IN KIRKLEES 27

3.1 THE 'COUNTERFACTUAL' 27

3.2 THE SOP 28

KEY DESIGN FEATURES: THE RATE CARD AND ADAPTIVE SERVICE MANAGEMENT 34

4.1 THE RATE CARD 35
4.1.1. Rate card implications for service delivery 38

4.2 ADAPTIVE MANAGEMENT AND SERVICE INNOVATIONS 39

THE CAUSAL MECHANISMS OF THE KBOP SOP: 4 HYPOTHESES 42

5.1 ENHANCED PRACTICE OF MARKET STEWARDSHIP 44
5.1.1 Market stewardship under the fee-for-service contract 49
5.1.2 Increased constructive performance competition 50
5.1.3 A central data management and performance system to record performance and service demand 54
5.1.4 KBOP as a proactive market influencer and stakeholder mediator in a long-term contracting environment 56
5.1.5 Identifying the enabling characteristics of a market steward 58

5.2 ENHANCED PERFORMANCE MANAGEMENT 60
5.2.1 Performance management in the fee-for-service contracts 64
5.2.2 Payment-by-results mechanism 65
5.2.3 Dedicated resources for performance management 69

5.3 ENHANCED PROVIDER COLLABORATION 72
5.3.1 Collaboration under the fee-for-service contract 75
5.3.2 The evolution of collaboration under the KBOP SOP 76
5.3.3 KBOP as a facilitator of collaboration 77
5.3.4 The outcomes framework as a facilitator of collaboration 80
5.3.5 Implications of the end of the contract for collaboration 82

5.4 ENHANCED FLEXIBILITY AND PERSONALISATION IN SERVICE IMPLEMENTATION 85
5.4.1 Delivery under the fee-for-service contract 90
5.4.2 Dimensions of personalisation 90
5.4.3 Enablers to personalisation 99
5.4.4 Outcomes-based-contracting – barrier or facilitator to personalisation? 107

SYSTEM DYNAMICS IN THE KBOP SOP DELIVERY 112

6.1 MAP OVERVIEW 112

6.2 FINDINGS 113

CONCLUSION 119

RATE CARD DESIGN & PERFORMANCE TARGETS 119

SOP MECHANISMS 120

THE OPERATING ENVIRONMENT FOR A SOP 125

References 127

Appendix 131

A. DESCRIPTION OF THE KBOP SERVICE PROVIDERS 131

B. INTERVIEW GUIDE AND APPROACH, AND INTERVIEW PARTICIPANTS 132

Participants 132

C. SURVEY SAMPLE 134

D. REFERRAL MANAGEMENT – HOW USERS ACCESS THE KBOP SERVICE 135

E. MANAGEMENT OF KBOP SOCIAL PRIME AND GOVERNANCE STRUCTURE OF THE KBOP PARTNERSHIP 137

F. KBOP RATE CARD 141

G. EXAMPLE OF A PROVIDER MONTHLY PERFORMANCE REPORT 148

H. DESCRIPTION OF THE OUTCOMES CLAIM PROCESS 151

I. SERVICE INNOVATIONS 152

J. STATISTICAL ANALYSIS OF SURVEY 156

K. STATISTICAL ANALYSIS TABLES AND FIGURES 158

L. ADDITIONAL SYSTEM MAPS 168

M. TABLE OF ACRONYMS AND GLOSSARY 171

List of figures and tables

List of figures

Figure 1: Stakeholders' responsibilities in the Kirklees Better Outcomes Partnership SOP
Figure 2: Distribution of months frontline workers spent with service users
Figure 3: Caseload shift from the legacy contracts to the social outcomes partnership
Figure 4: Frontline staff survey question – how influential are users' activity preferences in determining what activities are included in the support you provide?
Figure 5: Percentage of personalisation fund payments by area
Figure 6: Average number of outcomes achieved per user, distinguishing between users with and without support through the personalisation fund
Figure 7: Frontline staff survey question – to what extent do you agree with the following statement: in this job, there are no set rules?
Figure 8: A different voice – KBOP user perspectives and stories of transformation. Findings from a peer-led research project
Figure 9: Work time allocation of KBOP frontline staff
Figure 10: Systems map of the KBOP SOP intervention

List of tables

Table 1: Summary of evaluation methods
Table 2: Comparison of key contract features
Table 3: Rate card outcomes and outcome metrics
Table 4: Summary of KBOP SOP hypothesis 1: 'Enhanced practice of market stewardship'
Table 5: Summary of KBOP SOP hypothesis 2: 'Enhanced performance management'
Table 6: Summary of KBOP SOP hypothesis 3: 'Enhanced collaboration'
Table 7: Summary of KBOP SOP hypothesis 4: 'Enhanced flexibility & personalisation'
Table 8: Frontline staff survey question – How many service users are you currently supporting?
Table 9: Frontline staff survey – percentage of time spent on different activities

EXECUTIVE SUMMARY

What is the Life Chances Fund?
The Life Chances Fund (LCF) was a £70 million programme funded by the Department for Culture, Media and Sport (DCMS). It ran between 2016-2025 and is the largest outcomes fund launched to date in the UK. The LCF was designed to tackle complex social problems across policy areas including child and family welfare, homelessness, health and wellbeing, employment and training, and more. The LCF is delivered through 29 locally-commissioned social outcomes partnerships (SOPs — also known as social impact bonds). You can learn more about the LCF on our website.

What is the Kirklees Better Outcomes Partnership?
The Kirklees Better Outcomes Partnership (KBOP) was one of the 29 SOPs in the LCF. KBOP sought to improve outcomes for adults with housing-related support needs through education, training and employment; accommodation; and health and wellbeing. As DCMS's knowledge and learning partner for the Life Chances Fund, the Government Outcomes Lab evaluated KBOP within a wider set of evaluations. You can read more about KBOP and SOPs on the Government Outcomes Lab website. In the SOP structure, KBOP saw the delivery of services from multiple providers brought under a single outcomes contract – with payment tied to the achievement of certain outcomes. Here, the intermediary (Bridges Outcomes Partnership) coordinated and oversaw the service delivery of multiple service providers, mediating between the service providers and the contracting authority (Kirklees Council).

This report
This is the final report of a five-year research study investigating how using a social outcomes partnership influenced the management approaches and practices of the Council, providers and frontline service delivery in the Kirklees Better Outcomes Partnership (KBOP). The evaluation compared the SOP model with the Council's previous commissioning approach, a traditional fee-for-service model. Both contracts covered housing support for people experiencing multiple and complex disadvantage and were delivered by the same providers (except one which exited the SOP contract early in delivery).

The evaluation asked: **what mechanisms within the SOP contributed to changed services and successful social outcomes?** In the first interim evaluation we identified four mechanisms by which the SOP model may influence service delivery and user outcomes. These are:

i) enhanced **market stewardship**
ii) strengthened and data-led **performance management**
iii) cultivation of cross-provider **collaboration**
iv) enhanced **flexibility and personalisation** of frontline services.

In this report, we examine the implications of these mechanisms, particularly for the delivery of complex, person-centred public services. The evaluation used a theory-based approach, applying a generative causation lens to assess how and why these mechanisms contributed to observed changes. The findings are outlined below. Furthermore, analysis of the rate card (the schedule of prices for pre-agreed outcomes; see Glossary section) is provided in section 3.3.

Market stewardship

Market stewardship is the commissioner's endeavour to create the conditions in which the market will deliver the desired outcomes of the service. In the KBOP example, Kirklees Council was the commissioner. Market stewardship was stronger under KBOP than under the previous contract because actions by the KBOP 'social prime' (see box below) enhanced constructive competition, improved transparency on performance and demand, and created opportunities for more coordination in service provision though contractual arrangements. In practice, KBOP filled important gaps in the Council's ability to effectively steward the market.

> ***Social prime (Kirklees Better Outcomes Partnership):*** *A 'social prime' is an independent organisation that coordinates and oversees service delivery by multiple service providers as an intermediary. It mediates between the service providers and the contracting authority (Kirklees Council), advocating for the providers and co-developing solutions. Responsibilities include holding the contracts, tracking performance, and ensuring outcomes are met. It can also be known as a network orchestrator or a partnership co-ordinator.*

The social prime ensured strong performance oversight by proactively monitoring providers' performance, applying strengthened quality standards and supporting underperforming providers with targeted performance improvement plans. KBOP's market stewardship was bolstered by its local knowledge and credibility, the trust it fostered with providers, and its ability to influence delivery by leveraging data for informed decision-making. As an independent intermediary, it also mediated between the Council and providers, helping shape the care and support market by responding to provider perspectives and service insights. KBOP invested significant capacity into proactive market oversight and provider support so it could perform these functions.

Though market stewardship is traditionally seen as a public sector role, delegating it to an external organisation enabled this more proactive oversight – but also introduced the risk of the Council becoming more detached from shaping the service delivery landscape. A concern raised was that reduced direct engagement between the commissioner and providers might limit the Council's opportunities to directly assess service challenges, respond to provider needs and ensure alignment with broader public service priorities. *Find out more in section 5.1.*

Performance management

Collaborative performance management was partially enabled by the social outcomes contract, which provided the framework for stakeholder alignment and established shared accountability across providers. The payment-by-results mechanism, based on pre-defined outcomes targets and outcomes verification, enhanced accountability and transparency. KBOP's performance management approach relied on managerial tools like its centralised data and performance system, which enabled timely responses to performance issues and facilitated the sharing of best practice across providers.

However, some stakeholders felt it was challenging to balance KBOP's user-centred strengths-based approach with adherence to outcomes-driven targets and their accountability requirements. Effective performance management relied on a culture of trust, shared learning and proactive engagement, fostered through the social prime, which helped mitigate pressure and strengthen collaboration among stakeholders. *Find out more in section 5.2.*

Collaboration

Collaboration among service providers was significantly greater under KBOP than under the legacy fee-for-service contract. A key driver of this improvement was the establishment of the social prime as a dedicated network coordinator responsible for collaboration through structured governance and relationship-building. The social prime facilitated a collaborative infrastructure by building trust-based relationships, ensuring transparent governance, convening regular meeting and training sessions, and creating opportunities for knowledge exchange and collective learning.

Another key enabler of increased collaboration was the shared outcomes framework (pre-agreed outcomes shared across providers), which aligned provider goals and fostered collaboration at managerial levels, while simultaneously spurring some competition among frontline staff.

However, enhanced collaboration was felt more strongly at the managerial level than amongst frontline staff. Despite the overall improvement in collaboration, uncertainty towards the end of the SOP contract created challenges. As providers anticipated the transition of the contract ending, organisational self-preservation took precedence over collective goals, weakening the collaborative ethos that had been cultivated. Provider staff expressed concerns over diminished cooperation and resurging competitive pressures that impacted staff morale and trust. *Find out more in section 5.3.*

Flexibility & personalisation

Compared with the previous fee-for-service model, the outcomes partnership provided enhanced flexibility in service provision. This was partially driven by the 'personalisation fund', a £250k fund which enabled case workers to tailor support to the user. Survey data indicated frontline staff were significantly more able to shape their support than they had been under fee-for-service models. The outcomes-based contracting model provided a structured framework that clarified expectations and enhanced accountability while maintaining light-touch service specifications, thus enabling user-focused and flexible service delivery.

The implementation of the outcomes framework relied on ongoing calibration of a strengths-based approach and on maintaining accountability through evidence requirements. On some occasions, evidence requirements strained staff-user relationships or failed to align with user interests. Some staff felt that the pre-defined outcomes conflicted with service users' primary interests. Mean caseload size increased under KBOP; this may have also posed challenges to delivering highly personalised support, as staff had to balance flexibility with workload demands. However, some workload mitigation was possible through adaptable service delivery approaches. Despite growing reporting requirements under the SOP, survey data indicated no overall increase in time spent on administrative tasks.

Personalisation was supported through the use of a personalisation fund underpinned by £250,000 of private capital. The funding enabled caseworkers to provide tailored, service user-led support. For example, it could be used to purchase one-off items to support participants to achieve their goals or to drive wider service innovations. Staff capacity was developed through strengths-based training that emphasised professional discretion and user empowerment, and tailored caseworker support was enhanced by specialist services like mental health experts. Finally, user voice was amplified through the co-production interventions of peer mentoring and user involvement in service development, including focus groups and staff recruitment. *Find out more in section 5.4.*

Key policy recommendations from across the KBOP evaluation reports

Identifying the mechanisms that contributed to improved outcomes in KBOP offers broader insights into how complex services can be designed and commissioned. The policy recommendations below set aside the specific contractual and institutional features of KBOP to distil lessons with wider relevance, highlighting features of an approach to contracting that supports person-centred, collaborative and adaptive service delivery. Some of these recommendations may be more readily facilitated by outcomes-based contracting, but they are not necessarily limited to this approach.

1. **Focus on building meaningful cross-sector partnerships:** *Contracts should be designed to support collaboration through structures that promote shared problem-solving.*

   Contracts that are overly rigid, target-driven and unilateral can create adversarial dynamics, undermining collaboration and shared problem solving. The KBOP model showed that complex service delivery requires active relationship-building, shared accountability and adaptive governance, with partners that pursue a shared vision of support for the people they serve.

2. **Enable flexibility and adaptation (test-and-learn) through contracting and governance:** *Contracts should be designed to facilitate adaptation as partners learn more about what is required from the service via an explicit process for change.*

   In planning a service which deals with the complex lives of people, and particularly those facing a variety of challenging life circumstances, it will not be possible to identify and specify the precise scope of the service upfront. The KBOP contract incorporated mechanisms, such as a flexible rate card design, data-driven performance reviews, and collaborative governance structures, that allowed for iterative service adjustments in response to emerging challenges and new insights.

3. **Use data for accountability and learning:** *Projects should implement a shared data system and use it actively and appropriately to support effective decision-making.*

   Kirklees Council procured and implemented a centralised data system to support performance monitoring and outcomes evidencing, with differential access according to each party's needs. Vitally, data in the KBOP project was used actively and in combination with other sources of information as appropriate to support decision-making.

4. **Focus on individual service user needs, enabling personalised support through flexible funding**: *Projects should find ways to enable flexible funding to meet service users' diverse needs, which may be more easily achieved when personalised services and purchases are made by non-government partners in an outcomes-based funding arrangement.*

   In a service supporting those with complex lives, each individual's challenges are unique, and a one-size-fits-all approach may not offer the best support. However, personalisation requires adequate resourcing. In KBOP, a £250,000 personalisation fund backed by social investment supported frontline staff to provide bespoke support to users.

5. **Ensure long-term contractual and funding stability**: *Contracts should be sufficiently resourced and cover a time period appropriate to the service, with clarity around the process for future rounds of contracting.*

   While a genuine partnership centred on achieving the SOP's objectives emerged over its five-year lifetime, the impending end of the contract (and resulting uncertainty) hindered this collaboration. Effective partnership working cannot overcome a lack of sufficient, stable funding to provide certainty around the future of the service.

6. **Cultivate the right partners and mindset and a culture of trust and learning:** *Successful contract implementation relies on partnerships with organisations that share a commitment to collaboration, adaptability and continuous improvement.*

   Successful service delivery in complex environments depends not only on formal contractual and financial mechanisms but also on the culture and mindset of delivery partners. The KBOP model demonstrated the importance of selecting partners with a willingness to share accountability, engage in open dialogue and adapt to emerging challenges. A culture of trust and learning, supported by relational governance structures, is key to fostering innovation and sustained service improvement.

THE LIFE CHANCES FUND EVALUATION

1.1 THE LIFE CHANCES FUND

The Life Chances Fund (LCF) was a £70 million fund supporting the growth and development of 29 locally-commissioned social outcomes partnerships (SOPs), also known as social impact bonds (SIBs), in England. These outcomes-based projects were co-commissioned by central government and a range of local public sector organisations.

LCF projects aimed to tackle complex social problems across policy areas like child and family welfare, homelessness, health and wellbeing, employment and training, criminal justice, and education and early years. Following three application rounds, funding was made available for multi-year SOP projects to run within the LCF's nine-year lifespan from July 2016 to March 2025. The first LCF projects began service delivery in 2018, with the bulk of projects launching between 2019 and 2020. LCF Projects were only able to claim payments for outcomes achieved up to the end of September 2024. Some projects continued to deliver services beyond the lifetime of the LCF.

The Fund had the following objectives[1]:

- Increasing the number and scale of SOPs in England
- Making it easier and quicker to set up a SOP
- Generating public sector efficiencies by delivering better outcomes and using these successes to understand how and whether cashable savings could be achieved
- Increasing social innovation and building a clear evidence base of 'what works'

[1] ICF (2021) Process evaluation for the Life Chances Fund. Available here.

- Increasing the amount of capital available to a wider range of voluntary, community and social enterprise (VCSE) sector providers to enable them to compete for public sector contracts
- Providing better evidence of the effectiveness of the SOP mechanism and the savings that are being accrued
- Growing the scale of the social investment market.

The LCF was administered by The National Lottery Community Fund (TNLCF, formerly known as the Big Lottery Fund) on behalf of the Department for Culture, Media and Sport (DCMS).

1.1.1 What are social outcomes partnerships?

While there is no single, universally agreed definition of social outcomes partnerships (often referred to as social impact bonds, SIBs, or social outcomes contracts, SOCs), they are best understood as cross-sector partnerships that bring organisations together in the pursuit of measurable social outcomes.

Typically, SOPs are defined as contractual arrangements that have two key characteristics:

- Payment for social or environmental outcomes achieved (an outcomes contract)
- Up-front repayable finance provided by a third party, the repayment of which is (at least partially) conditional on achieving specified outcomes.

As such, social outcomes partnerships bring together three key partners: an outcome payer, a service provider and an investor. In practice, multiple organisations may make up each of the three partnership roles. Often, technical advisers, performance management experts and evaluators are also involved. The contractual arrangements and the ways of working within social outcomes partnerships can vary widely as the textbook model has been considerably stretched to respond to different circumstances (Government Outcomes Lab, 2024).

1.1.2 What is the Life Chances Fund evaluation?

The Department for Culture, Media and Sport (DCMS) commissioned the LCF evaluation to understand how SOPs add value when compared with more conventional public service commissioning arrangements[2].

[2] The evaluation strategy for the Life Chances Fund is available here

The evaluation was structured across three strands:

- **Strand 1 – Fund-level programme evaluation**
  Sought to evaluate the whole LCF fund as a tool for growing the social outcomes partnership market. It evaluated the process involved and lessons learnt from fund administration[3]

- **Strand 2 - SOP mechanism evaluation**
  Sought to evaluate SOPs as a commissioning tool. It evaluated the impact, process and value for money of selected LCF SOPs and will compare the SOP model with alternative commissioning approaches

- **Strand 3 - SOP project-led evaluation**
  Sought to evaluate innovative interventions and specific aspects of the SOP model to inform local implementation[4].

The Government Outcomes Lab was responsible for the SOP mechanism evaluation (Strand 2). The LCF evaluation and GO Lab's accompanying research on social outcomes partnerships aim to respond to current evidence gaps by focusing specifically on SOPs as a tool for public service delivery and reform rather than centring only on the intervention effect. The ambition is to assess 'the SOP effect' – that is, the influence of this commissioning model on social outcomes.

Previous evaluations of SOP programmes have primarily focused on the implementation or efficacy of specific interventions (ie the particular service funded by the SOP), often without robust quantitative impact evaluation (Carter et al., 2018; see also Fox & Morris, 2019). Impact evaluations are important to help us understand how SOPs differ from typical government commissioning mechanisms in terms of the social 'impact' they deliver against objectives. As the largest outcome fund in the UK, the LCF provided an opportunity to undertake both process and impact evaluations to help improve future policy and practice.

1.2 THE KBOP EVALUATION

To explore the impacts of services commissioned through SOPs compared with traditional approaches, the Government Outcomes Lab conducted in-depth,

[3] The fund-level evaluation was contracted to ICF. Their process evaluation is available here.
[4] LCF projects were responsible for commissioning their own project-led evaluations. Where available, these reports have been collated here.

longitudinal analyses of two select Life Chances Fund projects. One of these projects was the Kirklees Better Outcomes Partnership (KBOP)[5], a social outcomes partnership in Kirklees, West Yorkshire.

The Kirklees Better Outcomes Partnership, offered a valuable learning opportunity, as Kirklees Council moved from commissioning the services under a fee-for-service model to using an outcomes-based contract involving a consistent group of providers. This provided a valuable opportunity to better understand how changing the payment model affects relationships, practices and outcomes when the same providers continue delivering the services. This evaluation focused specifically on the LCF-funded KBOP service and did not include any ongoing delivery following the conclusion of LCF funding.

The evaluation of the KBOP SOP addressed three research questions:

1. What was the quantitative impact of services commissioned by the KBOP SOP on the targeted social outcomes[6]?
2. What mechanisms within the KBOP SOP contributed to changed services and successful social outcomes?
3. Did the benefits of the KBOP SOP approach outweigh any additional costs associated with this model, when compared with legacy contracting arrangements?

This report focuses on question 2, the 'SOP mechanism.' Unlike Question 1, which examines impact (whether outcomes improved) or Question 3, which explores value for money (whether the benefits justify the costs), this stage of the evaluation aimed to understand the mechanisms at work that enabled service innovation and improved outcomes.

To that end, we conducted a theory-based process evaluation, drawing on the principles of generative causation (ie generating an understanding of the underlying mechanisms or processes that shape a phenomenon). This approach is well-suited to understanding complex change; rather than attempting to isolate a single causal effect (as in a counterfactual impact evaluation), it enables us to construct a plausible account of how and why the SOP mechanisms contributed to change, how they interacted with context, and where tensions or alternative dynamics emerged. The analysis also considered disconfirming evidence and alternative explanations – using triangulation across data sources,

[5] Also known as the Kirklees Integrated Support Service

[6] A full quantitative impact evaluation for KBOP is being prepared as part of the Labour market evaluation pilot fund and results are expected to be published in 2025. Research question 3 will also be addressed in the same evaluation.

within-case comparisons, and attention to variation across stakeholders – to test the strength of each causal claim.

This approach was complemented by systems mapping, which was used to understand the wider service ecosystem, exploring interdependencies and feedback loops within the service ecosystem that might shape or constrain these mechanisms. We then applied theory-testing process tracing to examine whether the expected four causal mechanisms identified in the first wave of this evaluation (market stewardship, performance management, collaboration, flexibility and personalisation) operated as theorised.

This report presents the findings from the third and final wave of research, building upon insights from the two previous evaluation waves:

A. **Life Chances Fund first stage evaluation report: Kirklees (July 2021).** The initial report explored the legacy fee-for-service arrangement used to deliver services to vulnerable adults in Kirklees. The report identified four challenges that the services faced under this contracting model and outlined the rationale for adopting a SOP model, namely that the SOP mechanism might lead to enhanced (1) practice of market stewardship, (2) performance management, (3) collaboration, (4) flexibility and personalisation of the service. Subsequent stages of the evaluation were designed to test this rationale.

B. **Life Chances Fund second stage evaluation report: Kirklees (August 2023).** The second interim report examined the four hypotheses developed in the first interim evaluation of the KBOP SOP, finding evidence of progress across all areas. It also highlighted challenges and tensions associated with setting up a new delivery framework, such as increased administrative burdens, capacity strains from higher caseloads, and the complexities of adapting to an outcomes-focused collaborative model.

Using the hypotheses from the first stage evaluation (2021) to explore the 'mechanisms' of the KBOP SOP, this final report seeks to validate and complement findings from the second stage evaluation (2023) while examining the evolution of relationships, practices and outcomes as the contract approached its conclusion.

This final report takes into account a wider range of stakeholders (including frontline staff and service users) and methods. By doing so, it captures both the sustained impacts of the SOP mechanism relating to the four hypotheses and the challenges arising from the transition towards the end of the contract.

The remainder of the report is structured across six overarching sections:

- **Section 2** sets out the research method.

- **Section 3** describes the KBOP SOP service and its 'counterfactual', the legacy fee-for-service contract. This section revisits key features of the SOP arrangement, including the overarching rate card of outcome measures and the role of adaptive management and flexible social investment. It also reflects on the longitudinal changes KBOP experienced and their implications observed during the final evaluation stage.

- **Section 4** returns to the first stage evaluation's four hypotheses about mechanisms through which the SOP model reforms and shapes management and frontline delivery practice. This section provides conclusive insights drawn from stakeholder experiences and data across the full evaluation period, highlighting how these mechanisms have evolved since the interim findings. We also examine how the end of the contract period influenced stakeholder behaviours, planning dynamics and the overall delivery of services.

- **Section 5** investigates the systems dynamics in the delivery of the SOP intervention. The section draws on insights from a mapping workshop conducted at the end of the contract. It maps the interdependencies between public service ecosystems, contract mechanisms and outcome design, provider capabilities, and responsiveness to service users' individual circumstances and needs.

- **Section 6** offers concluding remarks, synthesising the longitudinal findings into recommendations for policy and outlining further research outputs within the KBOP SOP evaluation.

RESEARCH METHOD

This report is the final process evaluation report within a mixed-method longitudinal research programme.

SUMMARY OF RESEARCH METHODS

- The main qualitative approach to data collection involved in-depth, semi-structured interviews with representatives from all stakeholder organisations. Further, system mapping workshops with provider organisations were conducted to explore the interdependencies and dynamics influencing service success. We also facilitated peer-led research with service users through workshops and vignette-based interviews.

- Quantitative data sources include a three-wave longitudinal survey of frontline staff, in which we asked them to compare delivery experiences under the legacy arrangement with the SOP arrangement.

- Interview data were analysed using thematic analysis. Survey data were analysed using descriptive statistics, and statistical tests were used to detect differences between survey waves.

- Limitations: the findings are specific to the KBOP SOP and not all findings are generalisable to other SOP projects. Some data resources, such as frontline staff interviews and survey data, rely on small sample sizes, self-reported information and a mix of cross-sectional and longitudinal data. Interview data from delivery organisations may feature positive or negative bias. Potential bias was mitigated by incorporating the perspectives of local government commissioners and a large number of interviews overall.

Table 1 provides an overview of the research methods used throughout the evaluation. Longitudinal methods were used to track changes over time and included repeated interviews with key stakeholders and a survey across all three waves. Cross-sectional methods were used to capture insights at a single point in time; they included interviews with frontline staff and service users, system mapping, and peer-led research. This mix of approaches and methodologies helped build a well-rounded understanding of the KBOP SOP model's impact.

Table 1: Summary of evaluation methods

Data type	Research participants	Data collection[7]
Semi-structured interviews	Provider managers	Longitudinal
	Frontline staff	Cross-sectional
	Council contract managers	Longitudinal
	Social prime managers	Longitudinal
	Social prime staff	Longitudinal
	Investment fund manager	Longitudinal
	Service users	Cross-sectional
System maps	Provider managers & frontline staff	Cross-sectional
Vignettes (peer-led research)	Service users	Cross-sectional
Survey (quantitative)	Frontline staff	Longitudinal

Source: Government Outcomes Lab

2.1 INTERVIEWS & SURVEY

2.1.1 Data collection

For the final wave of the research, 49 semi-structured in-depth interviews were conducted. Interviews were carried out using a phased, sequential approach to gather sufficient intelligence on key operational features, allowing for detailed probing with interviewees involved in the strategic management of the partnership:

- **Provider manager**s: 23 interviews[8] were held (conducted autumn and winter 2023/24). Among these, 13 had been involved in the delivery of the fee-for-service contract; 7 of the provider managers participated in all research waves.

- **Frontline staff**: 14 interviews were held (conducted in spring 2024). All but one had experience in the delivery of the fee-for-service contract.

[7] Longitudinal data collection refers to data collection at three points in time: prior to the launch of the SOP (ie at the end of the legacy fee-for-service contract); mid-implementation; and at the end of the SOP contract. In cases where a cross-sectional data collection approach was applied, data were collected in 2023 and 2024, shortly before programme completion.
[8] Four interviews were conducted with the same two interviewees. These interviewees were involved in two separate interviews in order to investigate their performance improvement plan experiences in more detail.

- **Social prime representatives:** 9 interviews with managers and staff from the KBOP social prime (5 individual interviewees) and representatives from the investment fund managers (summer/autumn 2024)[9]

- **Council managers:** 3 interviews with managers (winter/summer 2024).

Participants were selected using purposive sampling. For the manager interviews, the key sampling criterion was their prior involvement as research participants, which allowed us to trace how their experiences evolved over time. For the frontline staff, the key considerations were a variation in role profiles, length of involvement with the KBOP SOP service and, if possible, prior involvement with the preceding fee-for-service contract. To ensure coverage across the full set of delivery organisations and avoid bias in the data, at least two representatives from each organisation were interviewed. This interview approach ensured that insights were from stakeholders across all levels of the project[10].

In addition, this report draws on data from a longitudinal survey that investigated the shift in frontline staff's delivery practice from the legacy fee-for-service contract to the SOP contract. The same survey was used at three points in time:

- At the end of the fee-for-service contract in early 2019 (Wave 1, n=57)

- During mid-implementation of the SOP in autumn/winter 2021 (Wave 2, n=47)

- In the final stages of the SOP delivery in late 2023/ early 2024 (Wave 3, n=39).

The survey used standardised questions which were heavily informed by previous longitudinal studies that tracked the shift in contractual arrangements in employment support systems (Considine, 2001; Considine et al., 2015). The questions focused on staff's outcomes orientation and professional discretion, as well as indicators of personalisation such as tailoring, user choice, caseload rations, contact frequency with service users, and collaboration with other services. They also included measures of administrative burden and use of performance data. We ensured comprehensive coverage by including at least one frontline staff representative from each active delivery organisation in the interviews and inviting

[9] These nine interviews include one additional interview with the fund manager which involved a follow-up conversation for clarification purposes.
[10] Appendix B provides a detailed account of the interview approach, including recording and transcription methods, themes of the question design, and a table of the organisational affiliation and role of the interviewees.

all frontline staff from these organisations to participate in the survey. The survey was administered by the research team, which collected data on an anonymous basis.

2.1.2 Data analysis

Qualitative data analysis was conducted using ATLAS-ti software. Data coding was conducted using a thematic analysis (Ryan & Bernard, 2003) to reveal the SOP model's central features (the 'SOP mechanisms') shaping frontline delivery and the wider service ecosystem in Kirklees. Data coding followed the Miles et al. (2014) two-phased coding approach:

Phase 1: During the first data analysis cycle a deductive coding approach was applied. Codes developed from the initial set of 'SOP mechanism' hypotheses in the first evaluation report were used to break down the data into discrete parts. Furthermore, structural coding was applied to categorise major themes not included in the hypotheses (Saldaña, 2021).

Phase 2: In the second cycle an inductive coding approach was applied to expand the initial top-level codes with a list of more granular sub-codes. The sub-codes were generated using either descriptive or axial coding (Saldaña, 2021); the latter method describes a code's properties and dimensions and enables an exploration of how the code and its sub-codes relate to each other.

The survey data were analysed using R software. The analysis focused on descriptive statistics, and different statistical tests (Kruskal-Wallis; Fisher's Exact Test) were used to detect differences between survey waves.

2.1.3 Limitations

At the point of data collection in this final research stage, providers were facing considerable insecurity and were uncertain whether or for how long the KBOP service might be extended. Due to Kirklees Council's constrained financial situation, it seemed likely that not all providers could be part of any successor KBOP service. Contract extension was under discussion between Kirklees Council and Bridges Outcomes Partnerships.

This funding insecurity might have led to a negative response bias in some instances. However, in general, interview participants clearly distinguished between the overall delivery experience under KBOP and the specific insecure situation they were facing when interviews were conducted. Likewise, there might have been a positive response bias for some participants because they wanted to remain part of the re-commissioned SOP service. The incorporation of the perspectives of local

government commissioners and the large number of interviews might mitigate where this has occurred.

Only four respondents participated in all three survey waves (appendix C, tables 1, 2). Therefore, only a small subset of participants provided consistent feedback across the legacy fee-for-service contract, the mid-implementation phase of the outcomes-based SOP, and its final phase. This factor limited the respondents' ability to draw direct comparisons between the preceding contract in Kirklees and the outcomes-based contract. However, they often had experiences in other block contracts (ie fixed-fee arrangements for delivering services, regardless of usage) and thus were able to reflect on the implications of an outcomes-based arrangement compared with a conventional block contract. The small sample size constitutes a limitation to the analysis of the survey data. Additionally, the survey relies on self-reported data, which can be subject to bias or inconsistencies in interpretation.

That said, the survey captures longitudinal data over a five-year period, encompassing different contracting environments and evolving practices within the same delivery context. By capturing changes in perceptions and experiences during SOP implementation, it provides insights into the lived experiences of frontline staff and stakeholders.

2.2 SYSTEMS MAPPING

To allow for a participatory exploration of the factors and interdependencies that influenced the success of the KBOP SOP service, three system mapping workshops with provider organisations were conducted in spring 2024.

Systems mapping facilitates an exploration of causal relationships within complex systems. This method allows research participants to communicate their understandings and allows for the identification of spill-overs (intervention effects that influence other parts of a delivery system), critical factors (features which a number of other factors depend upon) and reinforcing loops (where a series of factors reinforce each other) (Barbrook-Johnson et al., 2022). Furthermore, the collaborative nature of the systems mapping workshop enabled the research team to transfer power to the people delivering the KBOP contract and create a shared understanding and consensus on the perceived main components influencing intervention success.

The creation of the systems maps involved the development and iteration of the maps in individual workshops with the different provider organisations. First, the scope of the maps were defined. They generally described the local system of support for people interacting with the KBOP service (including the factors that supported users to achieve what mattered to them). Next, workshop participants were asked to note down perceived key factors influencing the success of the intervention on post-it notes. These post-it notes were collated across a whiteboard and then explained by the note-taker. Finally, a common agreement on the terminology of the key factors and potential overlap was sought. The same process was repeated for additional factors influencing the key system factors.

Afterwards, participants were asked to describe the connections between the factors. Connections between factors could either be positively or negatively correlated; in rare instances they could also be contingent, ie positively and negatively correlated. At the end of the workshop the map was reviewed to identify missing factors and connections as well as duplications. Using the systems mapping software Kumu, a researcher from the Government Outcomes Lab created a digital version of the map. The digital version was shared and validated with the workshop participants. Their feedback was incorporated into the final maps shown in this report.

The workshops lasted on average three hours and included different organisational representatives, including frontline staff, service managers and operational leads. All workshop participants had significant experience in delivering KBOP services and related different experiences and reflections of the service. The workshops were facilitated by two researchers from the Government Outcomes Lab, and a third researcher was responsible for note-taking and observations. The sessions were also recorded. The whole mapping project followed a systems mapping methodology developed by CECAN (Centre for the Evaluation of Complexity Across the Nexus), a national research centre hosted by the University of Surrey.

2.3 PEER-LED RESEARCH

To explore the experience of KBOP service users, the study engaged peer researchers. Peer research is a participatory research method that uses people's lived experience of the issue to co-design and implement research (Burns et al., 2021). Two key considerations underpinned the decision to apply a peer researcher model. First, this approach made the research more inclusive (Terry & Cardwell, 2016). Second, it improved the data quality (Vaughan et al., 2018); peer researchers

often have better access to data, including gaining insights into fellow users' experiences.

2.3.1 Data collection

The peer research was conducted through a series of workshops between October 2023 and June 2024. This involved:

- Dedicated training on research ethics, data management and qualitative research by senior researchers from the Government Outcomes Lab
- Two research co-design workshops
- A data collection session
- A data analysis workshop.

The peer researchers consisted of a team of four KBOP service users who had already progressed substantially in their support journey or already exited the service; all of them were involved as peer mentors in the KBOP service. In addition, the peer research was supported by a peer mentor coordinator who was a former KBOP service user and subsequently moved into a permanent KBOP staff role. In alignment with the ethos of co-produced research, participants were recruited through an open invitation to all KBOP peer mentors that was facilitated by the KBOP peer mentor coordinator. Prior to the research, all participants provided informed consent as set out in the University of Oxford's ethics review process.

The peer researchers supported an investigation of the extent to which the KBOP SOP service allowed for the delivery of flexible and authentically person-centred support. Peer researchers actively drew on their own experience and the experiences of their mentees (ie people who were KBOP service users at the point of data collection).

The peer researchers developed two key tools for data collection: a semi-structured interview guide and vignettes (referred to as personal stories). The interview guide explored participants' experience of the KBOP SOP service, compared with their (past) experiences of more traditional services. The interview investigated the different dimensions of person-centred support such as choice, variation in support delivery, and the ability to access wrap-around support.

Vignettes, defined as 'text, images, or other forms of stimuli [to] which respondents are asked to respond' (eg Hughes & Huby, 2004, p. 37) are used in the qualitative-interpretive research strand to create a contextually sensitive and authentic setting for specific questions. All peer researchers drafted their own vignette that described their experience of services (past and KBOP). The vignettes were

introduced at the beginning of the semi-structured interviews and intended to encourage the interviewees to reflect on their understanding of 'good' (ie person-centred support) and their experience of KBOP support provision.
The data collection involved four face-to-face semi-structured in-depth interviews lasting between twenty and thirty minutes. Each of the four peer researchers conducted one interview, either with another peer researcher or with a service users who was part of the KBOP's mentee cohort at the time of data collection. For each interview, one member of the GO Lab's research team acted as an observer and took detailed notes. There was no overlap in interviewers or interviewees, so all participants were unique across the interviews.

2.3.2 Data analysis

A dedicated five-hour workshop for data analysis ensured that the peer researchers had agency in analysing and interpreting the data. The peer-led analysis involved two main approaches.

First, peer researchers employed thematic analysis to produce 'thick descriptions' (detailed and contextual insights) of emerging themes through a process of coding and systematising data (Guest et al., 2012). Thematic analysis was conducted through a three-stage process supported by GO Lab researchers. Peer researchers began by independently coding anonymised interviews. They then took part in a group discussion moderated by a GO Lab researcher to jointly agree on codes. Lastly, a comprehensive list of codes was reviewed and refined by the group to identify duplications, clarify terminology and draw out overarching themes.

Second, peer researchers used graphic recording, a method of visual notetaking in which key themes and ideas are illustrated live during a discussion using a combination of images, words and symbols (Zheng et al., 2021). This approach helped make abstract or complex ideas more tangible and accessible. It also enabled peer researchers to validate terminology, clarify ideas, and revisit previously overlooked issues as they discussed their support experiences. The dialogue was facilitated by an experienced graphic recorder who captured participants' reflections in real time using a large-format visual map.[11]

This combination of approaches:

[11] The professional graphic recorder was a former commissioner in social care and therefore possessed a foundational subject knowledge.

i) enabled participants to engage with the data in an accessible way and shape the narrative of the findings
ii) created a participatory research output that can be shared with diverse audiences and conveys the findings in an accessible and representative way.

After the data analysis workshop, a digital version of the graphic recording was shared with participants for validation. To ensure a comprehensive and consistent approach, all data gathered from the peer research project (ie interviews, vignettes and workshop meeting minutes) were uploaded into the coding software (ATLAS-ti). Some of the codes developed in the joint analysis workshop were integrated into the analysis framework. The write-up of the findings was validated by the peer mentor coordinator, who provided a description of the findings visualised in the graphic recording.

2.3.3 Limitations

A limitation of the peer research was the small number of participants[12]. This was due to the limited number of matched pairs of peer mentor (involved as a peer researcher) and mentee (involved as an interview participant), as well as the total number of peer mentors available and willing to participate in the study. Additionally, there is potential for positive response bias due to the peer researchers' successful completion of the programme and ongoing affiliation with KBOP as peer mentors. Ethical considerations also arise from mentors interviewing mentees, as the existing relationship could have influenced the mentees' responses or created pressure to align with the mentors' perspective. These factors were mitigated through training in research ethics and maintaining anonymity in the analysis process.

[12] Three additional people participated in the initial stages of the peer research project but ultimately disengaged before the project completed.

THE KBOP SOP AND COMPARISON WITH PREVIOUS SERVICE ARRANGEMENTS IN KIRKLEES

3.1 THE 'COUNTERFACTUAL'

In Kirklees, the provision of services for adults with housing-related support needs was previously commissioned as a Floating Support service under the umbrella of the Supporting People programme, a national grant programme launched in 2003. This service was expected to function preventatively, supporting users to sustain independent living and avoid tenancy issues. The contracts underpinning this previous service didn't explicitly set out to support users into training or employment[13].

The Floating Support service sat alongside accommodation-based services which delivered interventions for people who were homeless. Support was delivered on a 1:1 basis for a specified number of hours per week, and support intensity was adjusted according to users' categorisation as 'low, medium or high risk.' The intervention duration was limited to 12 months (initially 24 months) due to funding cuts. In early 2019, the services were delivered by the same nine voluntary sector provider organisations which then became delivery partners in the KBOP SOP.

Before the launch of the SOP, the Floating Support service in Kirklees involved 15 individual contracts managed by three council contract managers. The payment to providers was made monthly in advance as a block fee. There was no central data management system, and standardisation in referral processes or case management

[13] The description in this report is based on findings from the first interim evaluation report on the pre-SOP fee-for-service arrangement (Rosenbach and Carter, 2020).

was limited. The legacy services aspired to achieve 'independent living' of users, but there was no standard definition of what this meant or expectation of evidence to demonstrate that users' circumstances had improved. Providers were only required to record support plans, which were subject to occasional file auditing. Likewise, the sustainment of outcomes was not part of the contracts' key performance indicators.

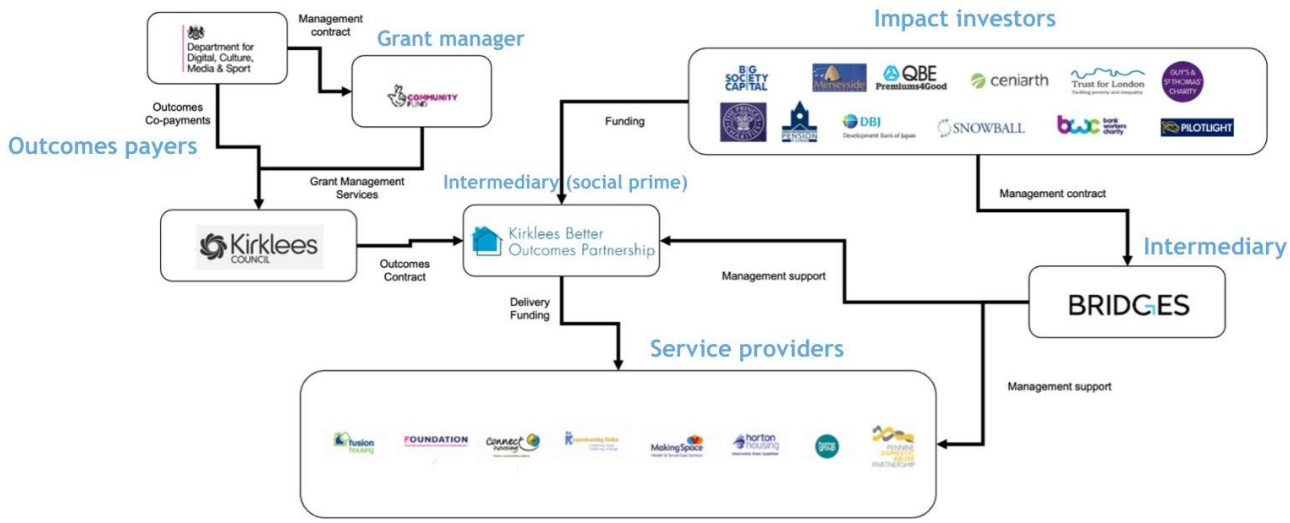
3.2 THE SOP

The KBOP SOP service launched on 1 September 2019 as a commissioning partnership between the Life Chances Fund and Kirklees Council. The service[14] sought to improve accommodation, employment, stability and wellbeing outcomes for vulnerable adults who were in need of support to live independently. Users may have faced multiple challenges, including homelessness or the immediate risk of becoming homeless, mental health or substance misuse issues, experience of domestic abuse and offending. When the programme ended on 31 March 2024, a total of £22.6m had been paid for outcomes achieved.

Kirklees Council funded 70% of the total contract value for the outcome payments, with the remaining 30% covered by central government through co-funding provided by the Life Chances Fund. Following the conclusion of the Life Chances Fund, Kirklees Council committed to continuing service provision under a new outcomes contract, retaining the same contractual model, with KBOP continuing to act as the prime contractor supported by Bridges Outcomes Partnerships. However, the new arrangement will operate with significantly less funding, a scaled-down service and fewer service providers.

[14] In the report, the term 'KBOP SOP'/'SOP' or 'service/project/programme', is used to refer to the commissioning arrangement, whereas the term 'social outcomes contract' is used to refer specifically to the contract between Kirklees Council and the KBOP social prime.

Figure 1: Stakeholders' responsibilities in the Kirklees Better Outcomes Partnership SOP



Source: KBOP Social Prime

Figure 1 summarises the key stakeholders in the SOP. The service was commissioned by Kirklees Council, which set the initial outcome measures for the programme. Bridges Outcomes Partnerships, a not-for-profit subsidiary of Bridges Fund Management[15], sourced upfront funding for service innovations and initial costs from a group of 10 social investors; ongoing funding was generated through outcome payments. Bridges also established and owned the SOP's 'social prime' (Kirklees Better Outcomes Partnership, or KBOP), which was responsible for the overall design and coordination of delivery. Kirklees Council held a contract (referred to as a 'social outcomes contract') with KBOP and paid KBOP a pre-defined amount for each outcome achieved by an individual programme user.

At its start, KBOP held bi-lateral contracts with the same nine voluntary sector organisations involved in the provision of the pre-SOP Floating Support service, though one provider left after nine months by mutual consent[16]. The initial distribution of the contract volumes (ie the number of service users engaging with each delivery organisation) was based on the preceding fee-for-service contracts. Two of the eight providers[17] shared a significantly higher contract volume. These contracts featured key performance indicators that were tailored to each provider. The service providers were paid a monthly fee in arrears. The majority of the

[15] Bridges Fund Management is a specialist sustainable and impact investment manager.

[16] This is discussed in the second interim evaluation report in more detail.

[17] Provider F and H.

provider organisations delivered general housing-related support, while one provider offered specialist support for mental health and another offered specialist support for people experiencing domestic abuse (details of the participating providers is available in appendix A).

Users were allocated to service providers through a central referral hub managed by KBOP. From 2020 onwards, after a change of leadership within KBOP, the programme pivoted to personalised service provision, based on a strengths-based approach[18] seeking to transfer greater power to users. The ambition (from both commissioners and the KBOP team) was to disrupt a perceived deficit culture of 'fixing' by shifting the focus from users' deficiencies to their strengths, encouraging users to shape their support journey. Providers were granted greater flexibility in the mode of support provision than they had possessed under the legacy contract (the 'counterfactual'). There was no prescribed length or frequency of support; each case was closed once the user had achieved all relevant outcomes, as set out in the LCF contract. After case closure the user could still re-access the service. However, outcomes could only be claimed once for each user. Alongside its floating support service, KBOP offered a triage service for vulnerable people who only required one-off support.

User data, including outcome achievements, referral assessment and support plans, were saved on a central data management system (CDPSoft). The CDPSoft system was administered by the Council and granted full accessibility to the KBOP, whereas providers were only able to access their own data[19].

The outcome claims and verification process involved two steps:

i) Under the supervision of KBOP, providers uploaded the evidence for outcomes into the CDPSoft system. Evidence requirements for the outcomes were defined in the outcomes contract.
ii) The Kirklees Council team verified the provided evidence and paid the pre-defined outcome payment to KBOP. The Council had the right to withhold the payment if the evidence was considered insufficient.

We can view the introduction of the SOP as a bundle of reform interventions, within which it is important to pay particular attention to three features:

[18] The KBOP SOP's personalised, strengths-based service provision was based on the 'person-led, transitional and strength-based (PTS) response approach' developed by the Mayday Trust. In general, a strengths-based approach focuses on identifying, building on and leveraging an individual's existing skills, abilities and resources to empower them and achieve positive outcomes.

[19] This ensured confidentiality for the individual and GDPR compliance.

- a rate card with multiple outcome measures,
- very light-touch service specifications, and
- an adaptive management approach that allowed for learning and adjustments to the service, supported by flexible upfront social investment and active support from an intermediary focused on identifying and implementing such changes.

These are discussed in more detail below.

Table 2: Comparison of key contract features

Contract features	Counterfactual: fee-for-service contracts	SOP: Kirklees council and KBOP - social outcomes contract	SOP: KBOP and providers - fee-for-service contracts
Year launched	**2003**	**2019**	**2019**
Contract parties	Kirklees Council and provider organisations	Kirklees Council and KBOP social prime (investor-owned special purpose vehicle)	KBOP social prime and individual provider organisations (bi-lateral contracts)
Contract management responsibility	Kirklees Council	Kirklees Council	KBOP social prime
Payment mechanism	Monthly *advance block payment*	Monthly outcomes payment (ie payment is contingent on achieved outcome number and type)	Monthly, *paid in arrears*
Key performance indicators (KPIs)	Service utilisation; Throughput; Independent living	Accommodation; Education, training and employment (ETE); Health and wellbeing; Financial resilience	Referral numbers; New starts on service; Accommodation; Education, training and employment (ETE); Health and wellbeing; Financial resilience
KPIs require sustainment of outcome achievements?	No	Yes	Yes
Auditing	No pre-defined evidence requirements; spot checks of	Pre-defined evidence requirements;	Pre-defined evidence requirements, as specified in rate

	qualitative evidence (eg workbooks)	Council audits the evidence for every outcome	cards; ongoing performance monitoring via KBOP
Contract duration	Maximum 2 years	5 years	5 years (subject to performance)

Source: Government Outcomes Lab

KEY DESIGN FEATURES: THE RATE CARD AND ADAPTIVE SERVICE MANAGEMENT

A central distinguishing feature of the KBOP SOP model, compared with the previous fee-for-service arrangement, was the use of a rate card: a structured schedule of payments for specific, verifiable outcomes. Whereas the legacy model reimbursed providers based on inputs (eg hours of support), the rate card shifted the focus to demonstrable improvements in users' lives, such as sustained accommodation or employment. This design change aimed to enable clearer success indicators, to align incentives across providers, and to encourage a stronger orientation toward long-term outcomes.

The rate card also enabled a more adaptive approach to service management. The flexibility built into the outcomes-based funding model allowed KBOP and its partners to respond to emerging challenges by adjusting delivery, refining evidence requirements, and piloting targeted service innovations.

KEY FINDINGS

- **Shared outcome measures:** The rate card contained a shared set of outcome measures for the providers of generic housing-related support, thus fostering stakeholder alignment. A separate rate card was used for a specialist provider for domestic abuse (Pennine Domestic Abuse Partnership, PDAP).
- **Introduction of education, training and employment (ETE) outcomes**: A key difference between the fee-for-service arrangements and the KBOP social outcomes contract was that KBOP included ETE outcomes (education, training and employment). While some participants reported challenges in achieving and measuring ETE outcomes, potentially straining staff-user relationships, ETE outcomes ultimately fostered a more aspirational approach.
- **Rate card design challenges:** Research participants highlighted several challenges regarding the rate card design, including:

- concerns over over the feasibility and unintended consequences of the 18-month sustained accommodation outcome, which could inadvertently incentivise prolonged service dependency
- the inability to claim outcomes for users who re-entered services, leading to frustration and potentially limiting service flexibility.

- **Adaptive management and innovations:** Flexible funding within the KBOP model enabled ongoing adjustments in service delivery via responsive service innovations.

4.1 THE RATE CARD

This section explores the design of the KBOP rate card and its implications for delivery. A rate card is a schedule of payments for specific, pre-agreed outcomes that an outcome payer is willing to make for each user, cohort or entity that verifiably achieves each outcome[20]. The following section provides an overview of the outcomes and associated evidence requirements of the KBOP SOP.

Rate cards were not used in the previous service provision (the 'counterfactual'*)*. The outcome measures in the KBOP rate card provided an overarching set of shared success indicators for all providers of generic housing-related support[21]. A different rate card was used for a specialist provider for domestic violence[22].

The KBOP SOP sought to improve users' outcomes in the following fields:

- Wellbeing
- Accommodation
- Education, training and employment (ETE)
- Emotional and mental health
- Drug and alcohol misuse
- Domestic abuse.

Because users who continued to engage with providers were more likely to achieve long-term independence, outcome payments were structured to reflect both the initial achievement of an outcome (eg entering accommodation) and its sustainment over time (eg sustaining accommodation over six months). The outcome payment level increased the longer the outcome was sustained (eg £500 for 'entry into employment', £2,200 for '26 weeks of sustained employment') to align incentives

[20] In the KBOP SOP, Kirklees Council and the LCF were the outcome payers.

[21] The rate card also applied to Community Links, a provider which offered specialist mental health support.

[22] Pennine Domestic Abuse Partnership, PDAP

between the financial payment mechanism and the achievement of long-term outcomes. As service delivery evolved and learning deepened, evidence requirements were adjusted on a rolling basis in response to providers' feedback that existing requirements created significant administrative burden and privacy concerns (see Rosenbach et al. 2024 and section 5.2.2). For example, KBOP simplified the evidencing of ETE outcomes by introducing automated checks through accessing HMRC data and self-certification forms[23] that allowed service users to declare the achievement of given outcomes. For the outcome 'entering into employment'[24], service users were allowed to self-certify their employment by providing signed forms instead of showing an employment contract or payslips.

These adjustments were aided by the fact that KBOP and providers demonstrated their diligence and commitment to obtaining valid outcomes, which helped to build trust and allowed for the adaptation of evidence requirements (earned autonomy). However, self-certification was never accepted in isolation, and required secondary evidence. For example, full details of employment – including employer name, role, start date, and salary – had to be recorded and substantiated through event notes. The Council was mindful not to loosen evidence requirements in a way that would compromise the integrity of the outcomes process. To ensure compliance, sample audits – covering approximately 15% of claims – remained in place as an oversight mechanism to ensure the integrity of this outcomes process. Additionally, an external audit was conducted quarterly and submitted as part of LCF payment claims, providing further assurance of accountability and accuracy. These adjustments highlighted the parties' willingness to find innovative ways of addressing the challenges of resource-intensive evidence requirements whilst ensuring a commitment to accountability. However, overall, evidence requirements remained largely unchanged due to the fixed framework set by the contractual agreements and the original LCF bid, occasionally causing frustration among KBOP and providers as it did not always align with personalised or strengths-based approaches.

[23] Here, providers uploaded supplementary evidence on the service user history into the central data management system.

[24] The evidence requirements for sustained employment were stricter, requiring payslips/employer confirmation or confirmatory data from HMRC.

Table 3: Rate card outcomes[25] and outcome metrics[26]

Outcomes	Payment trigger
Wellbeing	1st Wellbeing assessment
	2nd Wellbeing assessment
	3rd Wellbeing assessment
	Wellbeing improvement – 1st to 2nd assessment
	Wellbeing improvement – 1st to 3rd assessment
Managing money	Financial resilience outcomes
Emotional & mental health; Drug & alcohol misuse	Accessing services
	Mental health sustained engagement with services
	Drugs/alcohol sustained engagement with services
Accommodation	Prevention/relief/entry into suitable accommodation
	3 months accommodation outcomes
	6 months accommodation outcomes
	12 months accommodation outcomes
	18 months accommodation outcomes
Education, training and employment (ETE)	Entry into education and employment
	Part completion of Ofqual approved qualification
	Completion of full Ofqual approved qualification
	Entry into employment[27]
	6.5 weeks equivalent employment F/T
	13 weeks equivalent employment F/T
	26 weeks equivalent employment F/T
	Entry into volunteering
	6 weeks volunteering
Prevention of domestic abuse	Reduction in risk of domestic abuse
	Accessing rights to legal protection
	Empowering and promoting independence

Source: Adapted from KBOP social prime internal document

[25] The figure combines the outcomes from the generic housing related support rate card and the rate card of the specialist domestic abuse provider (PDAP).
[26] At the time of research completion.
[27] A 'second entry into employment' outcome was introduced during COVID to reflect employment instability, as some users required support to re-enter employment multiple times.

4.1.1. Rate card implications for service delivery

Providers found that a rate card with a clear set of pre-defined outcomes created a greater focus in their support work than they had experienced under the 'counterfactual' fee-for-service delivery model.

They appreciated the inclusion of a wide range of outcome measures which aligned well to user need and allowed for holistic support, including the achievement of longer-term impact. However, the Council and the KBOP leadership team advocated for reducing the number of outcomes if the service were re-commissioned. Some provider staff were concerned that too many specified outcome measures might be a distraction and hinder person-centred support due to a prioritisation of outcomes over actual user need.

A key differentiator between the fee-for-service arrangements (counterfactual) and the KBOP social outcomes contract was the introduction of ETE (education, training and employment) outcomes. Initially, providers were sceptical of service users' ability to achieve these labour market outcomes because the users were often experiencing challenging life circumstances. Some manager and caseworker voices remained critical over the course of the contract, stressing in particular that the ETE focus might have strained staff-user relationships. Some staff articulated a concern that service users might have perceived this aspiration to achieve more challenging outcomes as lacking empathy and understanding for their life circumstances.

Proponents of the ETE outcomes explained that they incentivised more aspirational support work, ultimately helping to break the recurring cycle of support dependency. A case worker[28] reflected:

'It's been a good surprise that actually when you open up those conversations and you're not focusing on the presenting problem at the time, but looking at the person more holistically and seeing the strengths that they've got to bring to the table and opening up the possibility of employment being on the table, it has been a wonderful surprise and it has been very rewarding to be working in that way and just not making that assumption right at the start that the people are not wanting to go out there and find work and contribute to society while whilst they have these problems going on.

I'm working with somebody who's sleeping in the car at the moment and he's still happy to be going out and looking for work because he understands that through

[28] Provider F. research wave 3.

looking into employment options, it can increase his financial circumstances and that's going to open up the door to more housing possibilities.'

Providers did note drawbacks in the rate card design. There was agreement that the outcome measure '18 months sustainment of accommodation' incentivised staff to keep users on the service even if there was no longer a support need. A potential mitigation strategy suggested by the KBOP investment director was to separate support delivery and the length of measurement in the outcome specification. For example, support delivery could be ended after 12 months, but the final (18 months) outcomes payment would be conditional on providing evidence that the outcomes had been sustained for 18 months.

Providers were also critical of an evidence requirement: a workbook for budget planning used to demonstrate the outcome 'achieve financial resilience.' A number of caseworkers criticised this measure as being too simplistic, noting that achieving financial resilience often required addressing more complex financial issues. However, while Council staff recognised the financial workbook's limitations, it remained a required evidence criterion, particularly when no other verifiable proof of the achievement of the outcome was available. Some frustration among staff resulted. The following statement from a caseworker[29] illustrates the problem:

'I don't like the way the Council often would say to us "…and just do a financial workbook." I actually think that's too simplistic and it doesn't actually help the customers…some of the stuff [support work] we've done is far better than just doing a basic workbook, but often they will reject it. As an example, a support worker can spend quite a lot of time doing a review [personal independence payment] form. They will reject that and…They would say to us "do a financial expenditure form." That takes 5 minutes. Actually, that's quite lazy and wouldn't achieve anything.'

4.2 ADAPTIVE MANAGEMENT AND SERVICE INNOVATIONS

A distinct feature of the KBOP SOP was the availability of flexible funding to allow for ongoing service improvements. In the KBOP SOP, additional financial resource to enable adaptive improvements was either generated by reinvesting outcomes payments (funds received for meeting pre-defined performance targets) or provided as additional capital from the social investors. This reinvestment of underspend allowed for adjustments to and improvement of service delivery while also supporting the achievement of further outcomes, thereby ensuring continued performance against contractual outcomes. Unlike traditional fee-for-service

[29] Provider B. Research wave 3.

models in which funding is tied to specific activities, the KBOP approach provided room for targeted innovations in response to emerging challenges. The 'black box' nature of the KBOP outcomes contract (between Kirklees Council and KBOP, see Figure 1), which featured very limited service specifications, was a necessary precondition for this adaptive approach.

Decisions over service innovations were governed by a structured decision-making process that ensured alignment with strategic priorities, financial feasibility and anticipated impact. The implementation of service innovations required different levels of approval, depending on their scale and financial implications. Prior to making a business case, the KBOP management team (ie investment fund director, project director, data and impact manager) worked collaboratively on problem identification and potential mitigation strategies. The project director and the data and impact manager brought in operational intelligence, while the KBOP investment director supported business case development through their financial modelling capacity.

Stakeholders took a variety of factors into account as they developed innovation proposals. In addition to cost considerations, alignment with the values of the service and with commissioners' strategic interests was a critical concern. Another key consideration was the predicted value of outcomes that would result from the innovation. Depending on the problem specification, other factors to be weighed included: mitigating capacity constraints, increasing efficiency and service quality, community development, initiating cross-agency collaborations in the local area, and reputational and business development considerations.

Decisions about service innovations followed an adaptive approval process in which the level of review depended on the financial implications and the strategic significance. Smaller scale innovations, such as the Community Gardening Service to enhance mental health wellbeing through volunteering, were approved by the KBOP board directly. Initiatives involving more substantial investment and long-term commitment, such as the introduction of a dedicated ETE worker role to address low performance in employment outcomes, reviewed and cleared by the Bridges Investment Committee. Rather than being based on a fixed financial threshold, decisions were made flexibly, considering the potential impact and sustainability of each innovation.

Selected KBOP service innovation examples

15 service innovations were implemented under the KBOP SOP. These initiatives demonstrate how flexible funding and adaptive management enabled targeted improvements in service delivery and enhanced user outcomes. Examples of these

innovations reflect a broad spectrum of interventions, from low-cost, community-based initiatives to more complex, resource-intensive service enhancements. The following selected examples illustrate this range (for a full list of innovations, see appendix I):

The **tenancy deposit scheme** was introduced to facilitate access to private rental properties by offering bond agreements and cash guarantees to landlords. Led by Fusion Housing and KBOP, this initiative supported 283 clients and led to 268 outcomes, including 57 bonds securing new accommodation.

The **young persons pathway** focused on preventing homelessness among individuals under 25 by streamlining referral processes and ensuring early intervention. The automated referral system improved service accessibility so that 731 young clients (representing 17% of all referrals) received timely support to sustain their tenancies.

The **community gardening service** provided volunteering opportunities to enhance mental health and wellbeing. The project was facilitated by Home Group and KBOP and engaged 359 service users. Users reported an average 15% improvement in wellbeing as measured by the Home and Homelessness Star.

THE CAUSAL MECHANISMS OF THE KBOP SOP: 4 HYPOTHESES

The First Stage KBOP evaluation (Rosenbach & Carter, 2020) identified four broad challenges that existed under the pre-existing fee-for-service arrangements and commissioning environment prior to the adoption of the KBOP SOP model in September 2019[30]:

Challenge 1: Limited practice of market stewardship. Public service commissioners are expected to create the conditions needed for an effective market of providers. However, during the fee-for-service regime, the Council engaged in a limited practice of market stewardship. Shortcomings in its market stewardship included a lack of competitive pressure; limited transparency on the demand for, and performance of, services offered by different providers; and uncertainty over funding, which diverted providers' attention from service provision.

Hypothesis: The SOP might enable an enhanced practice of market stewardship, including increased constructive performance competition, a central data management system to record performance and service demand, and a stable, long-term contracting environment.

Challenge 2: Limited contract and performance management. It is important to ensure that providers are adhering to the terms of their contracts and delivering effective provision for people using services. Under the legacy arrangements, the Council engaged in limited contract management of provider organisations. It was inhibited by capacity limits as resource-constrained staff were responsible for managing many bilateral contracts. In addition, limited contractual levers provided perverse incentives or lacked clear, well-defined measures of success.

[30] Importantly, these challenges were not inherent or solely attributable to the legacy fee-for-service contracting arrangements; significant issues also stemmed from the constrained funding environment.

Hypothesis: The SOP might facilitate enhanced performance management as contracts would be managed through a single external entity and payment tied to the achievement of sustainable outcomes.

Challenge 3: Limited collaboration across provider organisations. Supporting people who experience multiple, complex disadvantage often requires collaboration between different service providers. Under the fee-for-service contracts, service users were expected to be enrolled with only one provider at any one time. As a result, the infrastructure for collaborative working was underdeveloped and lacked formal procedures for co-working. In addition, the requirement to evidence demand for individual services fuelled competition for referrals between providers, further inhibiting collaboration.

Hypothesis: The SOP might enable enhanced collaboration between providers by improving information sharing and co-working towards a shared interest in achieving outcomes.

Challenge 4: Limited flexibility in the delivery of services. Providers often require flexibility in order to meet the needs of individual service users. However, the legacy contracts under the Supporting People grant[31] were perceived to impose tight specifications on service intensity and length, restricting the adoption of creative, tailored approaches. This inflexibility ultimately limited the likely effectiveness of intervention, especially for 'harder to engage' service users.

Hypothesis: The SOP might bring enhanced flexibility in service delivery through autonomy for providers in service design and an adaptive approach to management by the social prime, KBOP.

This section seeks to explore whether the four initially developed hypotheses proved to be true, resulting in a shift in contract management and frontline delivery between the legacy fee-for-service arrangement and the SOP. The second stage evaluation report (Rosenbach et al. 2023) provided interim analysis of the SOP mechanism. This final report seeks to strengthen these findings by drawing on a wider range of stakeholders and methods. It captures stakeholder perspectives toward the end of the funding period, including reflections on uncertainty about future funding, shifts in collaborative dynamics, and the sustainability of innovations introduced during the SOP.

[31] The Supporting People (SP) Grant was a UK government programme introduced in 2003 to fund housing-related support services for vulnerable individuals, helping them live independently and avoid homelessness or institutionalisation. It was launched in 2003 with a £1.8 billion ring-fenced grant.

5.1 ENHANCED PRACTICE OF MARKET STEWARDSHIP

Hypothesis: *The SOP might enable an enhanced practice of market stewardship, including increased constructive performance competition, a central data and performance management system to record performance and service demand, and a stable, long-term contracting environment.*

Where service delivery relies on market arrangement, public sector commissioners are called upon to engage in the practice of effective market stewardship – that is, performing a set of functions in order to create the conditions for the market to deliver the desired outcomes of the service. Gash et al. (2013) define the practice of effective market stewardship as displaying five broad characteristics:

1. New providers can and do enter the market;
2. Providers are competing actively, and in desirable ways;
3. Providers are able to exit the market in an orderly way;
4. Those choosing services (whether service users or public officials choosing on their behalf) are informed, motivated and engaged to make choices; and
5. Levels of funding are appropriate to achieve the service's objectives.

The hypothesis above was based on an analysis of the factors limiting the practice of market stewardship in the pre-SOP legacy contracting arrangements. The analysis identified a number of limitations in Kirklees Council's market stewardship practice: 'a lack of constructive competition; limited transparency on performance and demand; short-term and unpredictable contracting environment; and multiple bi-lateral contracting arrangements' (Rosenbach and Carter 2020, p40).

Given that this evaluation's scope was limited to a single contracting period, there are constraints on the extent to which it could address the overall practice of market stewardship in Kirklees. The degrees of entry, exit and active competition, as well as the exercise of choice by public officials, will only be fully realised through further rounds of contracting which are beyond the scope of this study. It therefore focused on the extent to which the SOP arrangement addressed the identified limitations, and it highlighted how these changes may have informed enhanced market stewardship.

As this chapter details, the social prime modelled a number of practices associated with effective market stewardship, including enhanced market intelligence, informed and active market management and adaptation, and a practice of market influencing, which was supported by KBOP's credibility and connectedness within

the local service ecosystem. If the Council could replicate these features within its commissioning team, then it would be better able to effectively steward the market. However, there are some challenges to the Council's ability to operationalise this effective market stewardship. As noted, many of the skills and capabilities required for effective market stewardship currently rest within the KBOP social prime, and the Council has significantly decreased its contact with provider organisations. Ultimately, in order to act as an effective market steward itself, the Council would need to invest in cultivating those same skills and capabilities in-house, so that it might be well-placed to steward the whole service market through future contracting rounds.

In the KBOP SOP model, a dedicated team developed service insights, managed provider performance and also sought to shape the network of providers who were actively involved in delivering the service. Council staff acknowledged that their ability to manage performance and quality had been severely constrained under the legacy fee-for-service arrangement. At the mid-point of the evaluation, Council staff commented on the considerable resources that KBOP dedicated to managing the service provider 'delivery partnership.' The final stage qualitative data analysis indicates that the market stewardship function offered by KBOP continues to be valued both by the Council staff and provider managers.

A key facilitator of KBOP's market stewardship success was its confidence in constructively addressing poor performance via dedicated performance improvement plans. As Council representatives, KBOP and providers alike noted, the ability to question poor performance and promote better quality provision requires a shared understanding of what 'good' looks like. Under KBOP, stakeholders possessed that shared understanding thanks to clear articulation of contractual outcome measures and expectations and credible and dependable underlying data on users and their experiences. While both the interim and final analyses found strong and sustained mechanisms of market stewardship, the concluding findings noted that these mechanisms had come to be applied more broadly. Notably, there was a proactive and constructive use of performance improvement plans to address and remedy underperformance, alongside the expanded use of the CDPSoft system across other council functions.

KEY FINDINGS

- **Improved but shifting market stewardship functions:** Wave 3 findings confirmed that KBOP addressed key limitations experienced by the Council in the previous fee-for-service contract, thereby mitigating barriers that had constrained the Council's ability to operate as an effective market steward:

    - **Market intelligence and service insights:** KBOP enhanced market intelligence and service oversight. It proactively scrutinised provider performance and strengthened quality standards in implementation, assisting underperforming providers with targeted support through dedicated performance improvement plans.

    - **Market influencing:** KBOP acted as a proactive market influencer, using its position as an intermediary to mediate between the Council and the providers. The KBOP team incorporated multiple provider perspectives and service insights through a centralised data management system, and co-developed solutions with the Council, effectively shaping both current and future service provision. However, concerns persisted about loss of direct voice and contact between Council commissioners and frontline providers.

    As market stewardship is traditionally conceptualised as a role for a public agency (Gash et al., 2013), the shift of stewardship functions to KBOP raised questions about the balance between government oversight and market influence. While KBOP strengthened provider oversight and service adaptation, the diminished direct engagement of Council commissioners with service providers may have implications for the Council's long-term capacity to fulfil a stewardship role.

- **Key features of KBOP's market stewardship:** The following features were identified as key to KBOP's functioning as a market steward:

    - Local credibility and connectedness: KBOP successfully leveraged local knowledge to build trust among providers and influence Council policies.

    - Confidence in learning through data: KBOP implemented and effectively used a central data and management system (CPDSoft) to

improve performance monitoring and data-driven decision-making.

- Ability to spot opportunities for change: KBOP proactively identified systemic challenges and mediated solutions, leading to service improvements and enhanced cross-sector collaboration.

- Ability to test, adapt and learn proactively: KBOP used service delivery insights gathered through performance management to implement service innovations and performance adjustments.

Summary in table 4 (following page)
The chart summarises the evidence underpinning the practice of market stewardship in the pre-SOP fee-for-service contracts and under the KBOP social outcomes partnership. Detail on the challenges and implications of the fee-for-service contract is provided in the first interim report. The KBOP SOP is associated with a more intensive practice of market stewardship.

Table 4: summary of hypothesis 1 – enchanced market stewardship

Fee-for-service contract

Challenges and implications for service delivery

Limited capacity for market stewardship	Multiple short-term contracts	Limited use of data
• Overstretched Council's contract management capacity	• Reduced ability to address long-term participant outcomes • Uncertainty over funding diverted resources from support provision to service reduction/ termination	• Inefficient referral allocation (multiple waiting lists, referral self-selection by providers) • Limited ability to identify and nurture quality service provision • Gaps and duplication in service delivery
Evidence ----------	Evidence ----------	Evidence ----------
• Continuous contract roll-over without adjustments of contract terms • High-level and infrequent contract auditing • No pro-active fostering of service innovations	• Outcomes reporting in provider workbooks • Participants re-entering services • Providers' observations	• Lack of a central referral hub • Participants sitting on multiple waiting lists • No change in delivery organisations over multiple years

Social outcomes partnership

Facilitators and implications for service delivery

Dedicated resource for market stewardship	Improved market coordination	Centralised data management system
A more proactive approach to support quality and performance management across providers • Improves quality and performance standards in service implementation	**An ability to draw together different provider voices and access improved data intelligence** • More effective and concise solutions (co-developed with the Council) to systemic delivery barriers	**Introduction of a central intelligence system** • Facilitates learning, responsiveness to performance issues and the identification of best practices across delivery partners • Models best practice in data infrastructure and management
Evidence ----------	Evidence ----------	Evidence ----------
• New service components • A focused delivery mindset across providers • The exit of an under-performing provider	• Provider and Council observations • Establishment of new referral pathways	• Tightly managed performance improvement plans for under-performing providers • Replication of best practice across providers • Application of the data management system to other Council services
Limitations ----------	Limitations ----------	Limitations ----------
• Market stewardship centralised in a private entity instead of the public sector	• Loss of direct voice and interaction between the provider and the Council	

5.1.1 Market stewardship under the fee-for-service contract

Under the legacy fee-for-service contract, market stewardship was limited. Constrained by resource limitations, Kirklees council had reduced capacity for performance and contract management, leading to minimal oversight and accountability of service delivery. There was no central data management system which would enable an estimation of overall demand or enable effective performance monitoring, and multiple short-term bilateral contracts curtailed coordination and collaboration among providers. Together, these factors discouraged long-term investments in service innovation, impacting the overall quality of service delivery.

Key features	**Supporting qualitative data**
Council's limited capacity for performance and contract management	*'We had so many contracts and so few resources that we were only contract monitoring on a risk basis because it was all about making budget reductions.' – Procurement manager at Kirklees Council*[32].
Lack of central data management system to enable performance monitoring	*'Because there is no formal recording of outcomes, that's not necessarily the thing that has been monitored. It's more about "Are you working with the customer? Are you seeing the customer? Are you following the process, how much contact do you have with the customer?"' – Provider manager*[33].
Multiple short-term contracts limiting coordination and collaboration among providers	*'I think the main focus of the contract has been whether or not they will get extended or what the notice periods are. So, actually the concerns of providers have become much more focused around staff redundancies and de-mobilisation because we have been awaiting a decision for future funding.' – Provider manager.*[34]

[32] Rosenbach and Carter 2020, p. 24.
[33] Rosenbach and Carter 2020, p. 28.
[34] Rosenbach and Carter 2020, p. 22.

5.1.2 Increased constructive performance competition

Under the SOP arrangement, provider performance was much more closely reviewed and managed (as outlined in the performance management section, see section 5.2). KBOP focused on challenging underperformance and expanding higher-quality, better-performing services, essentially introducing performance competition to the service provider market.

In cases of severe underperformance, service providers could be removed from the partnership, as described in the second interim evaluation. The formal 'performance improvement process' outlined in the sub-contracts held between KBOP and provider organisations could be triggered to address service failures or negative outcomes. We interviewed a service provider manager and regional operational lead who were involved in this process and successfully implemented a 'performance improvement plan.' Their insights highlight how KBOP used the improvement process as a distinctive mechanism to proactively shape the quality and performance of services available through this provider partnership.

Provider staff generally recognised that, unlike more conventional service contracts with Councils, the KBOP partnership had a real focus on performance. One provider manager confirmed that this was the 'most monitored' of the seven contracts that they manage. A deputy CEO[35] for a high-performing provider noted:

'It is different, it's a lot more challenging than we find with other contracts and their [KBOP's] use of data is something new and we don't see that in the same way with other contracts. And again, the number of key performance indicators and the detail that they dig down into that they drilled down into is not something we're used to with other contracts.'

Case study: performance improvement plan

The KBOP management team responded quickly to underperformance. In [year], a particular service provider began to underperform. Up until this point, this service provider had been performing well and had been invited to scale up the size of their KBOP service so that KBOP could allocate more users to them (this process is also discussed in the second interim report). However, this scaling up created performance issues as the small team struggled with the induction of new staff members and to meet the new level of KPIs expected of a larger team.

[35] Research wave 3.

According to the local manager[36]: *'It takes a while for a support worker to understand KBOP, understand CDPSoft, understand what we're looking for.'* The team wasn't immediately able to meet the elevated performance expectations.

To address the new underperformance, KBOP undertook a series of meetings between the service provider managers and KBOP core team under an initial support plan. This involved increased management time to improve case reviews and guidance on how to facilitate more engaged case supervision by holding positive one-to-one conversations with staff. Nonetheless, performance continued to fall behind agreed levels against the provider's key performance indicators (KPIs) and in late 2022 a Performance Improvement Notice (PIN) was issued, formally starting a performance improvement plan.

Both the provider regional lead and manager[37] described the process leading up to the performance improvement plan as very clear and supportive, with 'no surprises'[38]. The initiation letter for the improvement plan drew out issues that were associated with user experiences *and* outcomes achievement – ie there were concerns with both the nature of support process and the outcomes against KPIs. The PIN noted that case reviews for KBOP service users were insufficiently frequent and so there was a concern around the quality of interactions and progression towards individuals' support objectives. Analysis identified that the outcomes achieved per person with this provider were the lowest in the KBOP partnership. The PIN was very direct: 'Achievements against KPIs are poor and individuals are not moving towards independence, instead disengaging at significant rates.'

Yet the provider team felt that *'It was there to help us…you could just tell, they [KBOP] want us to improve, they want to make this work…'*[39] The service manager[40] explained how they responded by having a really detailed and open conversation with the whole team:

'We said: "Do you want this service to work?" And we all said, "Yeah, we want to make it work. Not for KBOP. Because we care and we want to make it work for clients without being paternal."'

[36] Data analysis manager, Provider C. research wave 3.
[37] Provider C. research wave 3.
[38] Provider C. research wave 3.
[39] Data analysis manager, Provider C. research wave 3.
[40] Data analysis manager, Provider C. research wave 3.

The provider team then described undertaking work to get user feedback with co-production to ensure that the service was more client-led. They also developed clear individual action plans for staff. As part of this process, technological improvements and workplace adjustments were introduced to support staff performance. The manager and director each identified the importance of training as a key facilitator of good quality support that links to outcomes. The regional lead[41] underscored the value of dedicated coaching and extensive workshops with staff:

'So it all links together…what you need to see when you look on someone's case record is the person, not a series of facts and figures and words. You need to be able to look at that and get a feel for who this person is, what challenges they may have faced, what trauma they're carrying, what they want their life to be like, where they are now and how we can support them to get to where they want to be.'

This coaching around the golden thread helped support staff who were '*brilliant at delivering support but they were absolutely awful at evidencing it…*'[42]

Overall, what is notable about this formal performance improvement process is the fact that both the regional and local management leads for the provider organisation describe it as an overwhelmingly positive experience. It was collective – '*It was about "we": "let's learn, let's grow, let's evolve, let's improve" rather than "oh my god we've got to look like we're doing…*"'[43]. The review did not involve the Council staff. The dynamic between the service provider and KBOP was characterised as positive and enabling: '*from start to finish the process has been supportive. It hasn't felt punitive*'[44]. Ultimately performance did improve: performance data showed an average increase of outcomes per person by 26% in wellbeing, 13% in accommodation and 29% in education, training and employment (ETE). Additionally, outcome counts in the final months of the PIP were consistently double those recorded in the beginning, demonstrating the impact of targeted performance interventions. Provider staff echoed this positive development, explaining that they felt confident that performance would not slip back, as they retained the new processes to ensure delivery of a quality service.

[41] Head of operations, Provider C. research wave 3.
[42] Head of operations, Provider C. research wave 3.
[43] Head of operations, Provider C. research wave 3.
[44] Head of operations, Provider C. research wave 3.

In contrast to the scenario described in the second interim report, where the underperforming provider was not able to make improvements and ultimately left the delivery partnership, performance improvement processes in Wave 3 were as rigorous but more constructive. In the instance of the above case study, success appears to have been driven not by formal changes to the PIP process, but by parties' engagement with it, demonstrating the importance of constructive relationships between the provider manager and KBOP leadership to achieve improvements. The processes also highlighted the importance of balancing performance expectations with capacity constraints, as broader managerial decisions such as increased caseloads may have contributed to the challenges the provider faced.

Providers described the performance improvement process as demanding and challenging. Over time, however, relationships between KBOP and providers appear to have evolved, marked by greater trust, openness to constructive criticism, and more collaborative engagement, which played a critical role in driving improvements. Interviewees identified several features that facilitated a positive experience of the process:

- A shared understanding of the delivery challenges between KBOP and the provider organisation, with the delivery team being open to constructive criticism

- A cultural emphasis on honesty and learning. The regional lead noted: 'This organisation has a learning culture, not a blame culture' – that aligns with the culture of outcomes in KBOP, which was focused on a shared vision, transparency and a commitment to learning

- Senior leadership in the provider organisation that gave delivery teams the autonomy to make the changes needed and have difficult conversations with staff

- More frequent meetings between KBOP and the delivery organisation and within the delivery team that were supportive, 'not disciplinary.' Again, the regional lead explained: 'They didn't need to hit us with a stick and they knew that – the expectations were just laid out – they were supportive.'

Beyond this case example, the KBOP team is understood to have driven up standards by both challenging underperformance (ie taking action in situations of poor performance) *and* stretching and driving up standards amongst top performing providers by inspiring what 'good' looks like. Provider perceptions of due process

and even-handedness in KBOP's performance interventions were attributed to the high-quality data and monitoring systems. The clarity of expectations also appeared to be a crucial facilitator of market shaping in the eyes of a senior provider manager:

'…with KBOP, when it comes to performance management, it is easier to look at improvement plans because the contract and the expectations are really clear. Whereas some of the other services that I have [gives named example in a neighbouring local authority] it is a lot more ambiguous…it is fuzzier and greyer, less clear in terms of what are you wanting us to change'[45].

In addition to the elements of market stewardship identified in the second interim report, we found evidence to suggest that the KBOP team played an active role in driving up performance and quality standards in implementation. The KBOP management team are understood to have taken a more hands-on role in facilitating the introduction of new providers or service components, active and constructive competition between providers, and orderly exit of service providers. The Council is understood to have retained an ongoing responsibility for assuring quality and access and was also involved – through the contract review meetings (see section 5.2) – in considering potential shaping activities. It was the Council's vision of a high-functioning, person-centred and outcome-oriented service that set the backdrop for more proactive service-shaping interventions by the KBOP social prime team.

5.1.3 A central data management and performance system to record performance and service demand

A key enabler for the management of provider performance was the central data and performance management system, CDPSoft. It enabled more transparency of data during the programme and allowed funders to evaluate the impact of changes to the delivery mechanism.

In terms of technical infrastructure, the CDPSoft system was used by the Council for monitoring and validating outcome payments. The system was also used by KBOP for managing referrals of potential programme users and surfacing performance management data on relative provider performance; and by providers themselves for collecting and retaining key case management information. The data facilitated through CDPSoft continued to be highly valued by the Council at the final stage of the research, as noted by a senior contract manager:

[45] Head of operations, Provider C. research wave 3.

'…the fact everybody's all using one system. It's attached that better intelligence as well and better reporting and a better handle on exactly what's going on at any one time…'[46]

The granular, person-level data was particularly appreciated by another member of staff in the Council contract monitoring team:

'The key thing for us was having that individual data on every participant: knowing how long they've been on service, what outcomes have been achieved, where we've got to with them. That was really, really useful and something we haven't had before, just knowing who we're dealing with and who we're looking at'[47].

Beyond KBOP, CDPSoft is now being used as the data infrastructure to underpin a broader range of Kirklees Council supported activities. A council contract manager[48] notes:

'It's still very much wanted and used [the CDPSoft system] and we have expanded it. We use it for all our supported accommodation placements now…and doing the housing benefit quality reviews through there. A lot of contract monitoring for our supported accommodation is now done on there. So we have case management for those individuals as well…So it's giving us a more holistic view of the services we have and how they link.'

The KBOP team led on service insights development, combining quantitative management data analysis with qualitative input from provider teams to identify challenges and advocate for changes in the KBOP service and more broadly within the Council and adjacent service areas. The KBOP programme manager[49] explains how data analysis was used to identify and respond to trends in disconnection with local services, especially for addiction recovery:

'…we know we've got lots of people that access [substance misuse treatment], but they're not sustaining it…you get to find that actually there's a model that's changed in how they deliver their service and there is a lot of it that's really group focused. So you're removing that one-to-one element and people generally find that difficult, so they drop out of services. So you get that really rich information…and then we were able to then subsequently feed that into

[46] Research wave 3.
[47] Research wave 3.
[48] Research wave 3.
[49] Research wave 3.

Commissioners to let them understand sort of what's happening within the environment of people accessing KBOP. So rather than it being like a performance management mechanism…we're acknowledging these are the reasons why…'

This example illustrates KBOP's ability to use data not only as a performance management tool, but also as a means of identifying how external trends can impact service delivery. In this case, KBOP was able to highlight the negative effects of reduced one-to-one support on service user outcomes, noting that the transition to group-focused support models – driven by funding constraints at the council – led to increased drop outs. These insights enabled KBOP to inform commissioners about the underlying causes of service disengagement, thereby fostering a deeper understanding of systemic challenges of service delivery.

5.1.4 KBOP as a proactive market influencer and stakeholder mediator in a long-term contracting environment

The second interim report found that KBOP was successful in producing effective data on service performance. The final stage of the process evaluation found more evidence of the tangible use of this data, particularly regarding the role of KBOP in speaking collectively on behalf of the partnership. The KBOP Director described the way that the core KBOP team speak as 'the voice of the partnership.' Building on the stability provided by the long-term outcomes contract, KBOP used its role to mediate effectively between the Council and providers, to develop a predictable environment where systemic issues could be addressed collaboratively, and to act as a conduit for troubleshooting. This was particularly apparent during some changes that Kirklees Council made to the administration of housing benefits for supported accommodation, which had major financial ramifications for some of the KBOP service providers.

Broadly, this advocacy function was described positively by service providers; KBOP '*do get things sorted*'[50], one said. KBOP's advocacy was illustrated by the services director[51] for one of the KBOP providers:

'…But I think KBOP has been good for that…[in noting] "that provider's struggling…can we do something? Can we do something collectively to raise this?" To give it more power…to collectively say this is an issue as KBOP rather than [the problem of an individual provider].'

[50] Team lead, Provider C. research wave 3.
[51] Provider A., research wave 3.

KBOP brought a perceived neutrality, authority and gravitas to interactions with the Council. However, some service provider staff were sceptical of the additional 'layer' that punctuated conversations between the Council commissioners and direct provider teams. There was also a sense of unease and uncertainty about whether KBOP was the 'right' organisation to be playing this mediator role, sitting between the Council and service providers. Pragmatically, providers acknowledged that the KBOP team was well positioned for this work as they were responsible for a contract with so many providers across Kirklees. But some provider managers questioned the way that their own organisation's expertise was relayed by another actor:

'…they [KBOP] seem to be the people that could have those conversations with different departments in the Council…Maybe other people should have those relationships. In this instance, KBOP had them'[52].

Both Council and provider staff expressed concern about the loss of direct voice and contact between locally embedded service providers and Council commissioners. This concern was identified at the mid-point of the evaluation (as discussed in the second interim report) and continued to surface in the final stage of qualitative data analysis. It persisted despite the introduction of revised board meeting arrangements which included the rotational attendance of providers in the contract review meetings between the Council and the KBOP social prime.

Council staff were pragmatic in tempering their concern around feeling remote from direct delivery organisations. A Kirklees Council contract manager[53] noted:

'…it's a difficult one because I think there's pros and cons for it. I think being a step removed it's been easier to facilitate change because going through KBOP is very easy: one route into nine providers. And KBOP then having the knowledge and experience from other services they've worked on and being able to really push different ways of working and show how beneficial it is, has been a real help for me…So whilst I can see what I might want to happen and things that I think need to change, they've [KBOP] really been able to do that. So that's been beneficial. I think the lack of contact with them [providers] has meant we're a step removed and I think the difficulty from that for me is that you don't always hear the problems at ground level…We may not be seeing as much of the negative stuff, so I suppose that's the only – not criticism – but the only negative point..."

[52] Services director, Provider A. research wave 3.
[53] Research wave 3.

5.1.5 Identifying the enabling characteristics of a market steward

Questions about the characteristics or features that enabled the KBOP team to credibly and successfully play the role of market steward revealed several features:

- **Locally credible and connected**
  When advocating for change, often within the Council's systems or approach, KBOP was seen as locally credible and connected. A service manager[54] explained: *'[T]hey're based in Kirklees, they understand the geography and the landscape. Whereas if it were just Bridges fund management, just based down in London, they don't understand the landscape and geography…'*

- **Confident in learning through data**
  The KBOP team had confidence in constructively challenging poor performance and in disseminating practice associated with improved outcomes achievement. This was due to sound data systems, frequent analysis and a self-assurance in facilitating data-led conversations across a network of delivery organisations

- **Able to spot opportunities for change**
  The KBOP team was seen as proactive in challenging operational and systemic issues and creating a trusting environment for cross-provider collaboration. This ethos was reflected in how the KBOP Director described her role:

'I'm basically operating as the enabler for change…and I'm the one that's there to create that environment of trust and support and collaboration, but also there as that point of accountability to make sure that all of us have that shared vision and that it's happening in the way that we all committed to that happening…[I]t's my job to lead that and to make sure that we have got that shared vision, that shared approach to support everyone...'[55]

This perspective aligns with feedback from service providers and Council staff, who described the KBOP team as actively facilitating coordination and communication between the stakeholders. Council staff, for instance, acknowledged that the KBOP team's proactive use of data enabled KBOP to spot and address systemic challenges in the delivery environment.

[54] Provider A. research wave 3.
[55] KBOP project director. research wave 3.

- **Able to test, adapt and learn proactively**
  The KBOP team effectively used insights gathered from performance management and the data infrastructure to identify trends, test new approaches and refine service delivery as needed. This iterative approach to problem-solving was coupled with a willingness to learn from and act on feedback from both providers and service users. This is not least reflected in the performance improvement processes described above, as well as in several service innovations (see appendix I). The investment fund manager noted:

'One of the reasons where [KBOP] has felt more impactful, [is that it is] bringing everyone together [leading to] more tangible…operational changes…We talk about an issue. We've identified it based on the data. [For example,] You can…see [when] referrals have been down for the last two months then you make a change and you can see the impact of that in the numbers. To me this feels…really tangible and you know that you're advancing [in terms of] impact'[56].

[56] Investment fund manager. Research wave 3.

5.2 ENHANCED PERFORMANCE MANAGEMENT

***Hypothesis**: The SOP might facilitate enhanced performance management as contracts would be managed through a single external entity and payment tied to the achievement of sustainable outcomes.*

Two distinct features informed performance management under the KBOP SOP: a shared accountability across providers for the contract's success, and the contract's payment-by-results nature. Because metrics were tied to cross-provider goals, performance management by the KBOP social prime required a collaborative approach across all service providers. Collaborative performance management involves a 'sharing of resources and information among different actors for the purpose of achieving a formal performance goal' (Choi & Moynihan, 2019).

This section builds on the innovations highlighted in market stewardship above, such as performance reviews and centralised data platforms, by examining their impact on the contractual and managerial factors that support collaborative performance management in a SOP. Between Waves 2 and 3, key elements of performance management, such as regular performance reviews and the use of the central data and performance management system, remained consistent. However, Wave 3 saw an increased and constructive approach to addressing performance issues, as well as efforts to alleviate some of the administrative burden caused by evidence requirements. Tensions between an outcomes-focused partnership and the implementation of a strengths-based approach to service delivery persisted.

KEY FINDINGS

- **Facilitators of collaborative performance management**:
  - The overarching social outcomes contract, which aligned stakeholders and established shared accountability across providers
  - Managerial levers, including the central data and performance management system and increased performance management capacity via the KBOP social prime

- **Payment-by-results mechanism:** The payment-by-results mechanism, involving pre-defined outcome targets and a strict outcomes verification process, led to enhanced accountability and transparency for service success. However, its outcomes focus also meant that perceived pressure to meet outcome targets occasionally stood in tension with the strengths-based delivery approach promoted by the KBOP social prime

- **Balancing accountability and administrative burden:** While the strict outcomes verification process enabled learning and enhanced accountability and transparency, providers expressed concerns about the administrative burden associated with the reporting requirements. This challenge was partially alleviated towards the end of the contract through adjustments such as automated data checks

- **Enhanced data quality and responsiveness:** The central data management infrastructure improved data quality. It also allowed for responsiveness to performance issues, facilitated the identification of best practices, and helped with these practices' dissemination across providers

- **Increased capacity through the social prime:** The dedicated resource of the KBOP social prime brought enhanced capacity in terms of size and skills, which improved the collection and use of performance data by providers. Frequent performance reviews engaged various stakeholders across technical skills and managerial levels, fostering immediate and comprehensive discussions on challenges, insights and learnings

- **Balancing target pressures with a strengths-based approach:** Tensions persisted between implementing a holistic, user-centric strength-based

approach and pursuing outcomes-driven performance targets and accountability requirements.

Summary in table 5 (following page)
This chart summarises the evidence underpinning data and performance management in the pre-SOP fee-for-service contracts and under the KBOP social outcomes partnership. Detail on the challenges and implications of the fee-for-service contract is provided in the first interim report. The practice of performance management was more intensive under the KBOP SOP than under the legacy fee-for-service contract.

Table 5: summary of hypothesis 2 – enchanced performance management

Fee-for-service contract

Challenges and implications for service delivery

Misaligned metrics

- Key Performance Indicators (KPI) didn't induce longer term participant outcomes such as entry into employment

Evidence ----------

- A focus on the KPI 'service utilisation', ensuring that the service was used to capacity

Lack of consistent metrics

- Contributed potentially to the high number of participants re-entering the service

Evidence ----------

- The KPI 'independent living' allowed for flexible success interpretation by providers
- Auditing based on self-certified evidence

Limited data transparency

- Providers were able to convey the impression of quality against tick-boxes

Evidence ----------

- Process-driven quality-assessment
- Infrequent performance reviews

Social outcomes partnership

Facilitators and implications for service delivery

Payment-by-results mechanism

Formal outcomes verification process with clearly defined payment metrics and evidence requirements over sustained period of time

- Transparency and accountability for intervention success

Evidence ----------

- Pre-agreed rate card defining service outcomes, payment metrics and evidence requirements
- Council audits every claimed outcome achievement and spot-checks evidence with other Council data

Limitations ----------

- Increased administrative burden
- Experience of heightend performance pressures

Dedicated resources

Social prime offering dedicated resources for performance management

- Enhanced focus on performance and swifter response to delivery issues
- Improved capacity of providers in collecting and using performance data
- More opportunities for collective learning

Evidence ----------

- Frequent performance review meetings with the Social prime team
- Introduction of a central intelligence system for data and performance management
- Capacity building for providers in case management and data collection and monitoring

Limitations ----------

Data management & infrastructure

Introduction of a central system for data and performance management

- Transparency on intervention success
- Enhanced participant data supports improvements to service quality
- Real-time information sharing and streamlined co-working on cases

Evidence ----------

- Providers' monthly performance reports
- Ongoing changes to service delivery
- Frontline staff observation

Limitations ----------

5.2.1 Performance management in the fee-for-service contracts

In the legacy fee-for-service contracts, misaligned and inconsistent performance metrics hindered the effective monitoring and achievement of longer-term outcomes. Moreover, performance management relied on a process-driven approach, and the quality of performance data was poor and inconsistent due to the lack of a performance management system.

Key features	**Supporting qualitative data**[57]
Misaligned and inconsistent performance metrics	*'It was more measuring inputs, so it was like how much staffing input you had, your throughput. But it wasn't measuring what was actually happening to those people that were going through your service and what their journeys were. And then you ended up [with] more of a revolving door where you had more people coming back into service because all you've done is put a plaster on. And then when something happened, that plaster got ripped off and they were coming back asking for support again.'* – service manager[58] *'I think it was all too easy in the past to sit with customers in a room and just talk about something.'* – support worker[59]
Lacking capacity for service monitoring & process-driven performance management	*'I felt previously the Commissioners would just kind of be in the background like ghosts and we knew they were there, but they weren't particularly involved.'* – support worker[60] *'I have worked on Supporting People contracts previously, it was very much*

[57] The quotes included in the table were collected as part of the final research wave (wave 3).
[58] Provider F. research wave 3.
[59] Provider B. research wave 3.
[60] Provider F. research wave 3.

	a tick-box exercise as "we've done this, we have done that."' – service manager[61]

5.2.2 Payment-by-results mechanism

Research suggests that accountability is crucial for performance management and collaboration (Koliba et al., 2011; Romzek et al., 2014). Likewise, research on collaboration suggests that accountability to the broader network is important (Milward & Provan, 2006; Provan & Lemaire, 2012).

The overarching social outcomes contract between the Council and the KBOP social prime created enhanced accountability and transparency. Broadly, providers experienced this increased scrutiny as positive. Having clear objectives and evidence requirements improved the focus and quality of the support work. A senior provider manager[62] explained:

'The SOP actually helped us to focus and really pin down what we were trying to deliver, how we needed to evidence it and how we need to come out the other side.'

Provider staff found it rewarding to be able to demonstrate the impact of their work with service users. Moreover, delivery staff appreciated the collective vision and shared accountability for the intervention's success, as specified in the overarching outcomes contract. This was unlike the disconnected delivery approach of the fee-for-service contract, under which each provider tended to operate independently.

However, provider staff also described the enhanced administrative burden as a strong drawback of the increased accountability in the outcomes contract. To evidence the achievement of outcomes, staff had to upload documentary evidence onto the central data management system. After the social prime approved the uploaded evidence, the Council team verified and approved each individual outcome claim made by the social prime.

In the early stages of the SOP arrangement, provider staff felt that the Council's verification process was particularly distrusting. Frequent rejections of outcomes claims and time-consuming re-submissions led to frustrations. Some of the evidence requirements negatively impacted relationships with service users because they

[61] Provider G. Research wave 3.
[62] Head of operations, Provider C. Research wave 3.

were considered difficult to obtain (eg proof of housing tenure) or intrusive to users' privacy (eg wage slip). Replacing some of the evidence requirements with self-certification forms (see Rosenbach et al. 2023) and introducing automated checks through accessing HMRC employment data eased some the administrative burden over time.

It is important to consider that the perception of an increased administrative burden happened against the backdrop of a lack of standardised evidence requirements in the previous contract. Still, interviewees strongly advocated for a change in the reporting requirements if the KBOP SOP were to be re-commissioned. While some providers even suggested removing evidence requirements entirely, there was broad consensus that the rigour of outcome verification needed to be maintained whilst inefficiencies in evidence documentation across systems were reduced. The programme's balancing around ensuring accountability while minimising administrative burden were seen as a key learning for future iterations of the model.

Alongside the administrative burden, providers reported another problem: that joint working across multiple providers resulted in competition for claiming outcomes when there was overlap in the support work between the providers. Given that the service providers were not directly financially rewarded for the demonstrable achievement of outcomes, it is somewhat surprising that there was a perception of competition for claiming outcomes. This dynamic may have been influenced by differing performance management approaches among providers; some providers focused more on numerical performance targets than others did. For example, where more than one provider was working with a single case, staff morale appeared to be negatively impacted in situations where a specific provider could not 'claim' the outcome (as it had already been reported by a colleague in another delivery organisation). This dynamic suggests that, even in the absence of direct financial incentives, performance targets and their associated accountability mechanisms played a significant role in shaping provider behaviour, at times creating tensions between data-driven performance tracking and service user-focused support.[63]

A further concern associated with the clearly defined monthly targets under an outcomes contract was the risk of delivery becoming too target-driven. Wider literature on payment-by-results contracts indicates that providers game contracts by focusing on 'those who are easiest to help, in order to hit targets' (Greer et al., 2017, p. 111). In the initial stages of the contract, the Council and the social prime

[63] For further discussion on how this dynamic influenced cross-provider collaboration, see section 5.3 on collaboration

observed practices by some providers which pointed to potential 'cherry picking', as some service users with more complex circumstances tended to remain on the waiting list. This issue was mitigated by establishing a central referral hub, managed by the KBOP social prime so that providers could no longer self-select service users.

While for the later stages of the contract there was no evidence of the application of 'creaming' and 'parking' methods (see Glossary for definitions), provider managers and staff reported a continuous awareness of performance targets and the need to achieve payable outcomes. The KBOP social prime management team was keen to ensure that provider managers did not pass down the numerical KPI responsibility to frontline staff, so it emphasised that a focus on a strengths-based delivery approach would lead naturally to the outcome achievements. Nonetheless, provider managers and frontline staff described the pressures of outcomes targets and a strengths-based delivery approach as conflicting on occasions. A services director[64] of a delivery organisation which strongly embraced the strengths-based approach noted mixed messaging from the KBOP leadership team:

'There is that thing of "We want you to go out, we don't want you to be driven by the targets, we want you to just work with people and get their achievements, but we will talk to you about your targets if you're not hitting them." So, it's all very well, but you do still have to make sure you're hitting them and you have to explain why you're not achieving in a particular area. There's no getting away from that. It has at times felt like it's slightly mixed.'

This perception of an unresolved tension was echoed by a case worker[65] who stated:

'I find it quite contradictory because KBOP says, "Make sure the outcomes come organically…" But they are setting targets every week that we have to meet every month. It's always in the back of your mind about the outcomes. I find it a bit contradictory.'

The KBOP project director noted differing organisational cultures across providers in relation to targets: some providers worked to shield frontline staff from the pressures of performance targets, while others did not. Other interviews also found this variation in attitudes. In some delivery organisations, managers avoided mentioning the KPI targets to frontline staff and aimed to give staff a safe space to

[64] Provider A. Research wave 3.
[65] Provider E. Research wave 3.

deliver the support work[66]. Amongst other organisations, interviewees described the passing down of performance pressures to support staff. For instance, managers conducted rigorous caseload reviews to identify further outcomes or instigated dedicated training sessions in areas of underperformance. A head of operations[67] described their approach:

'You get better outcomes with a hug than a stick. You use a stick as a last resort. But you don't use a stick on a permanent basis.'

Even when applying shielding practices, provider managers explained that they constantly encouraged and built staff capacity to maximise the achievement and evidencing of outcomes. While an understanding of the evidence requirements was necessary, this approach to training suggested an emphasis on the need to achieve payable outcomes. A specialist caseworker[68] explained:

'It's evident to all of us that we're outcomes-based. Outcomes play a large part in gathering the information. I don't know why that would sit with management level and not frontline staff because we're the ones that's gathering the information. We always discuss outcomes [in] every single team meeting. So, it's on the agenda. We get a celebration every month because we've got 53 outcomes.'

Managers described feeling pressured in instances where they were not achieving against their targets. These target pressures were amplified at various times through staffing challenges caused by recruitment issues or staff sickness. A team lead[69] criticised the contract for having insufficient flexibility to adjust KPIs in these instances:

'…[with] staff sickness and any staffing changes, recruitment issues in the sense of the KPI's would still be set at the same figure. If you got two members of staff down, that makes it really difficult to be able to hit that monthly figure…I don't think this type of contract was very flexible for situations like that where you are going to have gaps in outcomes and you know you may not hit on a month or your KPIs.'

[66] The Government Outcomes Lab's evaluation of the Mental Health and Employment Partnership (MHEP) identifies similar practices, see Hulse et al. 2024.
[67] Provider C. Research wave 3.
[68] Provider E. Research wave 3.
[69] Provider F. Research wave 3.

5.2.3 Dedicated resources for performance management

As discussed above (5.1), KBOP's performance management resources were integral to its role as a proactive market influencer. In contrast with the more strategic focus of market stewardship, which relates to shaping broader market dynamics and fostering collaboration, in this section the question is how dedicated performance management resources were used operationally; that is, how performance management was used and implemented in day-to-day activities to achieve particular performance goals. Further, performance management in an outcomes-based contract is inherently linked to risk allocation. In the KBOP model, while some performance risk was cascaded down to sub-contracted service providers through activity-related KPIs, the primary risk of non-achievement of outcomes was held by KBOP as the (social investment-backed) prime contractor. Meanwhile, the council retained responsibility for ensuring sufficient volume of referrals. This meant that KBOP had to take a proactive approach to monitoring, supporting, and where necessary, intervening in provider performance to mitigate financial risks. This dynamic influenced how performance management was operationalised.

The transfer of contract management from Kirklees Council to the KBOP social prime brought enhanced capacity in terms of team size and skills to improve the collection and use of performance data. Like the data management infrastructure, this greater team capacity was central to the implementation of a structured and collaborative approach to improving provider performance and accountability.

The KBOP central team supported performance management in many ways:

- The KBOP data and impact manager built providers' capacity in collecting and monitoring performance data, thereby improving the quality of providers' performance information.
- The KBOP data manager analysed providers' individual performance on a monthly basis. This data was utilised during the monthly operational performance review meetings with KBOP and providers, known as contract learning meetings, to identify successful practices and areas needing improvement.
- The KBOP programme manager assisted providers with their case management to enhance efficiency and ensure service quality.
- In cases of severe performance issues, the KBOP project director and the KBOP investment director bolstered the contract management conversations with more senior, strategic expertise.

In comparing the contract management approach of the KBOP social prime with the previous approach deployed by the Council, providers recognised the enhanced resources of the KBOP social prime as critical for improving the quality in performance management. A service manager[70] stated:

'I think if we just all went to individually contracting back with the local authority, I don't think performance standard would be maintained to the same level. I think we would have less oversight on what we do just because Bridges were there and we have these contract review meetings and they know the data. I think it just makes us all a bit more accountable for what we're doing.'

A central element of the KBOP social prime's performance management approach was the performance review meeting. These performance review meetings are best described as 'performance dialogues' (Rajala et al., 2018).

Provider performance review meetings were conducted on a monthly and quarterly basis. The quarterly reviews included senior representatives from providers and the KBOP social prime. Provider managers perceived the social prime's proactive performance management approach and the consistency of the review meetings as a stark contrast compared with the previous contract management approach. These reviews brought increased focus, accountability and quality in delivery. Alongside the provider review meetings, the KBOP SOP management team also participated in a monthly Council contract review meeting. It involved the Council commissioners, representatives of the social prime and the investment fund management company, while representatives from the providers attended in turns. The diversity of forums and the involvement of stakeholders with different technical skills and from different managerial levels and organisations ensured a holistic discussion of problems and learnings.

The foundation for the monthly performance reviews with the providers were performance reports. These reports, compiled by providers, included a mix of quantitative (ie monthly outcome achievements, new starts, referral numbers) and qualitative information regarding service delivery. The blended reporting approach enhanced understanding of performance data by incorporating contextual data, such as case load complexity and user engagement rates. Most providers experienced the social prime's approach as collaborative. Interviewees described the performance discussions as fostering trust and emphasised the importance of transparent communication. Service provider staff described KBOP's approach as an empowering way to seek solutions to barriers that inhibited service delivery and

[70] Provider F. Research wave 3.

identify opportunities for longer-term service development. In cases of severe underperformance, the social prime's performance management approach involved a stronger, more directive, top-down approach through the use of the formal performance improvement plan (PIP), as discussed in section 5.1 on market stewardship. These plans involved strict monitoring of case management and quality assurance, interventions in staffing allocations, dedicated trainings and frequent review meetings with senior management.

A further performance management tool applied in the early stages of the contract was the benchmarking of provider performance. Here, the KBOP core team used the 'power of comparison' to incentivise 'competition' across providers. Benchmarking practice was not pursued in the later contract stages of the contract. The social prime was concerned that increased competition towards the end of the contract might undermine the objective of nurturing cross-provider collaboration (see section 5.3 on collaboration). Some providers considered the benchmarking practice as beneficial, since it facilitated cross-provider learning and instilled a 'healthy competition' to improve delivery. While some expressed regret over its discontinuation, there was no formal request for re-introduction.

5.3 ENHANCED PROVIDER COLLABORATION

Hypothesis: *The SOP might enable enhanced collaboration between providers by improving information sharing and co-working towards a shared interest in achieving outcomes.*

This section investigates the KBOP SOP's impact on cross-provider collaboration and the evolution of collaborative practice across the duration of the social outcomes contract. Between Wave 2 and Wave 3, key facilitators of enhanced provider collaboration remained consistent. Among these facilitators were the role of KBOP in facilitating trust-based relationships and the alignment of providers around shared outcomes and mutual accountability. However, the approach of the contract's end brought increased uncertainty, leading to a shift of focus among providers from collaboration to organisational self-preservation. While provider collaboration was sustained, its impact was overshadowed by resurgent competitive pressures and concerns about the sustainability of the collaborative ethos in the light of the contract's impending conclusion.

KEY FINDINGS

- **Improved collaboration under the KBOP SOP:** Collaboration among service providers was significantly higher under the KBOP SOP than it had been under the legacy fee-for-service contract. KBOP's function as social prime and the shared outcomes framework were key aspects to improving collaboration.

- **KBOP leadership and collaborative infrastructure:** The KBOP social prime implemented a collaborative leadership approach supported by infrastructure designed to foster trust-based relationships and transparency in governance. This included regular meetings, training sessions and informal opportunities for knowledge exchange and collective learning. However, comments from research participants suggest that the impact of these collaborative efforts was more strongly

felt at the managerial level than amongst frontline staff.

- **Shared outcomes framework:** The shared outcomes framework aligned provider goals through common, measurable outcomes. It provided a sense of mutual accountability and collective success, reducing competition and encouraging providers to utilise their specialisms. Despite the collaborative intent of the shared outcome measures, frontline staff also reported that they created pressurised performance expectations and a sense of competition.

- **Collaboration challenges as the contract's end loomed:** The approaching conclusion of the KBOP SOP contract created uncertainties that posed challenges to collaboration between service providers. Provider staff increasingly shifted their focus from collective goals to organisational self-preservation. This undermined the collaborative ethos that had been cultivated as staff – particularly senior managers – expressed concerns over diminished cooperation and resurging competitive pressures. The looming contract end impacted staff morale and trust. Research participants feared a regression to pre-KBOP dynamics where competition overshadowed collaboration.

Summary in table 6 (following page)
This chart summarises the evidence underpinning the collaborative practice across service providers under the pre-SOP fee-for-service contracts and under the KBOP social outcomes partnership. Detail on the challenges and implications of the fee-for-service contract is provided in the first interim report. Collaborative practice across providers was greater under the KBOP SOP than under the preceding fee-for-service contract. At the contract end collaborative efforts diminished due to funding insecurities regarding the re-commissioning of the service.

Table 6: summary of hypothesis 3 – enchanced collaboration

Fee-for-service contract

Challenges and implications for service delivery

Contractual and system barriers

- Key performance indicator 'service utilisation' (ensuring the use of service to capacity) and the de-centralised referral system induced competition for referrals
- Limited development of co-working culture due to initial grant conditions impeding co-working
- Diversion of resources to relationship building/maintenance with referral agents to achieve KPI targets on 'service utilisation'

Evidence ----------

- Long provider waiting lists with participants sitting on multiple lists
- Providers' observations

Under-developed collaborative infrastructure

- Co-working took place on an ad-hoc basis and was dependent on individual frontline workers' relationships

Evidence ----------

- Lack of a streamlined approach for sharing knowledge and best practice
- Infrequent provider group meetings

Social outcomes partnership

Facilitators and implications for service delivery

KBOP leadership and collaborative infrastructure

The KBOP social prime established a governance structure that strengthened collaboration among service providers through transparency, trust-building and knowledge sharing

- A central data and case management system improved coordination and service integration

Evidence ----------

- Regular cross-provider operational meetings, training sessions, and informal learning opportunities fostered trust and collaboration
- Established routines for resource-sharing and joint service development enhanced overall service quality

Limitations ----------

- The impact was more pronounced at the managerial level than among frontline staff
- As the contract neared its end, collaboration weakened, with providers shifting focus from collective goals to organisational self-preservation. This eroded trust and reignited competitive pressures

Outcomes framework

A shared outcomes framework aligned provider goals, fostering mutual accountability and collective success

Evidence ----------

- Strengthened provider identification with the partnership, reinforcing a sense of shared purpose
- Encouraged providers to leverage their specialisms rather than compete for contracts

Limitations ----------

- While designed to promote collaboration, the framework also introduced performance pressures on frontline staff, increasing competition
- The impending end of the contract heightened uncertainty, leading to concerns about sustainability and a return to pre-KBOP competitive dynamics

5.3.1 Collaboration under the fee-for-service contract

The evaluation of the legacy contract revealed several challenges to collaboration:[71]

- Delivery of services via the providers was 'siloed.' Individual fee-for-service contracts between Kirklees Council and several providers created an underdeveloped infrastructure for collaboration. Co-working across providers tended to take place in an ad-hoc manner and providers only rarely tapped into each other's expertise and specialisms.

- Contractual KPIs increased competition between providers for service user enrolment. For example, service providers were required to demonstrate demand under the 'utilisation' KPI. This motivated provider staff to refer potential users to their own services rather than share or coordinate support. To demonstrate demand, service providers would refer service users to long waiting lists even if another service was better suited to address a user's need.

- The absence of a standardised referral or case management system meant that neither the Council nor the providers could easily access information about people using the services, including their past experiences with providers. This led to a duplication of efforts and meant that providers may have repeated support practices that were previously unsuccessful.

Key features of fee-for-service contracts regarding collaboration	**Supporting qualitative data**
Contractual and system barriers to cross-provider collaboration	*'Previously we tended to work in competition more against each other. We all tended to work in our silos a little bit more because we were competing for local authority contracts.'* – Service manager[72]

[71] A detailed analysis of the challenges associated with the Floating Support fee-for-service contract in Kirklees can be found in the first interim evaluation report of the Government Outcomes Lab (Rosenbach & Carter, 2021).
[72] Provider F. Research wave 3.

Under-developed collaborative infrastructure	*'There wasn't a great deal of collaboration at all…prior to this contract. Just even the things like the meetings, the strategic meetings, the operational meetings, the opportunity, the space to get together.'* – Services director[73]
Under-developed collaborative infrastructure	*'We didn't really necessarily work before in much of a joined-up way. You might work together with regarding one participant, but not in this broad way that we do now.'* – Deputy CEO[74]

5.3.2 The evolution of collaboration under the KBOP SOP

The second evaluation report concluded that the use of the KBOP SOP model significantly improved collaboration between provider organisations. The report highlighted (1) the role of KBOP as a social prime and (2) the shared outcomes framework as key enablers of improved collaboration.

The KBOP social prime applied a collaborative leadership approach by fostering trust-based relationships, ensuring inclusiveness and transparency in governance, mediating between diverse stakeholders, and catalysing innovation to align efforts toward shared goals and enhance the effectiveness of service delivery (Rosenbach et al. 2023). The governance infrastructure was key to nurturing provider relationships and increasing co-working capacity. Additionally, regular training sessions and informal opportunities for knowledge exchange supported collective learning and the development of mutual trust.[75]

The shared outcomes framework helped to align provider goals through common and measurable outcomes. It provided a sense of mutual accountability and collective success. Moreover, the outcomes framework and implementation support from the KBOP core team enhanced consistency in service delivery standards and encouraged the utilisation of provider specialisms, enabling the delivery of comprehensive, wrap-around support.

Resource constraints and increased caseloads limited providers' capacity for collaborative activities. A notable tension emerged between the outcomes

[73] Provider A. Research wave 3.
[74] Provider A. Research wave 3.
[75] Research supports the idea that regular interactions between stakeholders can be conducive to cooperation; see Brown et al. 2018.

framework and individual provider KPIs. Immediate internal competition for service users was a challenge in the legacy contract that was mitigated by KBOP's centralised referral allocation system, but KBOP's practice of benchmarking against the performance of other providers in performance review meetings introduced another kind of competition – in this case, one with ambiguous effects, according to respondents. While benchmarking and benchlearning (a process that systematically ties benchmarking to mutual learning activities) might have incentivised improved performance, they might also have created competitive pressures. However, interview findings from the final research wave suggest that benchmarking was seen to have supported collaborative learning.

Competitive pressures between service providers were compounded by the ongoing pressures to compete for other local tenders, which may have affected the provider teams' willingness to share certain best practices.

5.3.3 KBOP as a facilitator of collaboration

The last phase of the evaluation revealed an intensification of dynamics both conducive and detrimental to collaboration. On one hand, there were indications that collaborative practices were becoming more established, suggesting a potential 'acculturation' process among stakeholders. Streamlined case management processes, repeated practice of knowledge sharing, and the integration of specialised expertise across providers contributed to the strengthening of collaborative ways of working and improved service delivery. On the other hand, the impending conclusion of the KBOP SOP contract introduced uncertainties that threatened to undermine collaborative efforts. While the KBOP social prime team continued to facilitate collaboration through regular meetings, training, and a shared case management system, the approach of the contract's end brought challenges: stakeholders shifted their focus toward re-commissioning and securing future funding. Their response underscores the challenge of maintaining collaboration during a period of transition and uncertainty.

Throughout the final phase of the contract, the KBOP social prime team maintained a commitment to promote integration among service providers. A provider CEO[76] explained:

'*I feel like we've got really good relationships with the other partners and…we probably wouldn't have had that, to be honest, if it wasn't for the alliance and KBOP bringing everyone together.*'

[76] Provider G. Research wave 3.

Regular meetings and training sessions remained central to keeping the partnership cohesive and focused on shared objectives. For example, a service manager[77] reflected on the sustained importance of operational meetings as a platform for open dialogue, sharing updates and best practices and common challenges:

'We have the regular OPS meetings where information is shared and what's going well within each service, and then we can take that back and reflect. If there's any questions on things, we feel that we can openly talk about that in those meetings.'

This 'collaborative infrastructure' helped to develop skills and build cross-organisational relationships. Likewise, it incentivised the sharing of learning and expertise to better support individual user needs, as described by a service manager[78] from a specialist provider organisation:

'I think within the partnership, everyone does get on…and you can turn to another service [for help]. I do have other services contacting myself regarding advice around [what] that client's needs are and what can they do.'

However, as the contract's end approached, senior provider managers voiced concerns over a reduction in meeting frequency and more 'splintered meetings"[79]. Interviewees attributed these shifting organisational priorities to the re-commissioning of the contract and resource limitations. Additionally, contractual restrictions during the final period along with individual provider requests for reduced communication meant that KBOP was required to operate with a higher degree of confidentiality. This shift occasionally led to a perception of KBOP's role becoming more administrative rather than actively collaborative, especially as managerial staff felt increased pressure to secure their own organisations' outcomes in anticipation of the contract's end.

While overall, cross-organisational relationships and collaborative service delivery matured, with managers reporting continued benefits from strategic coordination, frontline staff expressed mixed views of KBOP's role in facilitating greater coordination in service delivery.

A frontline worker[80] highlighted the ability to tap into fellow providers' specialist knowledge:

[77] Provider G. Research wave 3.
[78] Provider E. Research wave 3.
[79] Head of service, Provider A. Research wave 3.
[80] Provider H. Research wave 3.

'I've done quite a bit of…joint working with [other providers] because they have a very different role and that's been a good working relationship, good communication.'

Some frontline staff[81] commented on the how the partnership matured over the years, becoming more collaborative over time:

'I did feel in the beginning it did have more of a competitive edge around it…But I think we've all worked really well together so it just feels more like we're part of a bigger organisation, a bigger entity now.'

In contrast, other frontline staff didn't observe any substantial changes in partnership working compared with their involvement in the legacy contract. A provider CEO explained that the impact of collaboration was primarily felt *'more [on] managers and the strategic lead level'*, where strategic coordination and communication were more prevalent. A greater focus on collaboration at the managerial level might be an explanation for the discrepancy in frontline and managerial perception. Further, collaboration at different staff levels may have been influenced by providers' distinct organisational cultures, which may have shaped how collaboration was embraced and practiced. Individual service specialisations, such as domestic abuse, may also have required varying levels of collaboration.

Respondents at all staff levels acknowledged improved processes of resource and knowledge sharing under the KBOP arrangement. As previously discussed, a central process innovation was the introduction of the shared case management system (CDPSoft). The system allowed for layered access to real-time information sharing and case tracking across multiple providers. This system was seen as a crucial tool for increasing service efficiency. Staff from different providers could access case information from fellow workers in cases of joint support work, reducing duplicative efforts. A frontline worker[82] reiterated its benefits:

'It's great that we're all working on the same system, so we can kind of refer to notes on CDPSoft – that's really beneficial…it saves time and [I don't have to] ring somebody up to get an update on their work, because I can literally just go on to the events and have a look for myself.'

Another frontline worker[83] noted: *'It's been good to share a system. So, it's possible to look at the system and see what work is being done or whether the contact that you've been trying to encourage and support has happened. And hopefully my notes*

[81] Provider F. Research wave 3.
[82] Provider F. Research wave 3.
[83] Provider H. Research wave 3.

are of help for the other partner to see. So having access to a shared system and an understanding of the overall picture of the participants is really helpful.'

Moreover, increased informal information sharing through the exchange of workbooks across frontline staff allowed for a more cohesive service approach.

Overall, research participants emphasised the critical role of the KBOP social prime as an entity actively coordinating service delivery. This is illustrated through the following statement of a provider CEO[84]:

'They coordinate the whole thing really and get everyone together. I think without them, that collaboration and coordination just wouldn't happen, I don't think.'

The social prime team's efforts to enhance partnership working addressed several challenges at both organisational and service levels. These included tackling recruitment difficulties, overcoming contextual issues like limited housing availability, and fostering the sharing of specialisms and resources. While both managerial and frontline staff recognised the positive impact of KBOP's facilitative role for collaboration, the impact was more strongly felt at the managerial level where strategic coordination and communication were more prevalent.

5.3.4 The outcomes framework as a facilitator of collaboration

The outcomes framework continued to play a key role in aligning provider interests, fostering a shared sense of purpose and learning in the final wave of analysis. Managers highlighted its importance in enabling collaboration; providers increasingly interwove specialisations and supported shared user outcomes. However, the outcomes framework also revealed tensions, particularly at the frontline level, where staff at times experienced increased performance pressures.

Interim evaluation findings highlighted the importance of the outcomes framework in aligning provider interests and creating a sense of shared purpose and mutual accountability. Provider managers underlined the continued importance of the shared outcomes framework to reduce provider competition. This perspective is exemplified by the following statement from a head of operations:[85]

'It took the competition out of our competitors. We didn't need to compete anymore because we all had our contracts and you know, yes, we're starting to kind of almost interweave within each other's specialities.'

A data analysis manager[86] noted that providers *'help each other out to get outcomes or to work together and that's been a success.'* This sentiment was also shared by

[84] Provider G. Research wave 3.
[85] Provider C. Research wave 3.
[86] Provider C. Research wave 3.

some frontline workers. Caseworkers explained how the outcomes focus supported the alignment of different providers around an individual user's needs and goals: *'[W]e're all working towards the same outcomes. We are all working towards the outcome that we want for that particular client'*[87].

However, interviewees also revealed ongoing ambiguities in the role of the outcomes framework. Interview responses suggest that the perception of the outcomes framework varied across staff levels. While many frontline staff acknowledged that the mechanism provided a shared sense of purpose and clear objectives down to the frontline, others expressed tensions around the role of outcomes, which may have strained collaboration.

As discussed in section 5.2, although provider organisations were not financially incentivised for achieving specific outcome measures, provider staff still 'claimed' particular outcomes for their service users. A competitive element resurfaced, particularly where multiple providers were involved with the same service user. The emphasis on achieving an outcome, and/or the impetus to 'claim' it, created occasional challenges around 'case ownership' and support for service users with joint case management. A specialist support worker[88] noted that frontline staff were:

'[S]till expected to have a certain amount [of outcomes] per month. So if somebody else kind of takes your outcome, it maybe can generate difficulty within the relationship with other with the other services.'

Another specialist support worker[89] noted: *'It's an outcomes thing…you're in battle for who was achieving the outcomes of which provider.'*

These findings suggest that there was some confusion around the outcomes framework and that this emerged from the way the focus on outcomes was passed down from management to frontline staff, where it should not necessarily have been emphasised. For example, some frontline staff[90] noted:

'There is often a conversation around where we're doing well in the partnership or we're not doing as well in the partnership and it does feel more like a competition…'

Nominally, frontline staff should have been given more flexibility to work in a strengths-based way (and this was certainly emphasised by the KBOP leadership team), but in practice, the emphasis on outcomes may have undermined this flexibility. Communication and implementation of the outcomes framework varied

[87] Specialist support worker, Provider G. Research wave 3.
[88] Provider F. Research wave 3.
[89] Provider E. Research wave 3.
[90] Provider F. Research wave 3.

across providers. Some provider managers were more effective than others in shielding frontline staff from these pressures. As a result, the outcomes framework both facilitated and constrained collaboration. This finding highlights the need for careful navigation by the KBOP social prime and providers in balancing collective goals with individual performance demands. It is demanding work to ensure that the emphasis on outcomes does not undermine the intended collaborative ethos.

5.3.5 Implications of the end of the contract for collaboration

As the KBOP contract approached its conclusion, challenges emerged in maintaining the same level of service and collaboration that characterised earlier contract phases. As mentioned in section 5.1 on market stewardship, the long-term nature of the contract, along with the introduction of KBOP governance and data and performance management system, played a key role in stabilising the partnership and establishing a sense of trust and collaboration among stakeholders. However, uncertainty concerning the service's re-commissioning introduced pressures which undermined the partnership's collaborative ethos.

While much of the uncertainty stemmed from the conclusion of the Life Chances Fund programme, the KBOP SOP was never meant to rely on LCF funding in the long term. The idea was that councils and other commissioners would test, refine, and eventually absorb the outcomes-based model into mainstream funding once its effectiveness was demonstrated. However, in the meantime, Kirklees Council has faced significant financial pressures, including substantial budget deficits, which have impacted its ability to sustain funding commitments across social care and housing services. Though the Council ultimately committed to continuing these services under an outcomes-based contract, it was only able to commit to do so with a reduced number of providers. Also, this decision came after a prolonged period of uncertainty, during which providers were unsure about the future model, further contributing to the erosion of collective goals and a shift of priorities towards individual organisational competitiveness. Combined with the announcement of potential job losses, this had a ripple effect on staff morale and trust.

The impending end of the contract introduced an underlying tension for managers, who had to balance collaborative objectives with their organisations' individual goals and prospects. This shift prompted some managers to adopt a more cautious stance on resource sharing and joint initiatives, as they became more focused on securing their own outcomes.

Reflecting on the development of cross-provider collaboration, the KBOP programme manager stated:

'[U]nfortunately, we had to go back to this competitive process. It really decimated that partnership feel and it was so sad to actually see that happening and be a part of it'[91].

This dynamic might also explain increased competitiveness around the outcomes framework, which inadvertently may have heightened competitive pressures as providers became more focused on meeting individual organisational targets. One frontline practitioner[92] described the tensions as follows:

'[T]he premise was that we were in this together, but ultimately each service has their set of outcomes. So, we're kind of not in it together because we need to achieve ours as much as you need to achieve yours…I think, again, it was kind of, you know the contract's coming to the end, there's uncertainty of how that's moving forward. You want to be in the best position you can be in as a service.'

A service manager[93] highlighted the tensions between the progress made in partnership working and the pressures brought on by the impending end of the contract:

'It does feel a little bit more of a partnership, but not totally because obviously funding goes, there is a potential that we might all be competing against each other for the available pots of money that are going to be left. I think that's inevitable, really…[We] will then go back to…a bit more of a competitive tendering process. And don't forget some of these organisations we compete against for other tenders in other service areas.'

A head of service[94] explained:

'I think coming towards an end of quite a big contract…a lot of people will be focusing inwards and just concentrate. I'm sure other services are doing very similar, you know working as a partnership but really concentrating, making sure everything that they're doing is the best that they can be to give them the best chance to move forward.'

Uncertainty and competitive pressures took a toll on staff morale and trust across the partnership. Staff at all levels expressed a sense of loss as the collaborative spirit eroded in favour of organisational self-preservation; some staff members highlighted increasing reluctance to share information across providers. To some, the end of the contract felt like a regression to pre-KBOP dynamics. The KBOP project director commented:

[91] Research wave 3.
[92] Provider F. Research wave 3.
[93] Provider F. Research wave 3.
[94] Provider A. Research wave 3.

'It was understandable but sad that after everything everybody had been through as the partnership, everything that we've learned that whole system and collaborative way of working, everyone was almost forced to revert back to the previous way of working as competitors as a survival mechanism, as a way of trying to make sure that they were able to protect their organisation and teams to move forward.'

5.4 ENHANCED FLEXIBILITY AND PERSONALISATION IN SERVICE IMPLEMENTATION

***Hypothesis**: The SOP might bring enhanced flexibility in service delivery through autonomy for providers in service design and an adaptive approach to management by the social prime, KBOP.*

This section explores how the KBOP SOP commissioning arrangement offered greater implementation autonomy and flexibility to providers and supported the personalisation of services. The analysis is based on interview data collected in the closing stages of the LCF KBOP SOP programme (year four) and longitudinal survey data. The survey data investigated frontline delivery practice in the preceding fee-for-service (referred to as Wave 1) and explored the SOP arrangement at mid-implementation (Wave 2) and contract end (Wave 3).

Flexibility and personalisation remained a key strength of the KBOP SOP across waves. In Wave 3, efforts to improve personalised services continued and strengthened through flexible funding, strength-based training for staff, and increased involvement of service user voices in the programme's operations. However, Wave 3 also highlighted continuing tensions between predefined outcomes and person-centred delivery, particularly around education, training and employment outcomes (ETE). Caseload pressures persisted but were better managed.

KEY FINDINGS

- **Dimensions of personalisation:**
  - The KBOP delivery partnership allowed for greater flexibility regarding the mode, frequency and length of support than the legacy fee-for-service arrangements had provided.

  - Frontline staff survey data suggests that service users were substantially more able to influence the nature of their support under the KBOP SOP arrangement.

- **Enablers to personalisation:**
  - One key enabler of person-centred delivery was the availability of flexible, responsive funding (in form of the 'Personalisation Fund') to allow for bespoke support. Analysis by the KBOP social prime suggests that the use of the fund had a positive influence on user engagement and the number of outcomes achieved.

  - Personalisation was cultivated by providing staff with dedicated training in a strengths-based way of working. This personalisation was underpinned by the principles of professional discretion for frontline staff and user empowerment. Tailored support with caseworkers was supplemented through access to specialists – such as expert mental health support – to enhance the service offer.

  - Co-production interventions were used to enhance service user voice. They included the integration of a peer mentor model and the continuous involvement of users in the development of the service, including focus groups and frontline staff recruitment.

- **Outcomes-based contracting: enabler of or barrier to personalisation?** Provider staff's perceptions of the compatibility of an outcomes-based contracting approach with strengths-based delivery evolved over time:

  - Those who perceived the outcomes focus as a barrier felt that the necessity of working with a set of pre-defined outcomes could be in conflict with or outside of the main interest of the service user.

  - Findings on the influence of performance targets and the need to achieve payable outcomes are ambiguous. Interview data suggests

that KBOP brought an increased focus on outcomes and performance targets, which some staff perceived as adding pressure. Others viewed this focus as beneficial, as it clarified expectations, improved accountability and enhanced the quality of support work.

- We did not identify evidence of a practice of 'creaming and parking' – focusing on easier-to-engage users and neglecting harder-to-engage user – in mid or late implementation of the KBOP SOP. Frontline staff were vocal in calling for more explicit recognition (in the rate card) of the work required to maintain engagement from some users, who may have disengaged without dedicated outreach activities.

- The outcomes-based contract was reported to have brought increased flexibility in delivery. This adaptability was somewhat constrained by an increased caseload, although high caseload challenges were alleviated through more effective caseload management.

- While reporting requirements increased in the SOP contract, survey data suggest that the overall time spent on administrative tasks was not higher under the SOP than under the legacy fee-for-service model.

- In terms of the rate card and design of the outcome metrics, most interviewees found the KBOP outcomes framework sufficiently broad to tailor to individual user need. However, the design of specific evidence requirements could act as a barrier by either straining the relationship between staff and user or catering insufficiently to the user's interest. Strong views emerged on the introduction of education, training and employment (ETE) outcomes. There was initial widespread concern that these outcomes could counteract a strengths-based approach because they might not acknowledge how the challenging life circumstances (eg homelessness) of users could limit their capacity or interest to engage in ETE activities. However, a number of interviewees emphasised the ETE outcomes as a catalyst to deliver more holistic support.

Summary in table 7 (following page)
This chart summarises the evidence underpinning flexibility and personalisation of the service under the pre-SOP fee-for-service contracts and under the KBOP social outcomes partnership. Detail on the challenges and implications of the fee-for-service contract is provided in the first interim report. The KBOP SOP is associated with more flexibility and personalisation in service delivery than the preceding fee-for-service contract afforded.

Table 7: summary of hypothesis 4 – enhanced flexibility & personalisation

Fee-for-service contract

Challenges and implications for service delivery

Limited flexibility in changing service provision	Limited availability of additional funding and bureaucratic application process
• Impeded more tailored support, especially for participants with more complex needs	• Impeded frontline innovation
Evidence ----------	Evidence ----------
• Service specifications narrowly defining support intensity and length • Process-driven auditing	• Providers' observation

Social outcomes partnership

Facilitators and implications for service delivery

Personalisation	Flexible funding	Staff capacity	Outcomes framework
• Enhances tailored support as frontline staff have greater leeway in determining frequency, length and manner of support	• Nurtures innovative capacity of staff • Allows enhanced tailored support provision	• Introduction of the strengths-based approach to support provision encourages user empowerment and allows for flexibility through professional discretion	• Wide range of outcomes allow for catering support to different user needs
Evidence ----------	Evidence ----------	Evidence ----------	Evidence ----------
• Provider contracts • Case studies of participants' journeys	• Innovations to service delivery (new staff roles, support offers and referral pathways) • Providers' observation • Creation of a personalisation fund (spend of £250,000), providing funding for tailored intervention support	• Providers' observations • Users' observations • Case studies of participants' journeys	• Providers' observations
Limitations ----------	Limitations ----------	Limitations ----------	Limitations ----------
		• Heightened caseload implied that occasionally users were moved on too early	• Enhanced outcomes orientation of staff implied that occasionally the user need was misinterpreted or support went beyond the actual user need

5.4.1 Delivery under the fee-for-service contract

Historically, provider managers and frontline staff found the requirements for service delivery in the prior fee-for service contracts to be highly prescriptive.

Key features of prior fee-for-service contracts regarding tailoring and personalisation	**Supporting qualitative data**[95]
Pre-defined frequency of weekly interactions, mode and length of support	*'We didn't have the staff to give them more than one person and we would give them a weekly appointment. It would be very structured, too structured, too rigid.'* – support worker[96]
Deficit-based delivery approach	*'The previous service was like "What's your problem? How would you want us to fix it?"'* – support worker[97]
Insufficient focus on longer-term aspirations for users due to lack of accountability	*'Sometimes I just felt like I was going out and meeting people for the sake of it because we were told that's what we needed to do on a weekly basis. And it might not have been working for them, might not have been working for us, but that's what we had to do to get to get paid.'* – support worker[98]

5.4.2 Dimensions of personalisation

Personalisation has become a mainstream approach to service reform and allows services to be tailored to individual needs (Fuertes & Lindsay 2016, p. 526) and wishes (Sainsbury, 2017, p.57), ultimately resulting in stronger user choice (Cutler et al. 2007). In unpacking the concept of 'personalisation', the literature (Torien et al., 2013) distinguishes between two approaches to enact person-centred support:

- Procedural personalisation comprises the 'how' of service provision. It refers to the process undertaken by frontline workers when delivering the service.

[95] The quotes included in the table were collected as part of the final research wave. The interviewees have been involved in the KBOP SOP delivery over the projects' whole lifecycle and have also been involved in the delivery of the preceding fee-for-service contract.
[96] Provider B. Research wave 3.
[97] Provider F. Research wave 3.
[98] Provider F. Research wave 3.

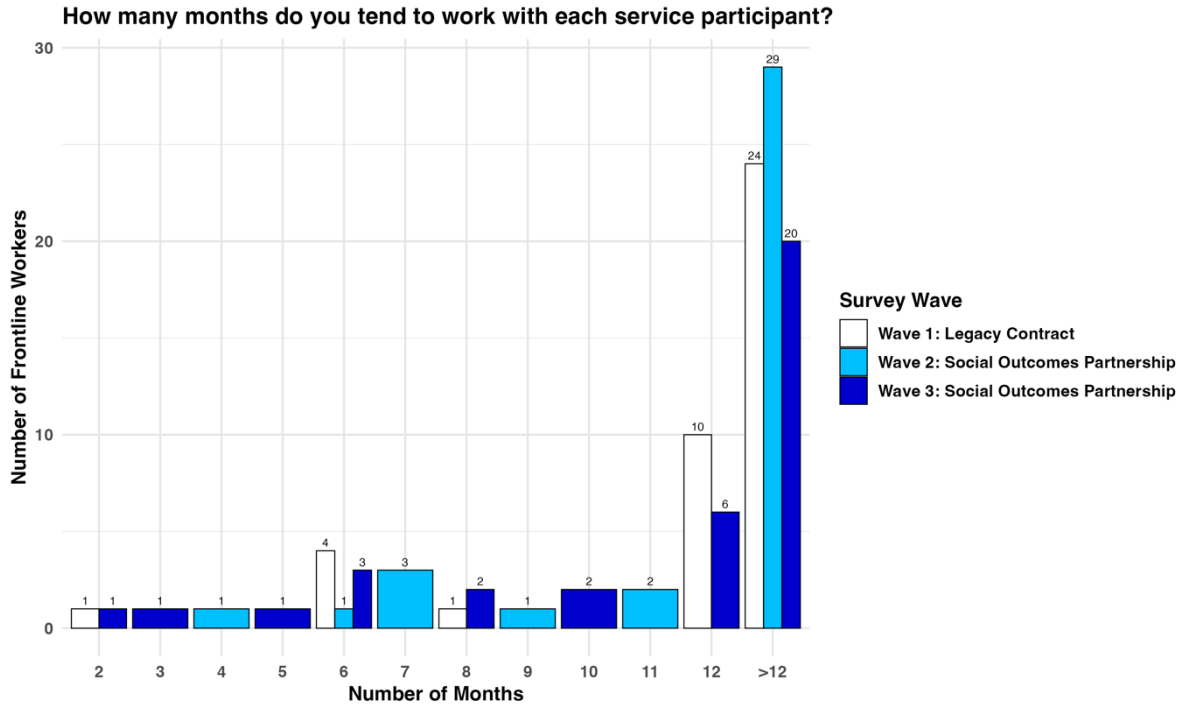
- Substantive personalisation concerns the worker's capacity to provide services that are tailored to the needs and circumstances of the service user. It refers to the substance of the support on offer, the 'what' of service provision.

Procedural personalisation

Under KBOP, frontline staff had discretion in determining – in agreement with the user – the format for support sessions, including the duration and location of the sessions, the frequency of support and whether they took place virtually or face-to-face.

Compared to the legacy fee-for-service arrangements, the SOP appeared to foster enhanced flexibility among frontline staff workers, as users were able to remain connected to the service for as long as required.

Figure 2: Distribution of months frontline workers spent with service users



Source: Longitudinal survey data on KBOP frontline staff service delivery experience administered by the Government Outcomes Lab

We estimated support duration by asking frontline staff workers how many months they typically worked with each service user. During the fee-for-service arrangement, most staff reported working with users for 12 months (42%). Midway through the SOP, the duration of engagement shifted: a larger proportion (43%) reporting working with users for *more* than 12 months (43%). By the end phase of

the SOP, the majority of staff once again reported working with users for 12 months (49%).

To assess whether these differences in responses across survey waves were statistically significant, we used mean ranking to consider the full distribution of responses, not just the most common categories. This analysis showed a significant increase in support duration from Wave 1 to Wave 2, followed by a decrease in Wave 3 (both changes significant at the 95% confidence level; see appendix K, table 2). This relative decline in support duration at Wave 3 is likely due to pressures from the contract's ending, which prompted staff to transition users out of service more quickly. However, it is important to note that longer support duration does not necessarily equate improved service personalisation. In some cases, well-tailored services may require less time, as they meet users' needs more effectively.

The greater duration and flexibility of the service were facilitated by a novel dual staffing model involving a support worker and an engagement worker, who engaged with service users at different stages. Support workers were responsible for the intensive support work phase, while engagement workers conducted regular check-ins during a light-touch support phase. This model allowed users to easily re-engage in the service if a point of crisis re-emerged. Flexible staffing allocations enabled delivery teams to increase staff resources for a single user over a short period of intensive support.

This flexible service model allowed for tailored support. It also meant that the actual duration of service provision varied significantly, influenced by individual service user needs and external factors. Some users required only short-term intervention for six months or less, while others received more long-term support lasting over a year. Towards the end of the contract, staffing reductions affected service provision, potentially influencing support durations. However, service duration alone is not an effective measure of personalisation, given that service users have varying levels of support needs at different times and often progress in non-linear ways.

Another precondition for procedural personalisation is a sufficiently low caseload (Rice et al., 2018). The survey data show a statistically significant increase in the number of users on staff caseloads in the SOP. The mean caseload increased from 14 users in the fee-for-service contract to 19 in mid-implementation of the SOP, a change that is statistically significant at the 99% confidence level. This trend continued, as in the final phase of the SOP the mean number of users per caseworker reached 21 (appendix K, figure 1). This was a statistically significant increase at the 99.9% level compared to Wave 1 (figure 3 & appendix K, table 1).

According to KBOP leadership, the increase in caseload was caused by a mix of factors, including staff shortages that left larger caseloads for existing staff and reductions in other community services resulting in higher demand for support within KBOP. Furthermore, there are questions around whether the lower caseload numbers in the legacy fee-for-service contract reflected structural limitations of the previous service delivery model: stakeholders suggested that service underutilisation may have led to lower active caseloads and longer waiting lists. Furthermore, the legacy contract's short-term, throughput-focused approach may have incentivised rapid case turnover rather than addressing underlying issues. Consequently, service users might have been signed off as 'ready to live independently' prematurely, leading to lower formal caseload numbers but higher rates of re-presentation. Finally, the previous model supported service users through informal drop-ins, which may not have been reflected in the formal caseload figures.

Nevertheless, the survey findings of increased caseloads were also strongly supported by qualitative evidence, as illustrated in this quote from a team lead:[99]

'Undoubtedly, there is pressure and I'm aware it's easy for me to sit here as a manager saying all the great things about it [KBOP] because I'm not the one that maybe had a case load of 12 that then became 14, that then became 16 and suddenly is 18.'

The compilation of data to understand caseloads and work intensity is not straightforward. Caseload figures for frontline staff were not typically collected as part of the data collection processes in the pre-SOP fee-for-service contracting arrangements, so the survey data are the most reliable, standardised measure to estimate caseloads over time. Following the introduction of the outcomes contract, there were also challenges in estimating caseloads because of joint casework and the dual staffing model of support workers and engagement workers, described above. Due to their lighter-touch role, engagement workers were expected to work with much higher caseloads, which could have driven the increase. Unfortunately, the research team did not have access to granular data on caseloads by staff job title or role and so this could not be tested statistically.

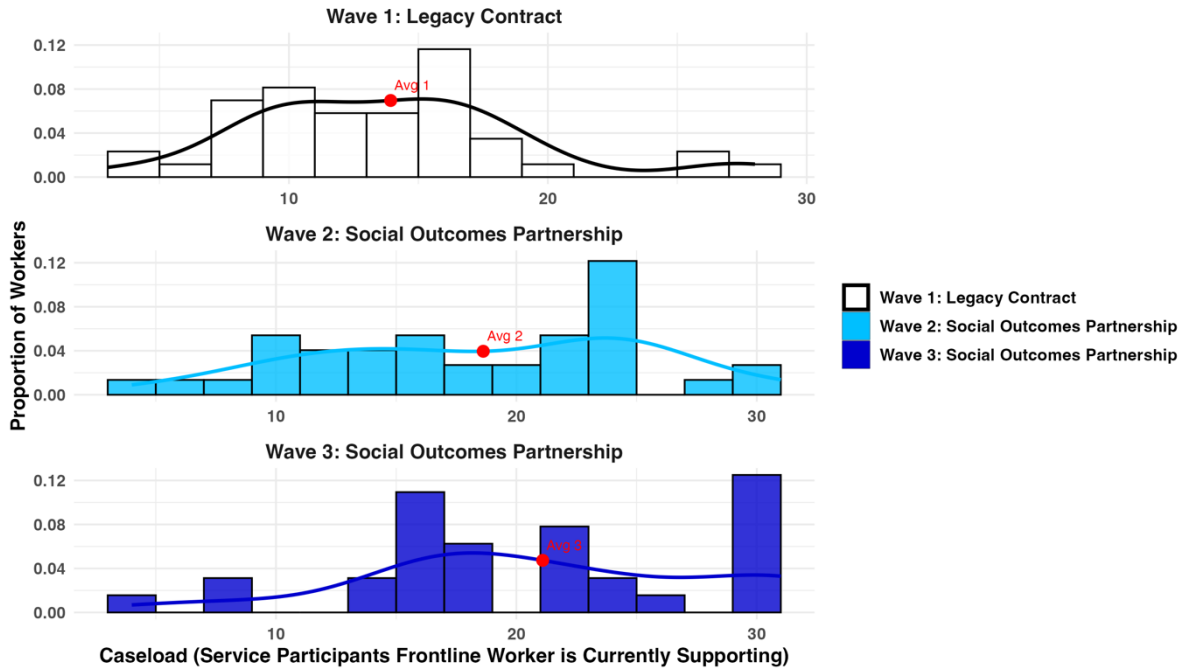
[99] Provider F. Research wave 3.

Table 8: Frontline staff survey question - How many service users are you currently supporting?

How many service users are you currently supporting?[100]				
Survey wave (N)	**Mean number of users**	**Standard deviation**	**Minimum**	**Maximum**
FSS Wave 1 (57)	14	5	3	28
FSS Wave 2 (47)	19	7	4	31
FSS Wave 3 (41)	21	7	4	31

Source: Longitudinal survey data on KBOP frontline staff service delivery experience administered by the Government Outcomes Lab

Figure 3: Caseload shift from the legacy contracts to the social outcomes partnership



Source: Longitudinal survey data on KBOP frontline staff service delivery experience administered by the Government Outcomes Lab

[100] Percentages have been rounded to the nearest whole number. For detailed figures, please refer to Appendix table K.1.

Moreover, the weekly percentage of time spent by frontline staff with users dropped in the transition from the fee-for-service contract (55%)[101] to the SOP arrangement (44% at Wave 2 and 46% at Wave 3). This difference is likely linked to the higher caseload in the SOP arrangement and to changed working practices.

Table 9: Frontline staff survey – percentage of time spent on different activities

In an average work week, what percentage of your time do you spend:[102]			
Survey wave (N)	Mean % of time	Standard deviation	N respondents
In direct contact with service users?			
FSS Wave 1 (57)	55	14	41
FSS Wave 2 (47)	44	18	36
FSS Wave 3 (41)	46	18	29
Working with other voluntary sector service providers?			
FSS Wave 1 (57)	9	5	41
FSS Wave 2 (47)	9	7	36
FSS Wave 3 (41)	10	7	29
Working with public sector service providers (eg health)?			
FSS Wave 1 (57)	7	4	41
FSS Wave 2 (47)	10	7	36
FSS Wave 3 (41)	8	6	29
Working with employers?			
FSS Wave 1 (57)	3	5	41
FSS Wave 2 (47)	7	10	36
FSS Wave 3 (41)	6	10	29
On general administration?			
FSS Wave 1 (57)	26	11	41
FSS Wave 2 (47)	29	16	36
FSS Wave 3 (41)	31	15	29

Source: Longitudinal survey data on KBOP frontline staff service delivery experience administered by the Government Outcomes Lab

KBOP's own analysis suggests that increased caseloads did not negatively impact service quality; KBOP overachieved on outcomes and experienced lower re-referral

[101] Percentages are rounded to whole numbers.
[102] Percentages have been rounded to the nearest whole number. For detailed figures, please refer to Appendix table K.5.

rates than those of the legacy fee-for-service contract. KBOP attributed this to several factors:

- Streamlined referrals which allowed service users to access support in a timely way
- A person-centred approach to working which encouraged better understanding of and responsiveness to service users' needs
- increased service flexibility, which enabled frontline staff to adjust their contact frequency with individual service users and to manage larger caseloads while maintaining service responsiveness.

However, qualitative evidence regarding the impact of increased caseloads is varied. Some interviewees expressed concerns that high caseloads hindered their ability to deliver a person-centred approach, while others reiterated KBOP's view that flexible caseload management allowed them to maintain the quality of service delivery. Interviewees felt that the extension of service duration aimed at achieving longer-term outcomes contributed to rising caseloads. However, they also highlighted the influx of new cases, as the KPIs established a monthly target for new referrals.

Interviewees reported that KBOP's more adaptable approach to caseload management, coupled with increased flexibility in engagement methods (such as in-person and virtual support), facilitated more effective resource and time management, thereby ensuring the continued quality of support provided. But the heightened caseload did, in certain cases, adversely affect staff morale. To address this issue, a drop-in service for post-service completion users was implemented, with the goal of enhancing staff confidence in case closures.

Caseload management was proactively supported by the KBOP social prime managers in monthly contract review meetings. The data suggest that the KBOP management team perceived providers as sometimes holding on to cases for longer than necessary, potentially reflecting aspects of more traditional service approaches. The KBOP project director described their case review approach:

'We would challenge if we thought that somebody wasn't being moved into that check-in process in an appropriate time because it's institutionalising people. It's not our role to keep hold of cases forever. Our role is to work with someone to empower them to enable them to move forward.'

Critical provider voices noted that service users were occasionally moved into the 'check-in phase' too early, reducing the time for intensive support. However, one interviewee also noted that in some instances, the KBOP managerial team

instructed providers to hold on to cases so they could claim future outcomes even though the user requested to close the case. Yet the survey data suggest that there was no statistically significant difference between the fee-for-service and the SOP contract in terms of staff's focus on getting users to complete/exit the service within a set time.

A further indicator of procedural personalisation is the extent to which the support is determined by standardised procedures. Overly standardised assessment forms can inhibit caseworkers from drawing up adequate problem assessments and determining sufficiently individualised support activities.

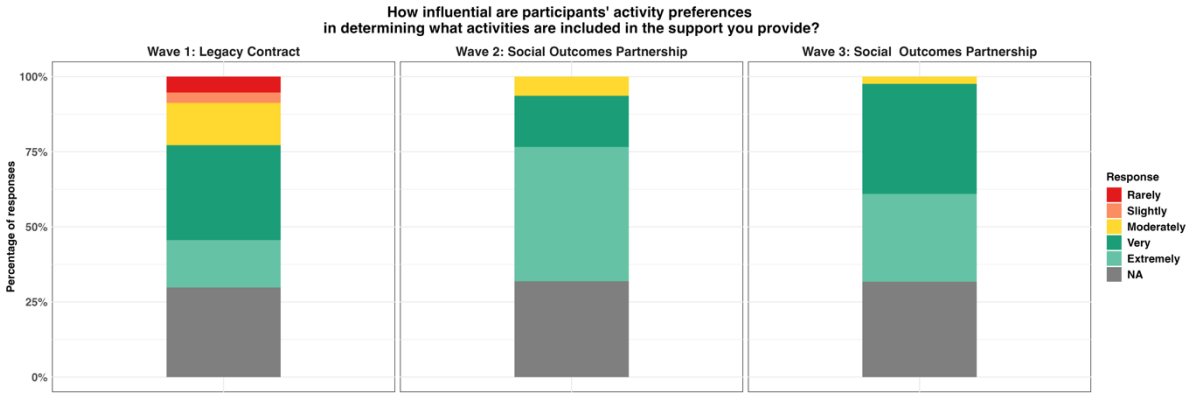
Survey data suggests that staff perceptions of the role of standardised procedures fluctuated slightly throughout the SOP; perceived influence increased during the mid-implementation phase before returning to levels similar to those of the fee-for-service contract by the end of the SOP (see appendix K, table 3 & figure 2). The temporary increase in perceived influence of standardised procedures may be linked to efforts to align the referral process, including the needs and risk assessment, case notes, and outcomes reporting. It is important to stress that the standardisation in the SOP contract did not concern the actual support work, which followed the strengths-based approach.

Overall, there is evidence that procedural personalisation was heightened under KBOP. There was a greater flexibility to shape and schedule user-caseworker interactions to the time, frequency, location and duration that suited each user. However, the contractual incentive to sustain outcomes and the high caseload might have resulted in instances that users might have been kept for too long, or might have been moved on too quickly. Caseload and weekly time spent with users differed under the two service approaches: data suggest that under the fee-for-service contract, support workers may have spent longer with service users in any given week but that service duration (ie number of weeks of support) was shorter and less focused. In contrast, case management practice in the SOP allowed for longer support duration but varying support intensity, as well as an enhanced impetus to adjust the frequency of support to the users' wishes.

Substantive personalisation

Frontline staff were asked how influential users' activity preferences were in determining the support they received. Responses were ranked on a scale from least to most influential (from 'slightly' to 'extremely'), and the 'mean rank' was calculated to reflect the average position of responses within each survey wave. The results indicate a significant increase in the extent to which frontline staff prioritised users' preferences following the introduction of the KBOP SOP.

Figure 4: Frontline staff survey question – How influential are users' activity preferences in determining what activities are included in the support you provide?



Source: Longitudinal survey data on KBOP frontline staff service delivery experience administered by the Government Outcomes Lab

During the fee-for-service contract (Wave 1), user preferences were 'moderately' influential for 32% of frontline staff. By the SOP's mid-implementation phase (Wave 2), 45% of staff reported being 'extremely' influenced by user preferences. This increase in importance from Wave 1 to Wave 2 is statistically significant at the 99% confidence level, as evidenced by the rise in the mean rank from 38 to 63. Although the mean rank decreased slightly in Wave 3, to 55, it remained significantly higher than in Wave 1 at the 90% confidence level. In Wave 3, a plurality of frontline staff (37%) indicated they were 'very' influenced by user preferences, suggesting a sustained emphasis on these preferences over time (appendix K, table 3 & figure 2).

Another indicator for substantive personalisation is the level of contact between frontline staff and external organisations such as healthcare providers, welfare services, employers and training providers. Frequent contact with these services and stakeholders is a proxy measure for substantive personalisation as it indicates the availability of a varied 'flanking' menu of social services. In substantive personalisation, the expectation is that more specific support is being drawn together to enable users to achieve outcomes that are important to them.

There were no statistically significant changes regarding the interactions with these external stakeholder organisations between survey waves. However, the time spent with employers increased from 3% in Wave 1 to 7% in Wave 2, a change that is statistically significant at the 95% confidence level. The subsequent decrease to 6% in Wave 3 is not significantly different from Wave 2 (appendix K, table 5 & figure 4). The increased interaction with employers was likely due to KBOP's novel focus

on enabling employment outcomes and the addition of an internal employment and skills coordinator.

5.4.3 Enablers to personalisation

Personalisation requires *resources* to provide substantively flexible services and *skills* to enable a person-centred approach to shaping support. Under KBOP, dedicated resources were provided in the form of the 'personalisation fund' and staff capacity was built through i) mainstreaming a strengths-based approach, allowing for professional discretion and user empowerment, and ii) co-production, which integrated users' lived experience into support provision.

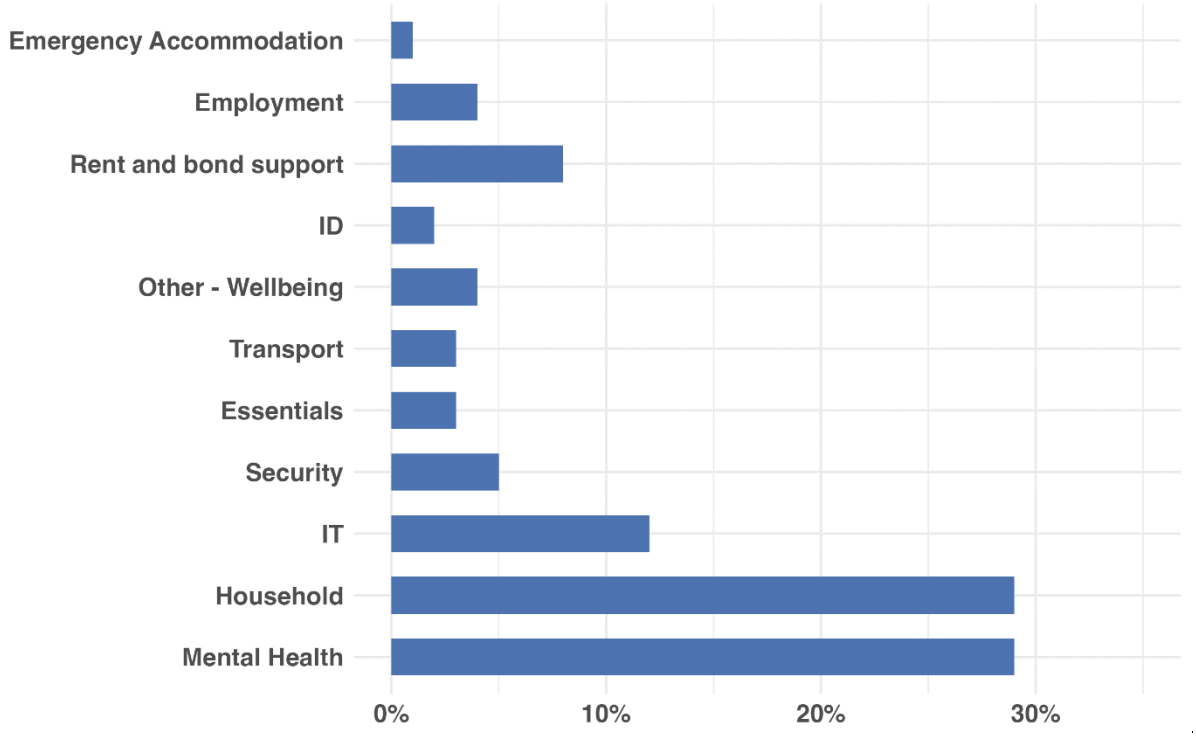
Flexible funding: the personalisation fund

The availability of flexible, immediate funding to deliver bespoke support and continuously develop the service was considered a key enabler to delivering personalised services. Council staff acknowledged that in the legacy contract, they would not have been able to provide this level of spending flexibility due to the bureaucratic constraints in the public sector.

The KBOP social prime set up a personalisation fund which provided additional funding to support any potential enhancement in service delivery, as determined by frontline staff. The fund had a total spending volume of £250,000. 20% of service users accessed the fund, and on average £214 was spent for each of these users. Council staff reflected that the personalisation fund was highly effective considering the relatively low levels of spend. Provider managers had discretion to spend up to £200 as long as they adhered to the funding criteria and process. For larger investment decisions, the KBOP board and investment committee held the decision-making authority.

The personalisation fund's objectives were aligned to the outcomes in the rate card. Use cases included payments for debt relief, laptops for educational purposes, driving licences to allow users to take up or sustain a job, bonds to landlords, and doorbell cameras for security. A large proportion of the funding was used for counselling sessions, thus filling gaps in public service provision.

Figure 5: Percentage of personalisation fund payments by area[103]



Source: KBOP social prime

Staff emphasised the transformative impact of the personalisation fund on users' service journeys and relished the ability to be more creative in developing personalised support. The following reflection of a support worker[104] illustrates providers' perception of the fund:

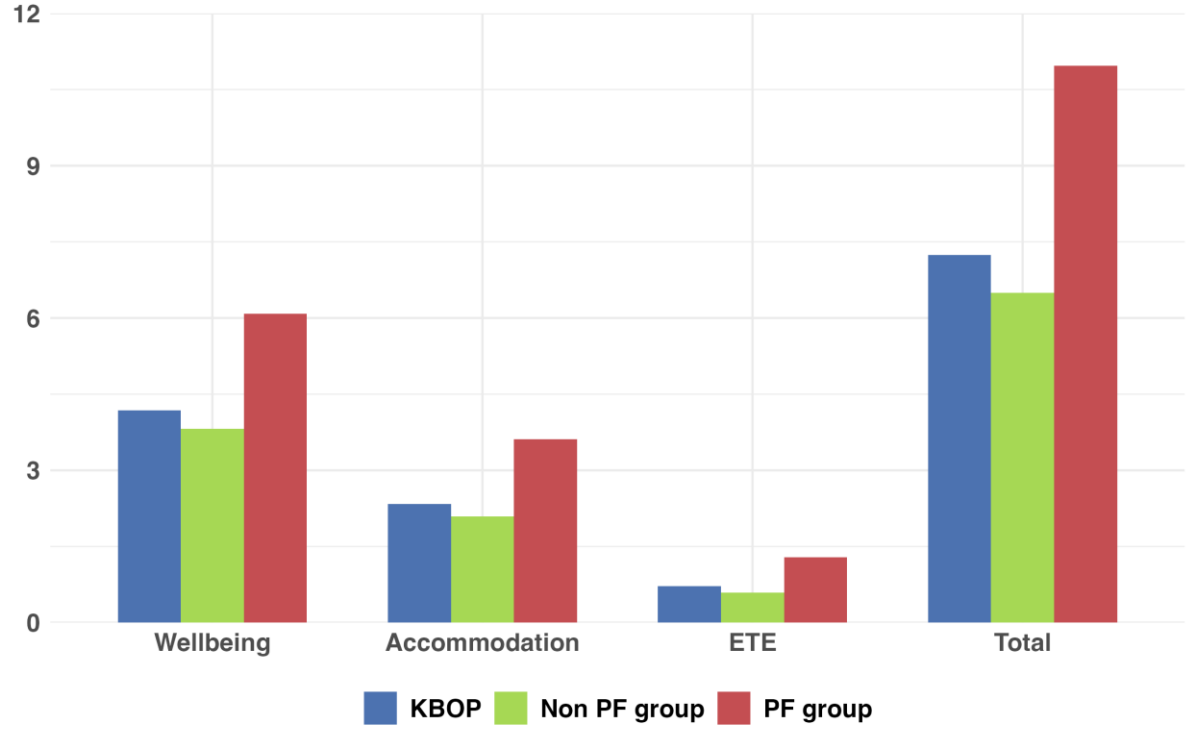
'I've worked in all this industry for far too long and the personalisation fund really helps change things that would never be possible otherwise and yet it does help climb outcomes. But actually it helps change customers' lives and which is obviously so much more important and just the ability to be able to get to it quickly if needed, for something quite small.'

Analysis by the KBOP data and impact manager, conducted at the end of the contract, suggests that the use of the fund had a positive influence on user engagement and outcomes achievement. Users who received support from the fund not only were more likely to remain engaged past 12 (>18% higher) and 18 months (>16% higher), but also demonstrated higher rates of achieving long-term outcomes, such as ETE outcomes, compared with those who did not access the fund.

[103] Visualisation of the total personalisation fund spend just before contract end (ie early 2024) prepared by KBOP.
[104] Provider B. Research wave 3.

Outcomes for users supported by the personalisation fund were found to be nearly 70% higher than the KBOP average; these users achieved 0.5 more ETE outcomes, 1.4 more accommodation outcomes and 2.1 more wellbeing outcomes. Importantly, this analysis does not control for other differences in user characteristics.

Figure 6: Average number of outcomes achieved per user[105], distinguishing between users with and without support through the personalisation fund



Source: KBOP social prime

Enhancing staff capacity: introducing the strengths-based approach

A further enabler to person-centred service delivery under KBOP was an emphasis on building staff capacity in delivering services with a strengths-based, trauma-informed support approach. The notion underpinning a strengths-based approach (sometimes used interchangeably in the literature with the term 'asset-based' approach) is that people have assets or 'strengths' and that services should focus on people's goals and resources rather than their problems (Price et al. 2020).

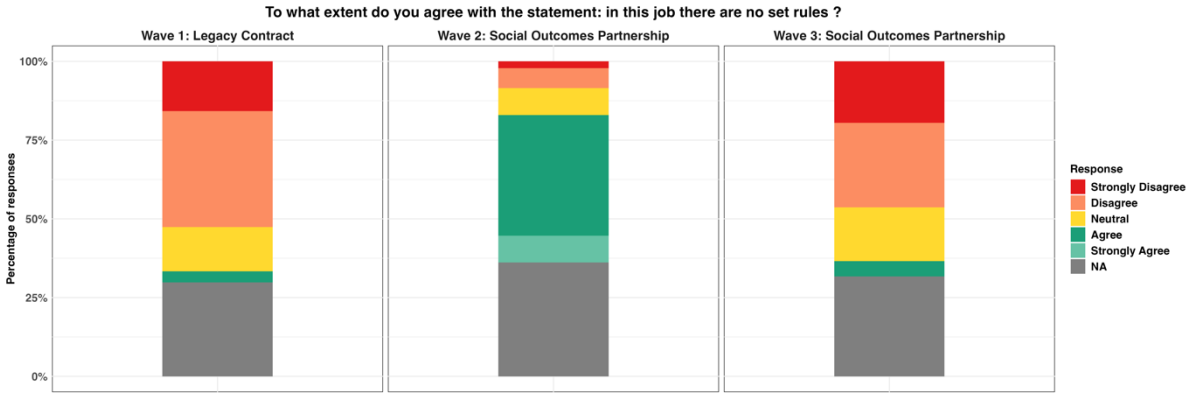
While occasionally interviewees stressed that their work had always been underpinned by a strengths-based approach, the majority of the caseworkers and managers clearly identified a change in practice, compared with the previous

[105] The figure was compiled shortly before the end of the contract (early 2024).

delivery practice. A Council contract manager described the introduction of the strengths-based approach as a key legacy of the contract:

'For me, that's the biggest thing that KBOP has done…They've had a massive impact on a lot of people because of the way they see them and interact with them and want to help them move forward. That's a real positive for me, for providers and participants. I think that's purely as an impact of KBOP.'

Figure 7: Frontline staff survey question – to what extent do you agree with the following statement: In this job, there are no set rules?



Source: Longitudinal survey data on KBOP frontline staff service delivery experience administered by the Government Outcomes Lab

In a strengths-based way of working, staff must feel empowered to exercise professional discretion. Wave 1 saw 37% of staff disagreeing with the statement 'in this job, there are no set rules.' In Wave 2, opinions shifted: 38% of frontline staff agreed with the statement. Reflecting these changes, the mean rank increased significantly from 38 in Wave 1 to 75 in Wave 2, a change that is statistically significant at the 99% confidence level. By Wave 3, the majority of frontline staff either disagreed (27%) or selected "neither" (17%), resulting in a decrease in mean rank to 39. This drop from Wave 2 to Wave 3 is also statistically significant at the 99% confidence level (appendix K, table 4 & figure 3).

The marked increase in agreement in Wave 2 suggests that staff perceived greater flexibility during the mid-implementation stage of the SOP. While the survey data provide mixed evidence of enhanced frontline staff discretion in the KBOP SOP, the majority of frontline staff interviewed in 2023 and 2024 described themselves as working with professional discretion when supporting service users. Managers' vision of an empowered workforce was instrumental to ensure that staff didn't

perceive a tension between the outcomes-based approach and the strengths-based ways of working. A head of operations[106] explained:

'But equally what I would say is in that the managers and the hierarchy of those organisations need to allow, encourage, promote that approach, because if you've got your staff who're absolutely "Yeah, asset-based; yeah, everything will come naturally." But then you've got a little voice up here going "But what about your outcomes?" Then you're defeating the object straight away because you're putting in controls.'

The KBOP social prime built staff's capacity to work in this way by providing mandatory training through a recognised expert organisation called the Mayday Trust. Key changes included adjusting language from deficit-based to strengths-based in the referral process and support plans as well as in the overall quality assessment of the service. Likewise, conversations between staff and users became more person-centred. Staff cultivated the technique of motivational interviewing with the objective of empowering each user. Users were encouraged to define their own support goals and take responsibility for working towards these goals. Contrasting the approach in the KBOP service with the legacy approach, a support worker[107] explained:

'I just think it's more partnership now with the people that were working with rather than us going in as the fixer and looking at looking at the problems and how to fix the problems.'

Transferring ownership back to the user was understood to help people to regain confidence, set boundaries and re-build relationships with families and friends. Reflecting on their KBOP support experience, a former service user[108] stated:

'I felt like I was 10 feet tall. This supportive and affirmative interaction with [name of support worker] empowered me. It transformed a potential setback into a stepping stone for further personal growth.'

A key capacity-building initiative designed to promote a strengths-based delivery approach involved the establishment of a specialist position: the ETE Coordinator. The primary responsibility of the ETE Coordinator was to upskill providers in the fields of employment-related support. This role included facilitating workshops and individual discussions with provider staff, as well as developing resources such as

[106] Provider C. Research wave 3.
[107] Provider F. Research wave 3.
[108] KBOP peer mentor coordinator. Research wave 3.

staff workbooks to support users in their job application processes. Additionally, the ETE Coordinator fostered relationships with the local employer market and compiled a database of employment opportunities that was accessible to all staff members. The cultural shift towards integrating employability support was further demonstrated by two providers who created their own dedicated specialist roles.

Enhancing staff capacity: embedding co-production

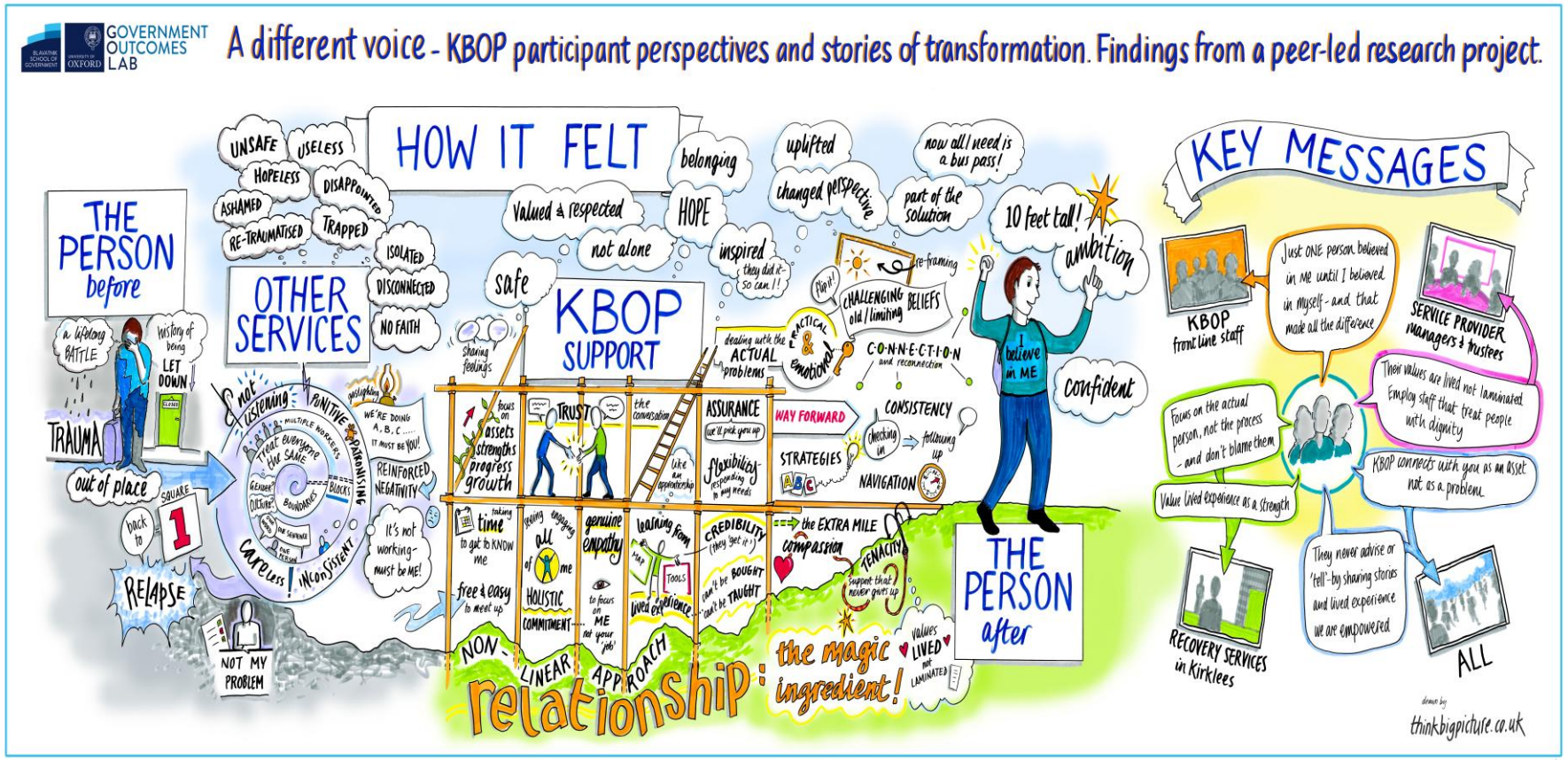
In the KBOP SOP, co-production became more prevalent across the various elements of support provision including recruitment, service design and delivery. This was particular notable in the establishment of the peer mentor model.

Co-production is a process by which the users create and shape their own services in collaboration with frontline staff (Lindsay et al., 2018). KBOP embedded co-production through a co-production forum and a peer mentor support group. Bringing lived experience into the design and delivery of the service ensured that user voice was reflected in the service. The co-production forum consisted of KBOP service users, KBOP frontline staff, and representatives from the KBOP social prime. Co-production activities included the involvement of service users in the ongoing development of the service (eg improving the outreach into 'harder-to-engage' communities) and in the outcomes design for a newly commissioned local SOP service in the field of domestic abuse. Another major piece of work was the design of a value-based recruitment process which aligned hiring practices with a strength-based approach and placed significant emphasis on the value of lived experience.

The peer mentor group was established to provide service users with a supportive environment for connecting with their peers. The group was facilitated by a peer mentor coordinator, a former KBOP service user who became a full-time staff member within the KBOP social prime. The peer mentors, who were also former KBOP service users, had made significant progress in their service journeys. Each peer mentor was paired with a mentee, a current KBOP service user, to offer guidance and model a positive path forward by sharing personal experiences and providing non-judgmental companionship. Mentors often engaged their mentees in uplifting leisure activities to promote mental wellbeing and build confidence. Additionally, the peer mentor role served as an extension of the KBOP service, providing support as the regular caseworker assistance was gradually reduced.

The model faced some challenges. The boundaries with the support workers were blurred, and in instances the stability of the relationship between the peer mentor and the mentee could be an issue, given that a point of crisis might also re-emerge in the peer mentor's life.

Figure 8: A different voice – KBOP user perspectives and stories of transformation. Findings from a peer-led research project



Source: Findings from a series of peer-led co-production workshops conducted by the Government Outcomes Lab evaluation team with KBOP users in between October 2023 and June 2024.

'The story of our lives: how KBOP's approach changed everything' by Michael Peoples

The graphic tells the story of the common themes from many diverse journeys. Everybody who took part has experienced significant adversity in their lives. The legacy of trauma can manifest in a variety of ways such as addiction, poor mental health; but the beliefs and feelings experienced by individuals can be similar: hopelessness, low self-esteem, shame and feeling isolated and completely disconnected. Frequently, our experiences with recovery, mental health or other support services reinforced and exacerbated negative self-perceptions. Professionals just didn't seem to care. This perpetuated problems instead of resolving them. Services often felt like a revolving door or a hamster wheel, very often leaving us stuck or back at square one: retraumatised, relapsing and lost and in need of even more support.

Our lives did not get any better.

Our experience with KBOP was in marked contrast. The person-centred, strengths-based approach helped us develop a trusting relationship with our workers who genuinely cared about us. They demonstrated this repeatedly by their tenacity and compassion. The fact that support was bespoke to us as individuals made a huge impact. We felt respected and valued. We started challenging some of the toxic narratives we held about ourselves for such a long time. KBOP also enabled profound meaningful connections with peers with similar lived experiences. Peers proved that change was both possible and achievable and gave us real tangible hope for the first time that our lives could get better. They had done it, so why couldn't we? Our beliefs gradually changed as we made progress. Our confidence in ourselves improved.

KBOP believed in us until we could believe in ourselves.
And our lives got better.

We are now living proof that this model works! If we could make four recommendations based on this project they would be:

1) Services should be relentlessly focused on people's strengths, not their deficits.
2) Tailored support should prioritise the individual's need above everything else.
3) Workers' suitability assessments should give at least equal weight to their characters and values as they do their skills and experience.

4) Lived experience is a major catalyst for inspiration, hope and transformation, and programmes such as coproduction and peer support should be embedded throughout organisations from top to bottom.

5.4.4 Outcomes-based-contracting – barrier or facilitator to personalisation?

Merging an outcomes-based contracting approach with a person-centred delivery approach was a central objective for KBOP. The interim evaluation stage identified a widespread concern among providers around dissonance in a service that aimed to be both outcomes-based and person-centred. This was rooted in the belief that pre-defined outcome measures required a prescriptive approach rather than one led by the needs of the user.

For some frontline staff, this concern remained prevalent at later stages of the contract. A former service user[109] indicated instances where the staff's delivery approach might have reverted to a target-driven approach:

'That delivery partner says there's no income without outcomes. So, if it's not outcomes, then basically [the support worker] wasn't going to do it.'

In contrast, the majority of provider interviewees considered the broad range of outcome measures to be a facilitator of more holistic and aspirational support work. The rate card helped to set a framework for the support work, thereby improving its focus.

Our findings on the influence of performance targets and the need to achieve payable outcomes are slightly ambiguous. The survey data indicate that the influence of numerical targets remained relatively stable. Across all three waves, the proportion of staff who agreed or strongly agreed that they were not influenced by numerical targets stayed relatively unchanged (17.5% in Wave 1, 17% in Wave 2, and 19.5% in Wave 3). Similarly, the proportion who disagreed or strongly disagreed remained consistent (24.6%, 23.4%, and 24.4%, respectively), with no statistically significant differences between survey waves. In contrast, there were notable fluctuations in perceptions of financial objectives over time. Agreement with the statement 'more and more the objective is to maximise our financial outcomes' was high in Wave 1 (38.6%) and Wave 3 (41.5%), but dropped significantly in Wave 2 (10.6%). Likewise, the proportion of respondents who disagreed or

[109] KBOP peer mentor coordinator. Research wave 3.

strongly disagreed was relatively low in Wave 1 (10.6%) and Wave 3 (14.6%), but significantly higher in Wave 2 (40.4%). These shifts between Waves 1 and 2, and then Waves 2 and 3, are statistically significant at the 99% confidence level (appendix K, table 4 & figure 3).

In contrast to the survey findings, qualitative interview data indicate strongly that managers and frontline staff were continually aware of performance targets and the need to achieve payable outcomes in the KBOP SOP.

The differences between survey and interview findings could be linked to the interpretation survey questions. We note that the staff understanding of being 'outcomes-focused' may have shifted over time. Staff may also have associated the survey questions with concern about 'gaming practices' and may have wished to quash an impression that their support work could be skewed through different contractual incentives (see below). There may also be variation across providers regarding the outcomes orientation of staff, depending on organisational culture. However, it wasn't possible to conduct a sub-group analysis due to the small number of survey responses.

A further risk to a person-centred delivery approach emphasised by the Council contract manager was that of perverse incentives involving 'creaming' and 'parking' of service users, ie favouring users who were more likely to achieve the outcomes. This practice by provider teams was observed at the start of the outcomes contract (described in the second interim report). As a mitigation action, the KBOP social prime set up a central referral hub so that providers were no longer able to pick and choose service users. Despite the Council's efforts to minimise the risk of perverse incentives as much as possible when designing the rate card, some provider staff and managers indicated that the rate card would still need to set better incentives for the work with harder-to-reach service users. Engaging service users with complex needs would require a lot of effort from staff, and there was a sense that this was not adequately reflected in the rate card. At times, this problem affected staff morale and left staff feeling penalised for not achieving outcomes. A service manager[110] described the issue:

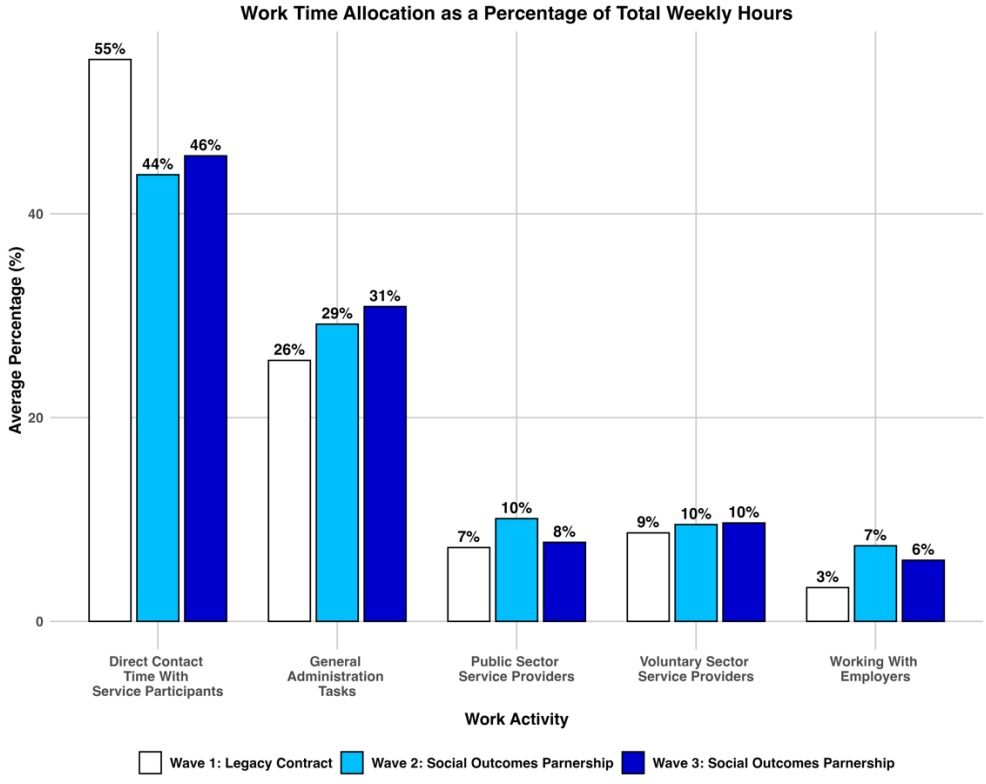
'I think there will always be a cohort of people who will not turn up for appointments, engage and disengage because their life is chaos…Staff might have to spend a lot of time chasing and trying to find out where they are. I don't think that is reflective and if they're not achieving the outcomes as fast as what the service is designed for, it's sort of penalising them in a way.'

[110] Provider D. Research wave 3.

However, the KBOP management argued that the introduction of needs-based categories would contradict the principles of person-centred services. Instead, KBOP sought to ensure engagement with harder-to-reach service users via closer case supervision and service innovations. Examples of such innovations include the Prison Leavers Pathway, which improved access to housing and support for individuals leaving custody; the BAME Community Specialist, who enhanced engagement and service accessibility for minority groups; and the Young People Pathway, which streamlined referrals and provided tailored support to young people at risk of homelessness.

A further potential barrier was caseworker time spent on administrative tasks. Notably, in the KBOP SOP, the survey data do not show a statistically significant change regarding the weekly time spent on general administrative activities; administrative-related tasks occupied around 26% of weekly hours under the fee-for-service contract and 31% of weekly hours in the final stages of the SOP contract (figure 9). However, qualitative evidence strongly indicates a *perception* of an increased administrative burden resulting from the enhanced reporting requirements. Hence, the data suggest that the nature of administrative tasks has shifted in the SOP contract (ie greater reporting on evidence requirements), but that overall staff did not spend more time on administration.

Figure 9: Work time allocation of KBOP frontline staff



Source: Longitudinal survey data on KBOP frontline staff service delivery experience administered by the Government Outcomes Lab

Regarding the specific outcomes detailed in the KBOP rate card, interviewees' perceptions varied as to whether they encouraged or hindered a person-centred delivery approach:

- **Accommodation outcomes**: The 18-months sustainment of accommodation was considered by a number of managers and staff to be a barrier to greater user empowerment because it encouraged users to remain in the service longer than necessary and limited the flexibility of case management for users who required only short-term support. A frontline worker[111] explained:

'…you've got to keep people on for 18 months at least. I've had clients where they only want to do one thing. They want to find housing or they want help with something else and that's it. And then because we've got to keep them on, they might, say, go and get full time employment. So, they're very busy all the time. But we've got that expectation that we have to check in with them once a month and sometimes the other side of it, I feel like I'm bugging some people like they just want to get what they want and go. But you've got to keep them on for 18 months. So that's the other side of it as well. I wish it was a bit more flexible in the timeframe that we have with people.'

- **ETE outcomes**: Supporting users into education, training or employment was a new stream of support work introduced with the KBOP SOP service.
  While initially all providers were concerned that the ETE outcomes were too ambitious for the cohort given the complexity of their needs and situations, this perception evolved over the course of the contract. Some managers and staff did sustain this view. They felt that a focus on ETE would alienate disadvantaged service users as staff would seem to lack empathy for users' substantial disconnect from the labour market. Other staff changed their views and highlighted its transformational impact, as illustrated by the following quote from a provider deputy CEO:[112]

'*The big one for me…is employment. Understanding the link between housing-related support and employment and how vital that is. We've seen people through KBOP going into employment. We would have never thought that they're able to do that and they are. Their self-esteem has grown and the future for them and*

[111] Provider E. Research wave 3.
[112] Provider A. Research wave 3.

their family is much, much brighter and much more positive than it would have been otherwise. That will be a legacy.'

- **Achieving financial resilience:** Critical reflections were voiced regarding the design of the financial resilience outcome, which required staff to evidence the completion of a financial workbook. This was considered to be a simplistic fix that failed to reflect the complexity of service users' reality.

Frontline staff commented:

'I think it's too easy for them to point us in the direction of doing financial income and expenditures, which don't actually achieve any financial resilience, if I'm honest…in many cases, it's not actually the required outcome of the customer would want"[113].

This overview illustrates the complexity of aligning a person-centred approach with an outcomes-based framework, where measurable outcomes need to meet the diverse and evolving needs of service users. A strong focus on service users is shaping discussions on future innovations in outcomes design for a future iteration of KBOP. One idea in consideration is the development of 'self-determined outcomes', where service prioritise their own goals within a structured outcomes framework. This approach would allow users to collaborate with providers to define what success looks like for them, aiming to enhance personalisation while maintaining accountability. Overall, these issues underscore the challenge of striking the right balance between accountability and flexibility when designing outcomes, whilst ensuring that outcomes are both meaningful and achievable. Achieving this balance requires adaptability, co-design and a governance environment which fosters collaboration and enables testing-and-learning.

[113] Provider B. Research Wave 3.

SYSTEM DYNAMICS IN THE KBOP SOP DELIVERY

This section aims to illustrate the different factors and their interdependencies influencing the intervention success, drawing on findings from a mapping workshop[114] with a KBOP delivery partner. The workshop included managers and frontline staff and was conducted at the end of the contract. While the findings are based on a case study of a single provider, and therefore generalisations cannot be made from the map, it is important to note that much of the analysis is consistent with findings presented earlier in the report analysis.

6.1 MAP OVERVIEW

The map contains the main components that staff identified as influencing the quality and success of the KBOP-backed service – that is, users' ability to live successful, independent lives after exiting the service. The factors are displayed in different colours according to their type. Furthermore, the map displays the intervention outcomes and delivery implications: whether the outcomes are a result of the positive or negative (or blended) influence of the factors.

The connections are categorised in terms of their influence:

- Green coloured connections represent a positive influence from one factor to the other (depending on the connection arrow direction)
- Red coloured connections represent negative influence from one factor to the other (depending on the connection arrow direction)
- Grey coloured connections represent an influence that is contingent, ie it could have either a positive or negative influence.

A dotted line signifies that if one factor increases, the other decreases (and vice versa).

[114] A detailed description of the method can be found in section 2.2.

6.2 FINDINGS

The system dynamics for the intervention were influenced by a variety of factors, which are clustered around the following main categories:

- the public service ecosystem
- the SOP contract
- the provider organisation capabilities and characteristics
- the service user (ie an individual's circumstances and characteristics).

The interaction of features associated with these components influenced the final outcomes of the service, namely health, financial security and secure housing. Workshop participants described a feeling of safety and security as an overarching objective of the programme.

The key insights are summarised below within the identified categories.

01| Public service ecosystem

Key insight 1: Access to support services was a foundational requirement

- Access to services included access to housing and complementary services such as health and addiction services

- Access to support services was constrained by the tight funding environment in Kirklees

- A result of the constrained funding environment was a deficit-based approach[115]: users had to demonstrate were required to evidence specific needs or vulnerabilities din order to access support provision, and this system impeded users' access to services.

Key insight 2: The deficit-based system created a tension with the strengths-based delivery approach in KBOP and reinforced past traumatic experiences

[115] A 'deficit-based approach' is a system or framework in which individuals must demonstrate a specific set of needs, challenges, or deficiencies (ie deficits) to qualify for access to services or support. The terminology is often used in contrast to a strengths-based approach which aims to build a framework of support around an individual's strengths and goals.

02 | Contractual features

Key insight 3: Long-term funding and contractual stability allowed staff to build trusting relationships and tailor support to the needs of the service user.

03 | Provider organisation

Key insight 4: A strengths-based approach was critical to building a supportive relationship with each user, responding sensitively and appropriately to past traumatic experience, and creating a feeling of safety and security.

Key insight 5: A strengths-based approach benefited delivery team culture by increasing staff resilience, leading to improved team morale.

04 | Service user

Key insight 6: There was a reinforcing loop between the user's motivation and achieving ETE outcomes.

- A motivated service user might be more open to volunteering, which might create opportunities for education and training, thus enhancing chances for employment and reinforcing the user's motivation in their support journey

- Developing a space to interact with people with lived experience could enhance the user's motivation through role-modelling.

05 | Intervention outcomes

Key insight 7: Accessing and maintaining housing was an important factor in increasing the user's health and wellbeing, as well as creating a feeling of safety and security.

- The lack of available housing in Kirklees impeded the achievement of housing-related outcomes

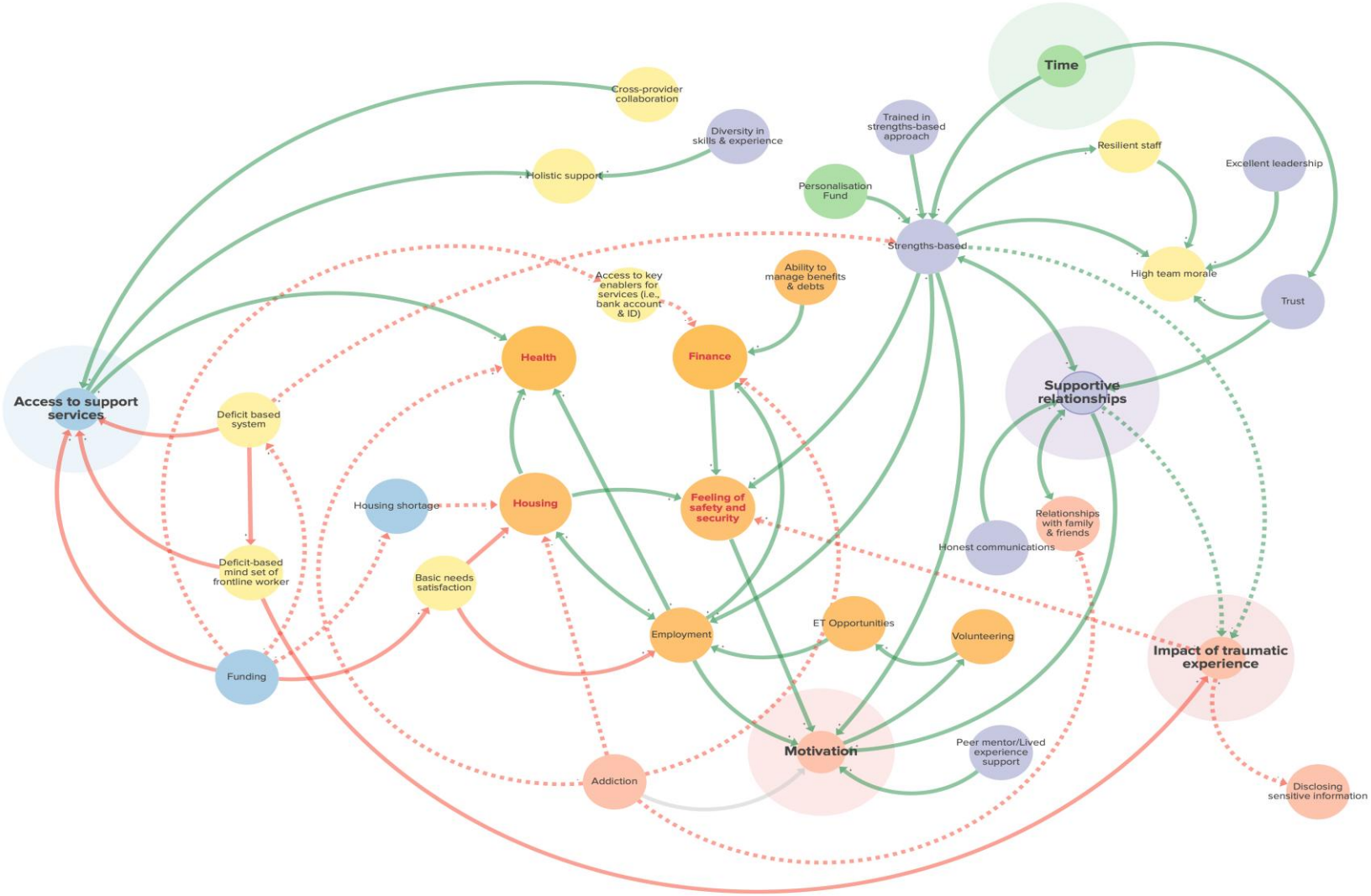
- The constrained funding environment meant that often support for basic needs satisfaction (eg funding for basic furniture; financial support for gas and electricity) could not be provided, making the failure of a tenancy more likely.

Key insight 8: Employment positively affected the user's outcomes related to health, housing and financial management.

- There was a reinforcing connection between employment and housing

- The constrained funding environment meant that support for enabling services (eg subsidies for transport to job interviews) could not be provided and this reduced chances of accessing employment or training opportunities.

Figure 10: Systems map of the KBOP SOP intervention



Index: *circles*> blue = public service ecosystem; green = SOP contract; purple = provider organisation; pink= service user orange= intervention outcome; yellow= delivery implication; *arrows*> red= negative causal link; green= positive causal

link; a *dotted* line signifies that if one factor increases, the other decreases (and vice versa). The system map was created with provider A. Further system maps can be found in Annex J.

Source: Systems maps developed through a series of participatory mapping workshops conducted by the Government Outcomes Lab evaluation team with KBOP provider organisations in Spring 2024

CONCLUSION

This five-year research study investigated how a SOP commissioning arrangement in the Kirklees Better Outcomes Partnership (KBOP) shifted the management approaches and practices of the Council and providers and influenced frontline service delivery. The evaluation compared the SOP model with the previous commissioning approach, a fee-for-service model[116]. Both contracts involved a housing support service for people with complex needs and were delivered by the same providers.

The evaluation identified four mechanisms underpinning SOP delivery: i) enhanced market stewardship; ii) strengthened and data-led performance management; iii) cultivation of cross-provider collaboration and iv) enhanced flexibility and personalisation of frontline services. Each of these mechanisms has broader implications for the delivery of complex, person-centred public services.

Key findings and recommendations for policy and practice are set out below across the following themes: the rate card design, the SOP mechanisms and the SOP's operating environment.

RATE CARD DESIGN & PERFORMANCE TARGETS

A number of issues were raised about the design of the rate card and the associated performance targets. Both the Council and KBOP team suggested that having too many outcomes may have led to an inappropriate focus on the specified outcome metrics, which may not reflect actual individual support needs.

The '18 months sustainment of accommodation' outcome incentivised staff to keep users on the service, even in cases where there was no longer a support need. Nevertheless, the outcome acknowledged the need to sustain change over time, helping to reinforce long-term stability for users. The inability to claim outcomes for users re-entering services and lack of differentiation in the outcomes design for harder-to-engage users affected staff morale; they felt these omissions prevented acknowledgement of their work. However, earlier attempts to differentiate

[116] Analysis of the fee-for-service model was the subject of the first interim evaluation report. A second interim evaluation report was conducted at SOP mid-implementation.

between service users with different service needs proved impractical and less person-centred.
Across providers, there was also frustration at performance targets which they perceived as unrealistic.

Policy & practice recommendations:

- The rate card should feature a simple design with a limited number of meaningful outcome measures to enable flexible tailoring of support provision in response to service user needs
- The rate card should account for service users who re-enter the service and for varying levels of engagement and support need, recognising the importance of flexibility in support for individuals across their engagement with the service
- The rate card should be flexible and designed with a 'test-and-learn' approach in mind. Rate cards need to allow iterative refinement based on real-world insights; they must enable adjustment for performance targets in response to substantial changes in the operational environment and remain responsive to the diverse and changing needs of service users.

SOP MECHANISMS

Market stewardship

The practice of market stewardship in the KBOP model was highly valued by the Council and providers. This evaluation focused on two particular functions expected of a market steward: market intelligence and service insights, and market influencing.

The key enabler of improved market intelligence was the introduction of a central data and performance management system, in combination with improved data quality through standardised and regular reporting.

In terms of market influencing, the dedicated team of the KBOP social prime was able to build on service insights to support underperforming providers through hands-on performance improvement plans. It was also able to initiate new service components based on service insights and its financial and impact modelling capacity, thereby supporting a more performance-oriented provider market.

The social prime's position as an external independent network orchestrator (ie neither being affiliated with the Council nor being a delivery organisation) enabled the KBOP team to take on an advocacy and mediator role between the providers and the Council. More specifically, the KBOP team could draw together multiple provider perspectives and service insights and co-develop solutions more effectively with the Council. However, there were also critical reflections from providers and the Council regarding the 'added layer' of the social prime, which markedly reduced their direct interaction with one another.

Policy recommendation: Develop an interoperable central data and performance management system that is co-designed with relevant stakeholders and integrates data from relevant services.

- The system should be applicable to a wider range of Council services
- Provider staff should be consulted to improve its User Experience (UX) design and facilitate provider adoption
- If possible, the system should be interlinked with other administrative data sets to reduce duplicative and burdensome reporting.

Policy recommendation: Provide funding for a dedicated team for network coordination and development.

- The following features have been identified as key to effectively practicing this role:
    - Local credibility and connectedness
    - Confidence in learning through data (ie quantitative impact analysis skills and operational service management experience to validate and develop qualitative insights)
    - Ability to spot opportunities for change
    - Ability to test, adapt and learn proactively.
- A number of considerations may influence whether this role is located within the Council, commissioned as a lead provider organisation, or commissioned to an external stakeholder, including:
    - Ensuring independence
    - Ensuring the sustainability of the resourcing model
    - The available skillset and resources
    - The commissioning approach (ie alliance model versus prime contractor model).

Performance management

Collaborative performance management in the KBOP SOP was facilitated through the payment-by-result nature of the contract; a central data and performance management system; and increased capacity through a dedicated resource (ie the KBOP social prime) which further enabled rigorous and constructive performance management.

The payment-by-results mechanism, which involved pre-defined outcome targets and a strict outcomes verification process, led to enhanced accountability and transparency of service performance. Drawbacks of the enhanced accountability were the perceptions of increased administrative burden and of enhanced pressures to achieve performance targets. The pressure to achieve the monthly performance targets was articulated by managers and frontline staff. Even though the providers themselves were not exposed to the payment-by-results contract, managers were highly sensitive to performance targets (here, 'targets' were linked to user outcomes rather than activity-based measures).

The central data management infrastructure improved data quality. It also allowed delivery teams to be more responsive to performance issues and facilitated identification and dissemination of best practice.

The dedicated resource of the KBOP social prime featured an enhanced capacity in terms of size and skills to improve the collection and use of performance data by providers. Performance reviews took place on a frequent basis and involved a diversity of forums in which stakeholders owning a variety of technical skills and belonging to a variety of managerial levels and organisations took part. This approach ensured an immediate and holistic discussion of problems and learnings.

Practice recommendation: Apply strategies to mitigate the increased administrative burden associated with evidence requirements for claiming outcomes in a payment-by-results contract. Strategies might include:

- Automated checks using administrative data
- Co-design of evidence requirements with provider managers and frontline staff to ensure that the requirements are practical and feasible
- Co-design of the data management system with providers, managers and frontline staff to ensure an efficient, user-friendly information management.

Practice recommendation: To prevent pressure of 'targets' amongst case workers, provide dedicated training for provider managers on specific shielding practices and implement flexible staffing models to diminish target pressures on frontline staff.

Policy and practice recommendation: invest into a central data and performance management system supported by adequate resourcing and appropriate staffing and governance:

- The team facilitating this work should feature a diverse skillset, including data analysis, service and programme management and financial modelling (in the case of a SOP model). For service and programme management roles it is beneficial that the managers have cross-sectoral experience, as this facilitates trust-building, understanding of the different sectoral challenges (ie delivery and commissioners), and mediating/catalysing of solutions

- The governance infrastructure should involve a range of forums involving stakeholders bringing a range of technical skills and belonging to different managerial levels and organisations.

Collaboration

Key aspects to improving collaboration were the shared outcomes framework in a rate card and the establishment of the KBOP social prime, as a dedicated network coordinator role facilitating the collaborative infrastructure.

The dedicated network coordinator role[117] enabled service-focused interactions and more cohesion between providers. Regularly scheduled provider meetings and the strategic pairing of providers with complementary expertise were key in developing trusting relationships and cross-provider collaboration.

The long-term contract duration enabled the development of trusting relationships; it supported collaboration and enabled a more efficient use of resources instead of investing resourcing in the re-commissioning and re-tendering of the contract. Nevertheless, the degree of collaboration was perceived to decline as the contract neared its conclusion.

[117] In the main body of the report, the network coordinator role is referred to as the KBOP social prime.

Policy & practice recommendations: Invest into a network coordinator role, which can support cross provider collaboration.

- Introducing greater cross-provider interactions requires adequate funding for a coordinator with strong relational leadership and service-specific network knowledge
- Cross-provider meetings need to be facilitated on a regular basis; in-person meetings are more likely to enhance collaboration. For frontline staff, training events are an effective way to foster relationship-building across staff.

Practice recommendation: Articulate clear, overarching service outcomes in a flexible rate card, which can bring about a focus on shared, measurable outcomes, facilitate goal alignment across service delivery, and enhance its focus.

Policy recommendation: enable longer-term commissioning, allowing for resources to be invested in building trusted relationships among the provider network rather than in recontracting and competition for further resources.

Flexibility & personalisation

In the KBOP delivery partnership, there was a greater flexibility to shape and schedule user-caseworker interactions according to the time, frequency, location and duration that suited each user; this adaptability was enabled through light-touch service specifications. Moreover, there was a substantive increase in the extent to which service users could influence the nature of support under the KBOP SOP arrangement. As such, personalisation requires *resources* to provide substantively flexible services and *skills* to take a person-centred approach to shaping support.

Under KBOP, dedicated resources were provided in the form of the 'personalisation fund', allowing for flexible, immediate funding to deliver bespoke support. Staff capacity was built through i) mainstreaming a strengths-based approach, allowing for professional discretion and user empowerment, and ii) co-production, by integrating people with lived experience in support provision.

The evaluation also highlighted barriers to flexibility and personalisation. Increased caseloads created pressures that sometimes limited staff's ability to provide highly personalised support; and reduced contact time, particularly as the contract neared its end, constrained opportunities for meaningful engagement.

Practice recommendation: Keep service specifications light touch, with service outcomes designed to balance accountability with flexibility, ensuring they reflect service user needs and priorities while allowing for adaptation to real-world challenges.

To ensure accountability, service outcomes should be complemented by pre-defined evidence requirements, while avoiding excessive administrative burden. If there are no pre-defined evidence requirements in place, a transparent and consistent performance management and governance process needs to be in place.

Policy recommendation: Enable flexible funding for tailored support.

- Flexible funding mechanisms, such as private social investment or public discretionary funds (eg DWP's Flexible Support Fund), should be designed and implemented to address individual service user needs and enhance service delivery. They can provide funding for practice innovations, system improvements, and the troubleshooting of operational challenges to ensure adaptability and responsiveness in service provision.

Practice & policy recommendation: Make a strengths-based approach and the experts-by-experience model more mainstream to public service provision; centre the goals of service users in support provision by taking a number of steps:

- Embed strengths-based practices into service design to empower service users by focusing on their strengths rather than deficits
- Provide targeted training and resources for staff to adopt a strengths-based approach
- Establish funding streams and flexible outcomes to support the implementation and sustainability of strengths-based practices
- Institutionalise co-production by integrating exerts-by-experience into service planning, delivery and evaluation.

THE OPERATING ENVIRONMENT FOR A SOP

A pre-condition for the successful delivery of a SOP commissioned service is a set of trusting and dependable stakeholder relationships between commissioners, delivery partners, and investment fund managers and the social prime.

Commissioners need to have an experimental mindset, giving the delivery partnership permission to be innovative in management and delivery. Similarly, there needs to be capacity-building in **procurement teams** to undertake the due diligence on a SOP contract which intentionally has limited service specifications to allow for a more flexible delivery. Commissioners may also need to be empowered to balance the formality of a contract with adaptation and interpersonal skills.

Providers need to have the capacity to respond to a more active contract management approach and the ability to create synergies between their own organisational culture and processes and those of the delivery partnership. This requires that provider representatives with relevant decision-making authority are involved in strategic discussions concerning the delivery partnership.

T**he social prime or investment fund manager** needs to exercise value-driven leadership and play an enabling, rather than directive, role in sustaining collaboration and innovation. This requires rallying commissioners, providers and investors around shared outcomes while ensuring that contractual and financial mechanisms support learning, innovation and responsive service delivery.

Effective contract design needs to frame and enable trusting and dependable stakeholder relationships, rather than posing a barrier. Key elements required are i) a clear but flexible outcomes framework with light-touch service specifications; and ii) governance mechanisms, alongside a central data and performance management system, that enable effective performance management as well as a test-and-learn approach to service development.

Commissioners should, as far as possible, establish **clear transition plans** to maintain service continuity, including discussions about future commissioning, continued stakeholder alignment and collaboration, and the sustainability of outcomes achieved under the SOP framework. Re-commissioning should incorporate learning from SOP experience, ensuring that key insights are fed back into future service design.

References

ACEVO (Association of Chief Executives of Voluntary Organisations) (2009). Making It Personal: A Social Market Revolution: The Interim Report of the ACEVO Commission on Personalisation, London: ACEVO.

Barbrook-Johnson, P., & Penn, A. S. (2022). *Systems mapping : how to build and use causal models of systems*. Palgrave Macmillan. https://doi.org/10.1007/978-3-031-01919-7

Broadhurst, Sarah, & Landau, Keri (2017). Learning disability market position statements, are they fit for purpose? *Tizard Learning Disability Review*, *22*(4), 198–205.

Brown, T. L., Potoski, M., & Van Slyke, D. M. (2018). Complex Contracting: Management Challenges and Solutions: Complex Contracting: Management Challenges and Solutions. Public Administration Review, 78(5), 739–747. https://doi.org/10.1111/puar.12959

Burns, D., Howard, J., & Ospina, S. (Eds.). (2021). The SAGE handbook of participatory research and inquiry. SAGE. https://doi.org/10.4135/9781529769432

Carter, Eleanor, FitzGerald, Claire, Dixon, Ruth, Economy, Christi, Hameed, Tanyah, & Airoldi, Mara (2018). Building the tools for public services to secure better outcomes: Collaboration, Prevention, Innovation. Government Outcomes Lab, Blavatnik School of Government, University of Oxford.

Carter, E., Rosenbach, F., Domingos, F., & van Lier, F. A. (2024). Contracting 'person-centred' working by results: street-level managers and frontline experiences in an outcomes-based contract. *Public Management Review*, 1–19.

Choi, I. & Moynihan, D. (2019) How to foster collaborative performance management? Key factors in the US federal agencies. Public management review. [Online] 21 (10), 1538–1559.

Considine, M. (2001). Enterprising States: The Public Management of Welfare-to-Work. Cambridge University Press.

Considine, M., Lewis, J. M., O'Sullivan, S., & Sol, E. (2015). Getting Welfare to Work: Street-Level Governance in Australia, the UK, and the Netherlands. Oxford University Press.

Department for Media, Culture and Sport, & Government Outcomes Lab. (2019, June). *Evaluation Strategy for the Life Chances Fund*. GOV.UK. https://www.gov.uk/government/publications/evaluation-strategy-for-the-life-chances-fund

Fox, Chris, & Morris, Stephen (2019). Evaluating outcome-based payment programmes: Challenges for evidence-based policy. Journal of Economic Policy Reform, 0(0), 1–17.

Gash, Tom, Panchamia, Nehal, Sims, Sam, & Hotson, Louisa (2013). Making public service markets work: *Professionalising government's approach to commissioning and market stewardship*. Institute for Government.

Guest G., MacQueen K. M., Namey E. E. (2012). Applied thematic analysis. Sage.

Greer, I., Breidahl, K.N., Knuth, M., & Larsen, F. (2017) The Marketization of Employment Services: The Dilemmas of Europe's Work-first Welfare States. First edition. [Online]. Oxford: Oxford University Press.

Hughes, R., & Huby, M. (2004). The construction and interpretation of vignettes in social research. Social Work & Social Sciences Review, 11(1), 36-51. https://doi.org/10.1921/17466105.11.1.36

Hulse, E., Nagarajan, S., & Carter, D. E. (2024). *Mental Health and Employment Partnership evaluation for the Life Chances Fund: Second interim report*. Government Outcomes Lab, Blavatnik School of Government, University of Oxford.

Miles, Matthew B., Huberman, A. M. & Saldaña, Johnny (2020). Qualitative Data Analysis: A Methods Sourcebook. Fourth ed. Los Angeles, California.

Milward, H. B., and K. G. Provan. 2006. A Manager's Guide to Choosing and Using Collaborative Networks, 6–28. Washington, DC.: IBM Center for the Business of Government.

Moynihan, D. P., & Kroll, A. (2016). Performance Management Routines That Work? An Early Assessment of the GPRA Modernization Act. Public Administration Review, 76(2), 314–323. https://doi.org/10.1111/puar.12434.

Lindsay, C., S. Pearson, E. Batty, A. M. Cullen, and W. Eadson. 2018. “Co-Production as a Route to Employability: Lessons from Services with Lone Parents.” Public Administration 96 (2): 318–332. https://doi.org/10.1111/padm.12408.

Price, A. L. Ahuja, C. Bramwell, S. Briscoe, L. Shaw, and M. Nunns. 2020. Research Evidence on Different Strengths-Based Approaches within Adult Social Work: A Systematic Review. Southampton: NIHR Health Services and Delivery Research Topic Report.

Provan, K. G., and R. H. Lemaire. 2012. “Core Concepts and Key Ideas for Understanding Public Sector Organizational Networks: Using Research to Inform Scholarship and Practice.” Public Administration Review 72 (5): 638–648. doi:10.1111/j.1540-6210.2012.02595.x.

Rajala, T., Laihonen, H., & Haapala, P. (2018). Why is dialogue on performance challenging in the public sector? Measuring Business Excellence, 22(2), 117–129. https://doi.org/10.1108/MBE-06-2017-0032

Romzek, B. S., K. LeRoux, J. Johnston, R. J. Kempf, and J. S. Piatak. 2014. “Informal Accountability in Multisector Service Delivery Collaborations.” Journal of Public Administration Research and Theory 24 (4): 813–842. doi:10.1093/jopart/mut027.

Rosenbach, F., & Carter, E. (2020). *Kirklees Integrated support service and better outcomes partnership: The first report of a longitudinal evaluation of a Life Chances Fund Impact Bond*. Government Outcomes Lab, Blavatnik School of Government, University of Oxford.

Rosenbach, F., van Lier, F.-A., Domingos, F. D., & Carter, E. (2023). The Kirklees Better Outcomes Partnership: The second report of a longitudinal evaluation of a Life Chances Fund Impact Bond. Government Outcomes Lab, Blavatnik School of Government, University of Oxford.

Ryan, Gery W. & Russell, Bernard, H. (2003). Techniques to Identify Themes. Field methods, 15(1), pp.85–109.

Saldaña, Johnny (2021). The coding manual for qualitative researchers. Los Angeles, CA: Sage.

Terry L and Cardwell V. (2016) Understanding the whole person. London: Lankelly Chase.

Vaughn LM, Whetstone C, Busch MD, et al. (2018) Partnering with insiders: A review of peer
models across community-engaged research, education and social care. Health and Social Care in the Community.

Zheng R., Fernández Camporro M., Romat H., Henry Riche N., Bach B., Chevalier F., Hinckley K., Marquardt N. (2021). Sketchnote components, design space dimensions, and strategies for effective visual note taking. In Proceedings of the 2021 CHI Conference on Human Factors in Computing Systems (pp. 1–15). Association for Computing Machinery.

Image credits:
Cover image: Sam Osborne
Graphic design p. 51, 60, 71 and 93: Sam Osborne

Appendix

A. DESCRIPTION OF THE KBOP SERVICE PROVIDERS

Name of service provider	Provider type	Provider size[118]	Type of support
Fusion Housing	Registered charity	Large	Generic housing related support
Horton Housing Association	Registered society	Major	Generic housing related support
The Pennine Domestic Abuse Group	Registered charity	Medium	Specialist domestic abuse support
Foundation	Registered charity	Major	Generic housing related support
Making Space	Registered charity	Major	Generic housing related support
Community Links	Registered society	Large	Specialist mental health & drug & alcohol support
Home Group Limited	Registered society	Major	Generic housing related support
Connect Housing Association	Registered society	Super-major	Generic housing related support

[118] The classification of provider size was made on the basis of their annual income using the classifications of the UK Civil Society Almanac 2019 classification of UK voluntary organisations.

B. INTERVIEW GUIDE AND APPROACH, AND INTERVIEW PARTICIPANTS

Interview methodology

The majority of the interviews were conducted remotely (n=46). All interviews were recorded and automatically transcribed in MS Teams. Interviews lasted on average 55 minutes. The research is endorsed by the University of Oxford's ethics review process.

The topic guide and question design were similar to those used in the second research wave, allowing the research to investigate the evolution of stakeholders' experiences. The question design was informed by the initial set of hypotheses derived from the first evaluation report. The interview guides included the following five themes:

- SOP governance
- Contract and performance management
- Cross-provider collaboration and the role of the network coordinator
- Delivery approach and experience
- SOP legacy.

The focus area of the topic guides varied depending on the specialist expertise of each research participant, but a similar interview protocol was used for all stakeholders.

Participants

Stakeholder Type	Role	No. of Interviews
Council	Senior contracting and procurement manager	2
Council	Contract manager for housing related support	1
KBOP social prime	Investment fund director	1
KBOP social prime	Project director	3
KBOP social prime	Programme manager	1
KBOP social prime	Data and impact manager	2[119]
KBOP social prime	Senior employment & skills coordinator	1
KBOP	Peer mentor coordinator	1
Provider A	Head of service	1
Provider A	Deputy CEO	1
Provider A	Services director	1
Provider A	Service manager	1
Provider A	Support worker	1
Provider B	Senior service manager	1
Provider B	Support worker	1
Provider B	Support worker	1
Provider C	Regional head of operations	2
Provider C	Team lead	1
Provider C	Data analysis manager	2

[119] The second interview was conducted as a follow-up interview for the first one.

Provider C	Support worker	1
Provider D	Strategic lead	1
Provider D	Service manager	1
Provider D	Support worker	1
Provider E	Deputy service manager	1
Provider E	Service manager	1
Provider E	Specialist support worker	1
Provider E	Specialist support worker	1
Provider E	Specialist support worker	1
Provider F	Service manager	1
Provider F	Team lead	1
Provider F	Team lead	1
Provider F	Support worker	1
Provider F	Support worker	1
Provider G	CEO	1
Provider G	Service manager	1
Provider G	Specialist support worker	1
Provider G	Specialist support worker	1
Provider H	CEO	1
Provider H	Service manager	1
Provider H	Senior team lead	1
Provider H	Support worker	1
Provider H	Support worker	1
Provider I[120]	Senior operational manager	1

[120] Provider I is the parental organisation of Provider D and Provider E.

C. SURVEY SAMPLE

Table C. 1.

Survey sample - Organisation												
Survey Wave	Fusion Housing	Connect Housing	Community Links	Home Group	Foundation	Horton Housing	Making Space	Pennine Domestic Abuse Partnership (PDAP)	Other	Not Available	Total N	Response rate
FSS Wave 1 (fee-for-service contract)	13 (33%[121])	5 (13%)	3 (8%)	8 (20%)	5 (13%)	5 (13%)	1 (3%)	0	0	17 (30%)	57	Approx. > 46% (estimate)[122]
FSS Wave 2 (SOP mid-implementation)	8 (22%)	5 (14%)	6 (16%)	6 (16%)	3 (8%)	7 (19%)	1 (3%)	1 (3%)	0	10 (21%)	47	46%
FSS Wave 3 (SOP final stages)	1 (3%)	11 (29%)	3 (9%)	2 (5%)	2 (5%)	14 (37%)	2 (5%)	2 (5%)	1 (3%)	1 (3%)	39	45%

Table C. 2.

Overlap in sample across the different waves			
Wave 1 and Wave 2	Wave 2 and Wave 3	Wave 1 and Wave 3	Waves 1, 2, and 3
4	8	1	4

[121] Percentages are rounded to whole numbers.

[122] We can't provide a precise response rate for Wave 1 (W1) since, during this first wave of survey administration, the research team were reliant on provider managers to distribute survey links to the survey across frontline staff in their teams. Given that N is larger at W1 and the service itself has not reduced in size, we expect that the response rate at W1 > 46%.

D. REFERRAL MANAGEMENT – HOW USERS ACCESS THE KBOP SERVICE

Prior to the KBOP SOP, referral agencies had referred service users directly to the service providers. This simultaneous referral to multiple providers contributed to long waiting lists. Individual service providers were able to self-select referrals. As a result, there were observations of potential 'cherry picking' practices by some providers, leading to some service users with more complex circumstances remaining on the waiting list.

With the launch of the SOP, the KBOP social prime became the central referral hub. The hub was responsible for the assessment of potential users and allocation of referrals to the KBOP delivery partners; it created a barrier to 'cherry picking.' The decision to transfer the ownership of the referral process to the social prime was taken in agreement with the Council. Key referral agencies constituted Kirklees Council (22% of referrals), other services of the KBOP delivery partners (12%). Referrals from police, custody, employment and health agencies amounted to 6% to 8% respectively. Self-referrals made up for 12%[123].

The KBOP project director noted that due to austerity-induced cutbacks in alternative local support, referral levels increased over the contract duration. Referral allocation followed a standardised assessment tool and was conducted by the social prime's 'triage team', which consisted of an engagement worker, a programme administrator and a referral assessor. Aligned with the strengths-based support approach, the assessment tool was designed to facilitate an initial inspirational conversation, encouraging the user to reflect on their aspirations for the support journey. Referrals were allocated according to providers' expertise (ie generic housing support or specialist support for domestic abuse or substance misuse) and capacity, taking into account the individual support intensity requirements of service users. The Council staff held an oversight function and would use a mix of informal case knowledge and formal checks on declined cases/long waiting times in CDPSoft to detect any potential perverse behaviours in the referral selection process.

In addition to managing referral allocations, the hub team liaised with referral agencies to promote the KBOP service. A further key strand of work involved accelerating service access by developing new referral pathways in collaboration with KBOP delivery partners and/or local agencies (eg HM Prisons, Kirklees Neighbourhood Housing) for specific target cohorts such as ex-offenders and young adults under 25.

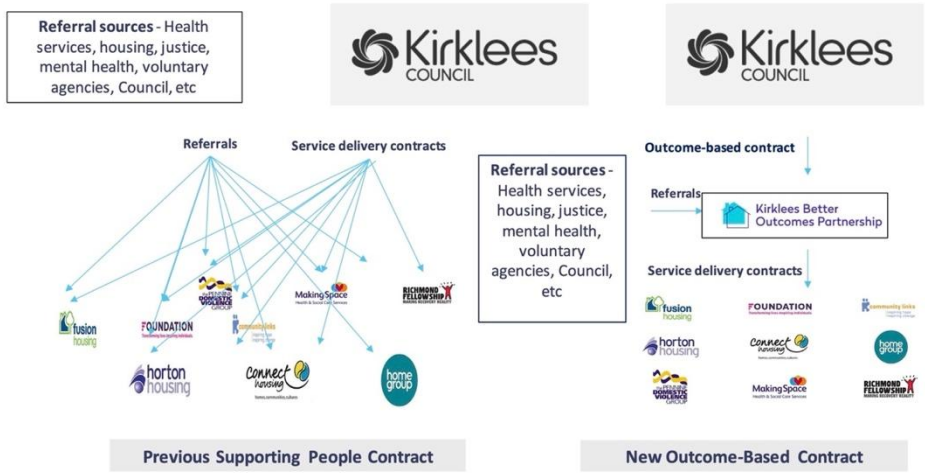
[123] Referral data as of March 2024.

In terms of dealing with re-referrals, the KBOP service offered an opportunity for drop-ins, providing light-touch or intermittent crisis support after users completed the service. The drop-in service was developed to reduce the number of full service referrals and enhance case throughput by increasing staff's confidence in making case closures.

Transferring the referral management responsibility to a central hub enhanced the efficiency of the process. It allowed for swifter service placements (usually made within two weeks and for priority cases within 72 hours) and support plan developments (on average 15 days, compared with 50 days in the initial months of the SOP service)[124]. Splitting referral and support responsibilities also allowed for a better use of resources as it enabled providers to exclusively focus on support. Moreover, the centralisation improved the quality of the referral process. One example is the development of standardised housing protocols, which enhanced the referral allocation's transparency and accelerated access to housing stock for those users with the greatest need.

A few provider managers noted that pre-KBOP the risk assessment was more thorough, and that following the introduction of the KBOP SOP, the service was now dealing with higher risk users. The KBOP project director emphasised that in situations where providers felt uncomfortable with the risk level, KBOP would work collaboratively to support the providers in the risk management approach. The KBOP social prime and the Council were both keen to ensure that the perception of being 'too high risk' wasn't used to decline people who were referred to the service with more complex needs.

Figure D.1: Referral process in the fee-for-service contract and in the SOP



Source: KBOP social prime

[124] Figures were provided by the KBOP social prime.

E. MANAGEMENT OF KBOP SOCIAL PRIME AND GOVERNANCE STRUCTURE OF THE KBOP PARTNERSHIP

The managerial structure of the KBOP social prime

Role	Responsibilities
Investment Manager and Director	○ Strategic business development ○ Liaison with investors ○ Technical expert advice ○ Financial modelling ○ Light-touch operational management involvement
Project Director	○ Strategic service development with supervision of project operations and finances ○ Leads on external liaison with stakeholders, authorities and public bodies to influence systems change and foster cross sector collaboration ○ Financial and operational modelling ○ Oversight of performance, data and quality standards. Identification of improvement requirements and liaison with management to implement changes ○ Development, facilitation and implementation of performance improvement processes.
Programme Manager	○ Operational compliance and case management ○ Conducting quality assurance and supporting provider teams in improvements ○ Leads on liaison with external stakeholders at an operational level to foster collaboration ○ Leads on co-production work
Impact and Data Manager	○ Monitors data collection and reporting of providers ○ Analysis of providers' performance ○ Technical advice to providers to facilitate learning and performance improvements
Programme Administrator	○ Manages referral inbox ○ Liaises with referral agencies
Engagement Coordinator	○ First point of engagement for referrals
Senior Employment & Skills Coordinator	○ Leads on engagement with external ETE stakeholders ○ Builds provider capacity in ETE provision ○ Develops learning tools and information material, supporting ETE ○ Individual service user coaching

Peer Mentor Coordinator	○ Leads on the facilitation of peer mentor programme of the service

The governance structure of the KBOP Partnership (next page)

Meeting description	Key function	Members	Frequency
Strategic Meetings			
KBOP board	Ensuring compliance towards social investors Subject: Investment management agreement	Director of social investment fund (check title); KBOP investment fund director; KBOP project director	Monthly
Council meeting	Ensuring compliance towards the commissioner (council) Subject: social outcomes contract	KBOP investment fund director; Council contract managers; KBOP project director; KBOP programme manager; KBOP data & impact manager; LCF project officer	Monthly
Investment committee meeting	Approval of initial social investment. Business case review and approval for major operational changes	Social investors; Director of social investment fund; KBOP investment fund director	On demand
Operational Meetings			
Contract & learning meeting ***(1:1 with individual provider)***	Ensuring compliance towards the KBOP social prime (operational focus) & capacity-building Subject: individual bi-lateral provider contracts	KBOP programme manager; KBOP data & impact manager; Provider service manager	Monthly
Quarterly strategic performance review ***(1:1 with individual provider)***	Ensuring compliance towards the KBOP social prime (strategic focus) Subject: individual bi-lateral provider contracts	KBOP project director; Senior provider service manager	Quarterly
Quarterly strategic performance review ***(all delivery partners)***	Ensuring compliance towards the KBOP social prime (strategic focus) Subject: delivery partnership performance	KBOP project director; KBOP data & operations analyst; Senior provider leads	Quarterly
Operational management meeting	Provider empowerment: advancing service delivery	KBOP project director; KBOP service manager; KBOP data & operations analyst; Provider service managers; Provider team leaders	Bi-Monthly

	Provider collaboration: facilitating social interaction and sharing of best practice		
Peer mentor forum	Capacity-building for peer mentors Co-producing service development	KBOP programme manager; KBOP peer mentor co-ordinator; peer mentors	Weekly

F. KBOP RATE CARD

Outcome	Definition	Evidence
Initial Wellbeing assessment	Support plan and Initial Wellbeing Assessment (Homelessness Star) completed and agreed with the Participant at the beginning of the period of support. For PDAP cases: Safety Plan and Initial Wellbeing Assessment (Power Form) completed and agreed with the Participant at the beginning of the period of support.	A completed initial Support Plan and Homelessness Star uploaded to the Referral System. For PDAP cases: A completed initial Safety Plan and Power Form uploaded to the Referral System.
2nd Wellbeing assessment (at 3 months +)	Wellbeing assessment can take place at any time from 3 months after the initial wellbeing assessment. This should include an assessment as to whether the Participant has achieved their ambitions and ready to be moved on from the Service. For PDAP cases: Safety Plan and Wellbeing Assessment (Power Form) completed and agreed with the Participant at the end of the period of support.	A completed Support Plan and Homelessness Star uploaded to the Referral System. For PDAP cases: A completed initial Safety Plan and Power Form uploaded to the Referral System.
3rd Wellbeing assessment (at 6 months +)	Wellbeing assessment can take place at any time from 6 months after the initial wellbeing assessment. This should include an assessment as to whether the Participant has achieved their ambitions and are ready to be moved on from the Service.	A completed Support Plan and Homelessness Star uploaded to the Referral System.
Wellbeing improvement – 1st to 2nd	Improvement will be self-assessed using the Initial Wellbeing Assessment and the 2nd Wellbeing Assessment. A Participant's score in Wellbeing Assessment must have improved by a minimum of 2 points from initial score captured at beginning of the period of support.	Completed assessment and results from the start of Service and latest assessment.
Wellbeing improvement – 1st to 3rd	Improvement will be self-assessed using the Initial Wellbeing Assessment and the 3rd Wellbeing Assessment. A Participant's score in Wellbeing Assessment must have improved by a minimum of 2 points from initial score captured at beginning of the period of support.	

Outcome	Definition	Evidence
Achieve Financial resilience	Enabling individual to achieve financial independence. This could be claimed for any one or more of the following; i) Supporting the Participant to maximise their income (including benefit entitlement) ii) Completion of a budget planning exercise (e.g. in household budgeting, relevant financial management learning toolkits, managing the benefit system), either through the relevant Subcontractor or a separate course. iii) The Participant has rent arrears from their current or previous property, or other outstanding debt. This can claimed by: (i) evidencing that a sustainable repayment plan is in place and is active (2 months' worth of payments made); and/or (ii) evidencing that the outstanding debt has been reduced to a level required for consideration for housing (this is set at £341.75 equal to 5 weeks average rent in line with the Authority's policy). iv) Supporting Access for "Right to Remain" legal classification – enabling recourse to public funds. v) For PDAP cases: Opening Bank account to support independence if previous account shared with perpetrator.	This can be evidenced through the support plan or events/case notes along with one of the following: ● an awards letter where the outcome is linked to accessing entitlements; or ● a completed budget plan/completed workbook for a budget planning exercise/course. ● a signed letter from the debtor confirming a payment plan is in place or completed; ● a statement showing payments being received ● Indefinite Leave to Remain (ILR) Legal documents, Written confirmation from Immigration services, ILR Certification ● For PDAP cases: Bank Statement, letter confirming new account ● For PDAP cases: Permission to Remain (PR) Certification
Reduction in risk of Domestic Abuse	This will be self-assessed using the DASH risk assessment framework. A Client's score in DASH risk assessment must have reduced by a minimum of 3 points from initial score captured at referral stage.	This can be evidenced through DASH forms (Initial document and secondary document) showing reduction in risk rating.
Accessing Rights to Legal Protection	Empowering participant enabling access to rights and legal protection via legislation: ● Non-Molestation Order ● Occupation order ● Child arrangement order ● Prohibited steps ● Reporting abuse to the police & statutory bodies	Evidence of enabling individual to access rights and legal protection via legislation: ● Court Order signed / stamped by Clerk ● Court application and supporting evidence ● Police report ● Letter from Social Services confirming arrangement requirements ● Self-certificate form, and all applications documented

Outcome	Definition	Evidence
		• Solicitor Letter
Empowering and Promoting Independence	Enabling and empowering an individual to achieve independence through completion of any one of the following courses: • Healthy relationship courses • Understanding Domestic Abuse • Completion of parenting rights course • Completion of Freedom Programme	Any of the following; • Certificate of completion of identified course • Self-certificate form reflecting healthy relationship intervention completion and all applications documented • Tech safety
Completion of or compliance with a Statutory Order	Minimum of 3 months support enabling individual to comply with or complete statutory order requirements.	Any of the following: • Record confirming completion of or compliance with statutory order by NPS / CRC Case Manager • Record of completion of or compliance with Unpaid Work, Rehabilitation Activity Requirement or NPS Programme. • Reduction in offending score on outcomes star reading identifying positive impact of support.
Prevention or relief / entry into suitable accommodation	This could be because: (i) the Participant is subject to the threat of eviction; (ii) they are already homeless; or (ii) their current property is unsuitable for their support needs, or (iii) their safety or security is compromised in their current situation	Any one of the following: • written confirmation from the landlord of intention not to evict; • documentation showing the landlord has withdrawn from legal proceedings; • a court decides not to issue a possession order; • a declaration from the Service saying they have received verbal assurance that the Participant will not be evicted • a letter/email from friends/family saying they no longer intend to evict; or their placement in this accommodation is secure • a signed copy of the new tenancy agreement; • a signed written agreement between the Participant and landlord if in lodgings • confirmation of temporary placement in refuge or supported housing.

Outcome	Definition	Evidence
		• identification of planning and adaptations required to support sustainment of current home or a planned move • where a property has been improved to address the need, evidence of the work must be provided, this can include a photo or invoice for the work performed • For PDAP cases: application, installation and completion of target hardening interventions with evidence of support provided
3 months sustainment of accommodation 6 months sustainment of accommodation 12 months sustainment of accommodation 18 months sustainment of accommodation	Outcomes for successful sustainment of accommodation over time claimed at specific intervals following referral or entry into suitable accommodation (3,6,12 months). This can be claimed for all Participants, regardless of whether they had an immediate housing need on referral. The Participant can move between appropriate accommodation over the course of the period if each is a planned move and not an eviction or abandonment. Accommodation sustainment outcomes cannot be claimed for participants who are residing temporarily in refuge or supported accommodation	One of the following: • Self-certification form • Landlord letter/email • Family/Friend letter/email Where possible, tenancy agreement to be uploaded as a supporting document *Self-certification format may be variable *Claims eligible by exception for individuals who may be deemed complex, high risk or have a history of non-engagement and will benefit from continuation of dual support. Evidence of this cohort via Risk Management / Safety Plan.
Entry into education and training	This outcome can be claimed on the successful engagement in education or learning activity. For accredited education courses, the individual must complete at least the first two sessions of the educational course. For unaccredited courses, the individual must complete the appropriate toolkits/workbook. This outcome can only be claimed once per Participant. Outcomes can be claimed for unaccredited courses related to: (i) healthier living/substance misuse/wellbeing; (ii) maintaining tenancies; or (iii) IT skills and Employability and any other course the individual completes to promote independence and improve wellbeing. The	Any one of the following: • Self-certification form confirming enrolment and attendance in first two sessions • A Letter/ email from trainer confirming enrolment and attendance in first two sessions For unaccredited courses the following: Completed toolkit or workbook (unaccredited courses) *Self-certification format may be variable

Outcome	Definition	Evidence
	courses can be attended face to face, through digital platforms or through agreed protected learning activity time this can include courses internally run by the relevant Subcontractor.	
Part completion of Ofqual approved qualification	A Participant completes course or units of a course which count towards a full Ofqual qualification, Level 1 or above. The course or units must be worth at least 3 credits in total. This outcome can be claimed up to a maximum of two times as long as the second qualification is of a higher level or in a different subject.	Claim form to include Ofqual number and any one of the following; ● A letter from the trainer confirming course completion; or ● A certificate evidencing completion of the course.
Completion of full Ofqual approved qualification	A Participant achieves an Ofqual approved qualification, Level 1 or above. The course must be fully complete and worth at least 9 credits in total. This outcome can be claimed up to a maximum of two times as long as the second qualification is of a higher level or in a different subject. The full and part qualification outcome can be claimed for the same course. (ie the Part claimed when 3 credits are achieved, and the Full when the course is completed).	Claim form to include Ofqual number and any one of the following; ● A letter from the trainer confirming course completion; or ● A certificate evidencing completion of the course.
Entry into employment	To claim this outcome the Participant must have been made, and have accepted, an offer of employment. They must also have attended at least the first day of employment. Self-Employment: starts trading. Apprenticeship: Where a Participant is enrolled on an apprenticeship the Contractor can claim both the employment and the education outcomes if they each meet the relevant outcome requirements. The outcome for entry into employment can only be claimed once and only when entry into employment took place after the service commenced.	Any one of the following: ● Self-certification form ● An employment contract; ● Payslips; ● An employer letter; ● Invoices and remittances; or ● A completed business plan (for self-employment only).
6.5 weeks equivalent employment F/T 13 weeks equivalent employment F/T 26 weeks equivalent employment F/T	Employment: There must be a contract in place. Employment does not have to be in the same place of work but each Participant **must achieve** the relevant **accumulated gross earnings detailed in the Earnings Table.** Self-Employment: Triggered when a Participant has invoiced revenue as detailed in the relevant section of the Earnings Table, or achieves a cumulative period of not less than 8 hours of self-employment per week in a period of 13 weeks. Apprenticeship: Where a Participant is enrolled on an apprenticeship the Contractor	Any one of the following: ● Self-certification form ● An employment contract; ● Payslips; ● An employer letter; ● Invoices and remittances; or ● Evidence of trading for self-employment (for self-employment only).

Outcome	Definition	Evidence
	can claim both the employment and the education outcomes if they each meet the relevant outcome requirements. The outcome for each duration of ongoing employment can only be claimed once. Unless otherwise agreed between the Contractor and the Authority, this outcome cannot be claimed for Participants who were in stable employment (consistently in work or with no more than two weeks gap in between roles) for 6 months or more at the point of referral to the Service. Only variation to this is if point of crisis identified risking or impacting sustainment of employment.	
Entry into Volunteering/Work Experience	A Participant enters volunteering or work experience placement(s). Outcomes are claimed at acceptance point and attendance of at least the first day of placement. This outcome can be claimed up to two times (once for volunteering and once for work experience) and only when entry into volunteering/work experience took place after the service commenced.	Any one of the following: ● Self-certification form; ● A letter from the organisation the Participant has volunteered with. *Self-certification format may be variable
6 weeks volunteering/Work Experience	A Participant carries out volunteering or work experience placement(s) for 6 weeks, averaging at least 6 hours per week. This can be a total average over longer period if placement is less than 6 hours per week. This outcome can be claimed up to two times (once for volunteering and once for work experience) and only when entry into volunteering/work experience took place after the service commenced.	
Accessing Services	This can be claimed for either; i) Participants with a mental health support need who are not currently receiving an appropriate service or have access to/complying with a treatment programme. It can be claimed on the acceptance of the referral by the 3rd party mental health service or attendance at a GP appointment with a treatment programme. This can include both statutory and non-statutory mental health services. ii) Participants who are not currently receiving an appropriate service in relation to Substance misuse. It can be claimed on the acceptance of the referral by the 3rd party substance	Any one of the following; ● Self-certification form ● a signed letter (or email) from the 3rd party service saying the referral has been accepted. ● Signed letter from GP or prescription reflecting access to correct medication. Context regarding reason for change and show why this is positive to be included on self cert. *Self-certification format may be variable

Outcome	Definition	Evidence
	misuse service and attendance at an initial appointment. This can include both statutory and non-statutory substance misuse services as per identified needs of participant. This outcome can be claimed up to two times (once for mental health and once for substance misuse).	
Mental Health sustained engagement with services	Supporting individual to engage with mental health treatment. This may include any Clinical Commissioning Group or Authority funded service as well as engagement with a treatment programme through their GP. Engagement must include attendance at appointments for a period of 3 months or until discharged from the Service (whichever is the sooner)/compliance with treatment programme prescribed by their GP. This includes cases where the individual was already engaging with a treatment programme prior be being referred to the Service.	Any one of the following: ● Self-certification form; ● A discharge letter (if less than 3 months sustainment); or ● A letter from the 3rd party service provider confirming attendance at appointments over 3-month period. ● Signed letter from GP or prescription reflecting access to correct medication. Context regarding reason for change and why this is positive to be included on self cert. *Self-certification format may be variable
Drugs/ Alcohol sustained engagement with services	Supporting individual to engage with Drug and Alcohol support programme. This may include any Clinical Commissioning Group or Authority funded service. Engagement must include attendance at appointments for a period of 3 months or until discharged from the Service (whichever is the sooner). This includes cases where the individual was already engaging with a treatment programme prior to being referred to the Service.	Any one of the following: ● Self-certification form; ● A discharge letter (if less than 3 months sustainment); or ● A letter from the 3rd party service provider confirming attendance at appointments over 3-month period. ● Signed letter from GP or prescription reflecting access to correct medication. Context regarding reason for change and why this is positive to be included on self cert. *Self-certification format may be variable

Source: Kirklees Council

G. EXAMPLE OF A PROVIDER MONTHLY PERFORMANCE REPORT

Delivery Partner:	Month:	Year:

1 - Flexibility in Service Design:

Project Achievements this month: Please include use of Personalisation fund, examples of best practice and case studies.
Project Challenges this month: Please include narrative regarding any barriers or challenges experienced preventing achievement of outcomes or systemic issues. How have you mitigated these?
Asset Based Implementation: How have you adapted delivery to ensure you are working in an asset-based way? Have you encountered any successes or learning?
Innovation: What have you done to facilitate the achievement of outcomes for participants or enable new ideas, techniques pilots?

2 - Performance Management and Accountability

Please copy and paste performance table from KPI tracker. Identify key areas of positive and negative performance against KPIs and report against them.

KPI	Monthly Target	Target to date	Actuals to date	Evidence outstanding	Variance	% of target achieved
Total referrals	-	-	-	-	-	-
New Starts on Full Service	-	-	-	-	-	-
Initial Wellbeing assessment	-	-	-	-	-	-
2nd Wellbeing assessment	-	-	-	-	-	-
3rd Wellbeing assessment	-	-	-	-	-	-
Achieve Financial resilience	-	-	-	-	-	-

Completion of or compliance with a Statutory Order	-	-	-	-	-	-
Prevention or relief / entry into suitable accommodation	-	-	-	-	-	-
3 months sustainment of accommodation	-	-	-	-	-	-
6 months sustainment of accommodation	-	-	-	-	-	-
12 months sustainment of accommodation	-	-	-	-	-	-
18 months sustainment of accommodation	-	-	-	-	-	-
Entry into education and training	-	-	-	-	-	-
Part completion of Ofqual approved qualification	-	-	-	-	-	-
Completion of full Ofqual approved qualification	-	-	-	-	-	-
Entry into employment	-	-	-	-	-	-
6.5 weeks equivalent employment F/T	-	-	-	-	-	-
13 weeks equivalent employment F/T	-	-	-	-	-	-
26 weeks equivalent employment F/T	-	-	-	-	-	-
Entry into Volunteering/Work Experience	-	-	-	-	-	-
6 weeks volunteering/Work Experience	-	-	-	-	-	-
Accessing Services	-	-	-	-	-	-
Mental Health sustained engagement with services	-	-	-	-	-	-
Drugs/ Alcohol sustained engagement with services	-	-	-	-	-	-
Added Value outcomes	-	-	-	-	-	-
Total outcomes	-	-	-	-	-	-

Positive Performance Commentary: Which outcomes have been identified with a positive trend this month? Why do you think that has happened?
Please also include any **Added Value outcomes** achieved this month.
Negative Performance Commentary: Which outcomes have been identified with a negative trend this month? Why do you think this has happened? Please include what you have implemented as mitigation within this area.

3 - Collaboration

How can KBOP support you to achieve your KPIs?
How can the KBOP Strategic Steering Group support you with challenges experienced this month?
What have you done to include participants, staff, or stakeholders in your service?

4 - Contractual Verification

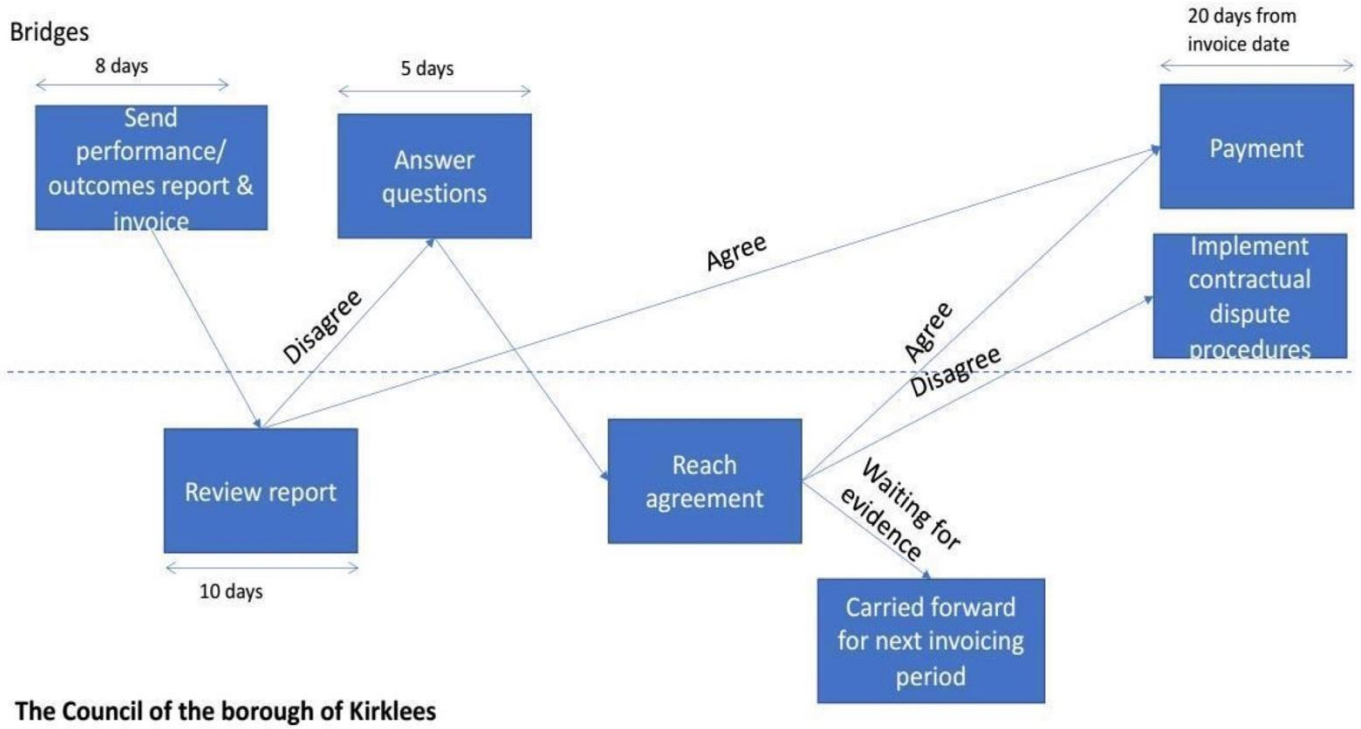
Please report against operational requirements of the contract:

Role	Staffing required Budgeted FTE	Sickness	Vacant Roles	Actual Staff in post

Quality Audit: How have you audited operational quality and compliance this month? Any findings to discuss?
Case Study:
Reportable Incidents: Please document any complaints, death in service or other notifiable incidents

Source: Provider

H. DESCRIPTION OF THE OUTCOMES CLAIM PROCESS



Source: KBOP Social Prime

I. SERVICE INNOVATIONS

Characteristic or innovation	Description	Lead provider	Impact
KBOP Hub	Introduction of central referral and allocation team to bypass system automation and ensure personal experience for anyone accessing KBOP. Hub received and understood presenting circumstances of all referrals into KBOP and once each case reviewed, allocated it directly across the partnership to prevent 'cherry picking' and opportunity for selection from system based on complexities of case.	KBOP	6395 total starts (5872 Life Chances Fund, 532 Historic placement) between Sept 19 and Mar 24. Hub had 8521 contacts in that time so additional work with 2126 + the onboarding of all the starts (multiple times in some cases). Reduced waiting lists and times by 50%.
KBOP Case Closure Process	Creation of new closure verification process requiring evidence of multiple, personalised and adaptive engagement for each referral or ongoing case to prevent early or inappropriate closure for complex or none engaging cases. Central oversight by KBOP Leadership team.	KBOP	Reduced re-referral rate dropping from 30% to 10%, breaking the cycle of repeat support through direct matching and improved, personalised and creative approaches to engagement.
Single IT System - CDP Soft	Introduction of single IT system for all providers to improve data accuracy oversight and quality.	KBOP	Improved oversight, data analysis and reduction of duplication of support.
Tenancy Deposit Scheme	Facilitated access to private accommodation through offering a bond agreement and other guarantees (eg cash deposits) to private landlords.	Fusion Housing and KBOP	283 supported clients. 268 outcomes including 57 bonds to assist clients in securing new accommodation.
HIPs Supported Accommodation	Direct access to 4 x purpose-built properties prioritised for KBOP users.	Horton Housing	838 supported Horton clients had these properties as a prospective housing option.

Accommodation For Ex Offenders Pilot (AFeO)	Supporting ex-offenders in improved access to Private Rental Sector properties; 12 month pilot. 2 further 12 month extensions awarded as a result of success of pilot and outcomes learning. Funding from MHCLG to pilot a new approach for supporting prison leavers into PRS accommodation. Building on the prison leavers pathway and collaborating with Housing Solutions to bring the Prevention and relief assessment process forward to determine priority need pre-release and improve access to accommodation and resettlement planning.	MHCLG Funded pilot. Delivered as a collaboration with Kirklees Council; Fusion Housing;	94 referrals. 38 bonds have been provided to date. A further 24 clients were supported to find accommodation without a bond.
Connect – Direct Access Pilot	KBOP managed referral pathway for access to accommodation.	Connect Housing: Homes England	444 Connect Housing clients, in particular the 94 who were homeless at referral.
Prison Leavers Pathway	KBOP redevelopment of 'Duty To Refer' collaboration. Collaborating with HMPs, Probation and Local Authorities to improve information sharing pre-release, preventing the need for homelessness presentations on release from prison and identification of address and access to community services.	HM Prisons, Probation, KBOP, KNH Housing, Kirklees Council	425 KBOP users across the partnership with a history of criminal behaviour and who were at risk of re-offending.
Foundation - Offender Direct Access	Collaboration with Foundation Homes to support access to supported or enhanced accommodation.	Foundation Housing, KBOP, KNH Housing, HM Prisons, West Yorkshire Probation	Improved access to the KBOP and service delivery for the 425 (10%) of referred clients who were ex-offenders.
Young Persons Pathway	Development of automated referral pathway for anyone under 25 to	KBOP and KNH	Improved access to the KBOP, via an automatic referral from KNH, and

	support homelessness prevention and enable young people to sustain their tenancies.		service delivery to protect tenancies and prevent homelessness for 731 (17%) of clients who were under 25 at the time of referral.
Gender-Based Approaches to Housing Standards	Collaboration with women's services in Kirklees to draft set of principles for women in accommodation. Improving experiences for individuals and standardising practice.	KBOP, Women's Alliance, Safer Women Leeds	Improved service principles and standards geared specifically to women benefited the 2439 female KBOP clients to date (55% of the cohort).
Community Gardening Service	Facilitate volunteering experience and enhancing mental health.	Home Group, KBOP	359 HG clients. On average, HG clients had a 15% increase in their wellbeing (measured by the Home and Homelessness Star).
PDAP Group Support Programme	A peer support group course to support and empower victims of domestic violence.	PDAP, KBOP	PDAP sought to support 100 clients per year through the peer group classes.
ETE Training	Design and facilitation of ETE training for all frontline staff. Promotion of motivational interviewing techniques to enable frontline staff to understand users' ambitions. A local cross-partnership forum to support information sharing and best practice.	KBOP	3641 ETE outcomes were achieved (by end March 2024). 800% increase on outcomes KPI forecasted. 66% of all individuals entering employment sustained for at least 6 weeks.
BAME community specialist	Working with Gurdwara and recruiting directly from the Sikh community to create specialist faith and multi-language roles. Supporting equality of access to the KBOP service for minority groups in Kirklees.	Community Links	Improved engagement from hard-to-reach communities, developing trusted relationships and increasing referrals into KBOP programme.

Volunteering and peer mentor programme	A cohort of mentors who, in turn, supported clients and increase user input.	KBOP	31 Peer Mentors completed training. 10 completed certified accreditation qualification.
Tenancy Rescue Service	Two new roles at Fusion to support clients in challenging and avoiding unfair evictions. 12 months pilot.	Fusion	66 individuals supported when their accommodation was placed at risk via expert legal advice and guidance to other DP services. 17 evictions prevented via direct negotiation with landlord.
Women at Risk of Offending – NPS Pilot	Dedicated role funded by NPS innovation budget to have dedicated worker for women leaving prison or on community orders. Building on strengths-based learning and personalisation of support to offer a gender specific service to improve access to permanent accommodation.	NPS Innovation	Not commenced to date – Pilot development in progress.
Maximus ETE Pilot	Collaboration with local ETE Organisation to fund paid placements for Peer Mentors across the KBOP Programme. Creating a pathway to employment and supporting meaningful delivery 5 to date (3 of which have gone on to permanent KBOP EW positions).	Maximus	5 Placements created to date. 3 completed, 2 individuals moved from peer Mento cohort into permanent paid employment within KBOP partnership (PDAP and Horton).
CPD Accreditation for Peer Mentor programme	Enabled peer mentors to have a recognised qualification in response to their time, work and effort supporting individuals on our programme. Supporting future work opportunities.	KBOP, Groundwork	Delivered in collaboration with Groundwork. 20 individuals supported to access ETE opportunities and funding enabled KBOP central team to design and develop a CPD accreditation for the Peer Mentor Training course. 10 x Peer Mentors completed qualification to date.

J. STATISTICAL ANALYSIS OF SURVEY

The objective of the statistical analysis of the survey data was to assess differences in KBOP frontline staff responses across the three survey waves. The approach varied according to the type of variable being analysed (ordinal, categorical or continuous), with appropriate statistical tests applied to ensure robust and meaningful results. For ordinal variables, such as those captured on Likert scales, the Kruskal-Wallis test was used. This non-parametric test, which serves as an alternative to the ANOVA, is particularly suitable for ordinal data as it does not assume normal distribution. The Kruskal-Wallis test assesses whether there are statistically significant differences in the median ranks across the survey waves. When a significant result was obtained, Dunn's post-hoc test was performed to explore all pairwise comparisons between the waves, with p-values adjusted using the Holm method to account for multiple comparisons. This adjustment helps control the family-wise error rate, thereby reducing the likelihood of Type I errors when conducting multiple tests.

For continuous variables, the Kruskal-Wallis test was also employed to detect differences in distributions across the survey waves. This test is appropriate for continuous data that may not follow a normal distribution. When significant differences were found, Dunn's post-hoc tests were applied to identify which pairs of waves differed significantly, again using Holm-adjusted p-values. Summary statistics such as the mean, standard deviation and sample size for each wave were also reported to provide a comprehensive understanding of the data distribution.

To assess differences in categorical variables, such as organisational affiliations across the three survey waves, Fisher's Exact Test was employed due to its suitability for small sample sizes. This test checks for statistically significant differences in the distribution of categorical responses across waves. Pairwise Fisher's Exact Tests were also conducted, with p-values adjusted using the Holm method to account for multiple comparisons.

Regarding the interpretation of mean ranks, these represent the average position of each group's responses when all responses are ranked from lowest to highest across the entire dataset. A higher mean rank suggests that, on average, the responses within that group tend toward higher values on the Likert scale (eg stronger agreement), while a lower mean rank indicates a tendency toward lower values (eg stronger disagreement).

The p-values reported in the analysis indicate the probability of observing the differences in mean ranks or categorical distributions by chance. A p-value less than 0.05 suggests that the observed differences are statistically significant, indicating they are unlikely to have occurred by random variation alone. Conversely, p-values greater than 0.05 imply that any observed differences could reasonably be

attributed to chance. Statistically significant findings are marked with an asterisk in the tables to denote meaningful changes between survey waves.

K. STATISTICAL ANALYSIS TABLES AND FIGURES

Table K.1.

How many service users are you currently supporting?					
Survey wave (N)	**Mean Number of Users**	**Standard Deviation**	**Minimum**	**Maximum**	**p-value**
FSS Wave 1 (57)	14	5	3	28	Wave 1 vs Wave 2: p = 0.00451 ** Wave 1 vs Wave 3: p = 0.0000417***
FSS Wave 2 (47)	19	7	4	31	Wave 2 vs Wave 1: p = 0.00451 ** Wave 2 vs Wave 3: p = 0.172
FSS Wave 3 (41)	21	7	4	31	Wave 3 vs Wave 1: p = 0.0000417*** Wave 3 vs Wave 2: p = 0.172
An asterisk denotes that the change in responses is statistically significant between survey waves at the .05 level.					

Figure K.1

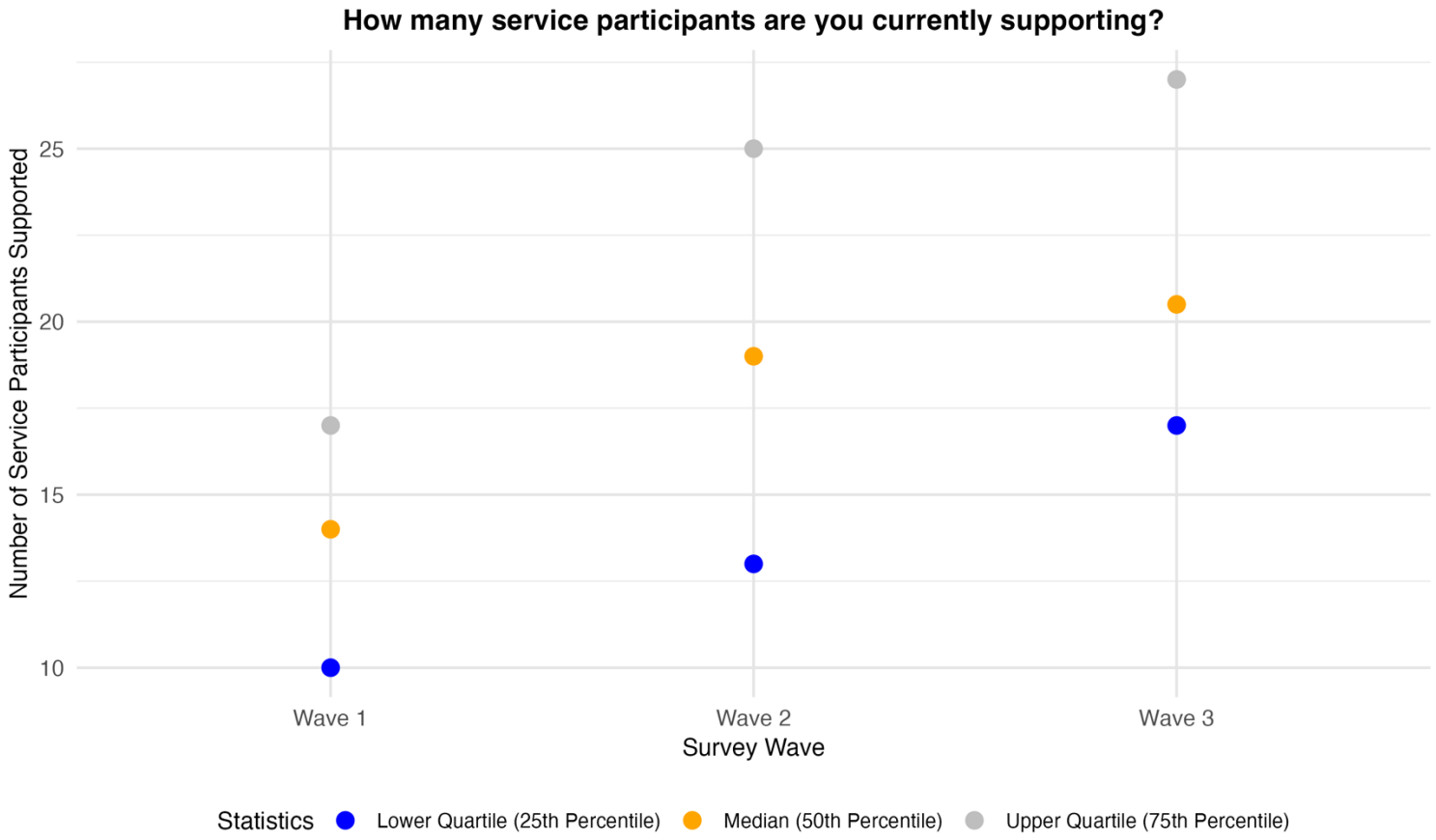

How many service participants are you currently supporting?
Number of Service Participants Supported
25
20
15
10
Wave 1
Wave 2
Wave 3
Survey Wave
Statistics
Lower Quartile (25th Percentile)
Median (50th Percentile)
Upper Quartile (75th Percentile)

Table K.2.

How many months do you tend to work with each service user?			
Survey wave (N)	**FSS Wave 1 (57)**	**FSS Wave 2 (47)**	**FSS Wave 3 (41)**
1. Less than one month	0	0	0
2. One month	1 (1.754%)	0	1 (2.439%)
3. Two months	0	0	1 (2.439%)
4. Three months	0	1 (2.128%)	0
5. Four months	0	0	1 (2.439%)
6. Five months	4 (7.018%)	1 (2.128%)	3 (7.317%)
7. Six months	0	3 (6.383%)	0
8. Seven months	1 (1.754%)	0	2 (4.878%)
9. Eight months	0	1 (2.128%)	0
10. Nine months	0	0	2 (4.878%)
11. Ten months	0	2 (4.255%)	0
12. Eleven months	10 (17.544%)	0	6 (14.634%)
13. Twelve months	24 (42.105%)	9 (19.149%)	20 (48.780%)
14. More than 12 months (censored)	0	20 (42.553%)	0
N/A	17 (29.825%)	10 (21.277%)	5 (12.195%)
Mean rank	49.763	75.635	45.889
p-value	Wave 1 vs Wave 2: p = 0.00048 *** Wave 1 vs Wave 3: p = 0.585	Wave 2 vs Wave 1: p = 0.00048 *** Wave 2 vs Wave 3: p = 0.00012	Wave 3 vs Wave 1: p = 0.585 Wave 3 vs Wave 2: 0.00012 ***
An asterisk denotes that the change in responses is statistically significant between survey waves at the .05 level.			

Table K.3.

How influential are the following factors in determining what activities are included in the support you provide?								
Survey wave (N)	1. Rarely	2. Slightly	3. Moderately	4. Very	5. Extremely	N/A	Mean rank	p-value
User's activity preferences								
FSS Wave 1 (57)	3 (5.263%)	2 (3.509%)	8 (31.579%)	18 (14.035%)	9 (15.789%)	17 (29.825%)	37.663	Wave 1 vs Wave 2: p = 0.000*** Wave 1 vs Wave 3: p =0.019*
FSS Wave 2 (47)	0	0	3 (6.383%)	8 (17.021%)	21 (44.681%)	15 (31.915%)	62.75	Wave 2 vs Wave 1: p = 0.000*** Wave 2 vs Wave 3: p = 0.255
FSS Wave 3 (41)	0	0	1 (2.439%)	15 (36.585%)	12 (29.268%)	13(31.707%)	54.839	Wave 3 vs Wave 1: p =0.0188* Wave 3 vs Wave 2: p = 0.255
My own judgement								
FSS Wave 1 (57)	0	5 (8.772%)	12 (21.053%)	18 (31.579%)	6 (10.526%)	16 (28.070%)	50.402	Wave 1 vs Wave 2: p = 1.000 Wave 1 vs Wave 3: p = 1.000
FSS Wave 2 (47)	3 (6.383%)	2 (4.255%)	11 (23.404%)	7 (23.404%)	9 (19.149%)	15 (31.915%)	50.172	Wave 2 vs Wave 1: p = 1.000 Wave 2 vs Wave 3: p = 1.000
FSS Wave 3 (41)	1 (2.439%)	3 (7.317%)	5 (12.195%)	15 (36.585%)	4 (9.756%)	13 (31.707%)	52.821	Wave 3 vs Wave 1: p = 1.000 Wave 3 vs Wave 2: p = 1.000
Need to get an outcome								
FSS Wave 1 (57)	1 (1.754%)	4 (7.018%)	8 (14.035%)	17 (29.825%)	10 (17.544%)	17 (29.825%)	57.125	Wave 1 vs Wave 2: p = 0.205 Wave 1 vs Wave 3: p = 0.299
FSS Wave 2 (47)	2 (4.255%)	4 (8.511%)	13 (27.660%)	7 (14.894%)	6 (12.766%)	15 (31.915%)	45.078	Wave 2 vs Wave 1: p = 0.205 Wave 2 vs Wave 3: p = 0.765
FSS Wave 3 (41)	0	4 (9.756%)	11 (26.829%)	9 (21.951%)	4 (9.756%)	13 (31.707%)	47.232	Wave 3 vs Wave 1: p = 0.299 Wave 3 vs Wave 2: p = 0.765
Answers to standard assessment questions (eg 'Homelessness Star' or initial assessment)								
FSS Wave 1 (57)	2 (3.509%)	2 (3.509%)	14 (24.561%)	17 (29.825%)	5 (8.772%)	17 (29.825%)	43.788	Wave 1 vs Wave 2: p = 0.056 Wave 1 vs Wave 3: p = 0.418
FSS Wave 2 (47)	1 (2.128%)	1 (2.128%)	6 (12.766%)	12 (25.532%)	12 (25.532%)	15 (31.915%)	59.156	Wave 2 vs Wave 1: p = 0.056 Wave 2 vs Wave 3: p = 0.418
FSS Wave 3 (41)	1 (2.439%)	1 (2.439%)	9 (21.951%)	10 (24.390%)	7 (17.073%)	13 (31.707%)	50.196	Wave 3 vs Wave 1: p = 0.418 Wave 3 vs Wave 2: p = 0.418
An asterisk denotes that the change in responses is statistically significant between survey waves at the .05 level.								

Figure K. 2

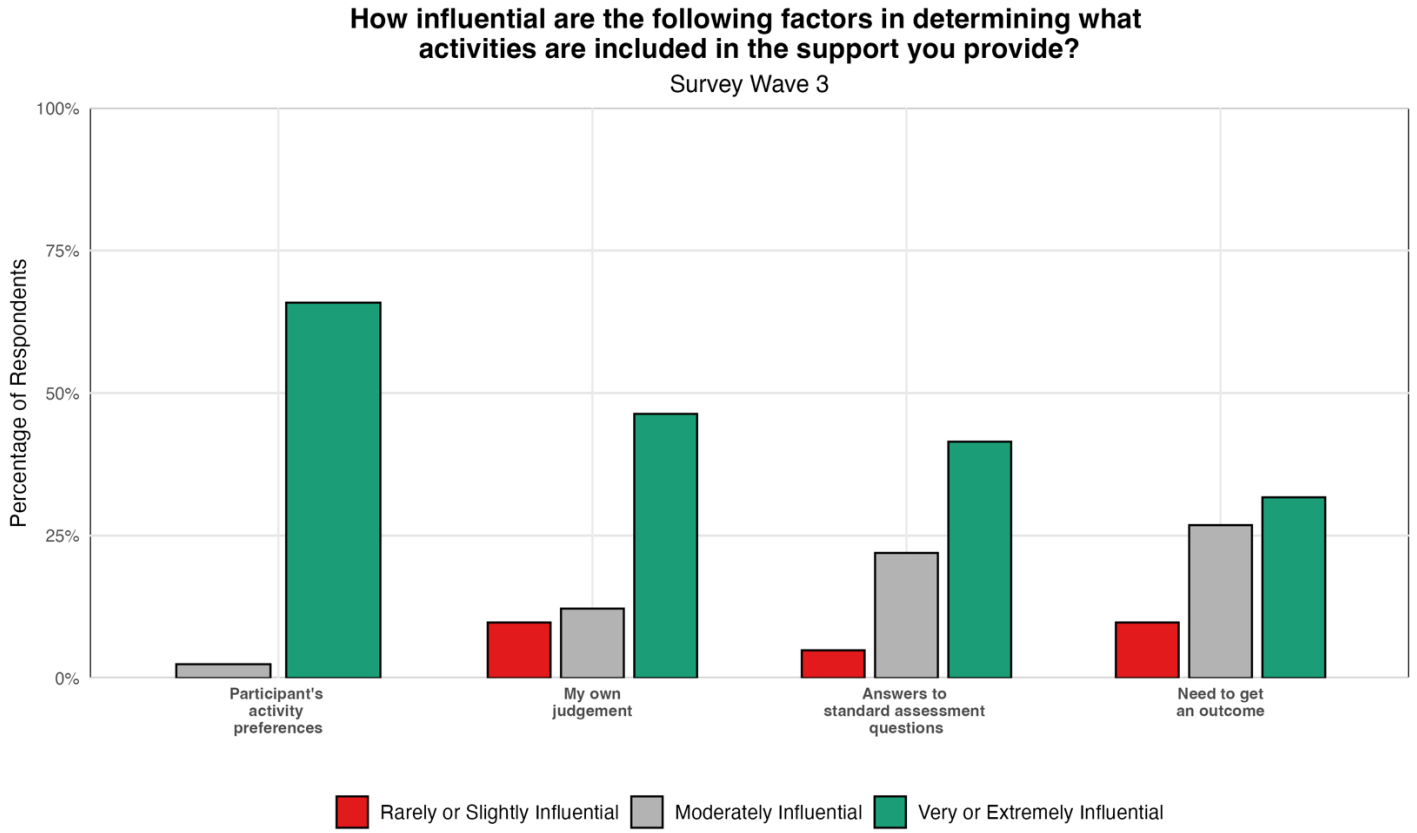


Table K.4.

To what extent do you agree with the following statements? In this job…								
Survey wave	**1. Strongly Disagree**	**2. Disagree**	**3. Neither**	**4. Agree**	**5. Strongly Agree**	**N/A**	**Mean rank**	**p-value**
It is important that service users are moved on quickly								
FSS Wave 1 (57)	0	17 (29.825%)	15 (26.316%)	6 (10.526%)	2 (3.509%)	17 (29.825%)	48.337	Wave 1 vs Wave 2: p = 0.439 Wave 1 vs Wave 3: p = 0.498
FSS Wave 2 (47)	1 (2.128%)	9 (19.149%)	7 (14.894%)	13 (27.660%)	0	17 (36.170%)	56.35	Wave 2 vs Wave 1: p = 0.439 Wave 2 vs Wave 3: 0.233
FSS Wave 3 (41)	3 (7.317%)	11 (26.829%)	8 (19.512%)	5 (12.195%)	1 (2.439%)	13 (31.707%)	43.821	Wave 3 vs Wave 1: p = 0.498 Wave 3 vs Wave 2: p = 0.233
There are no set rules								
FSS Wave 1 (57)	9 (15.789%)	21 (36.842%)	8 (14.035%)	2 (3.509%)	0	17 (29.825%)	37.812	Wave 1 vs Wave 2: p = 0.000*** Wave 1 vs Wave 3: 0.911
FSS Wave 2 (47)	1 (2.128%)	3 (6.383%)	4 (8.511%)	18 (38.298%)	4 (8.511%)	17 (36.170%)	75.283	Wave 2 vs Wave 1: = 0.000*** Wave 2 vs Wave 3: p = 0.000***
FSS Wave 3 (41)	8 (19.512%)	11 (26.829%)	17 (17.073%)	2 (4.878%)	0	13 (31.707%)	38.571	Wave 3 vs Wave 1: p = 0.911 Wave 3 vs Wave 2: p = 0.000***
My supervisor knows a lot about my day-to-day work								
FSS Wave 1 (57)	1 (1.754%)	1 (1.754%)	5 (8.772%)	26 (45.614%)	7 (12.281%)	17 (29.825%)	61.875	Wave 1 vs Wave 2: p = 0.000*** Wave 1 vs Wave 3: p = 0.659
FSS Wave 2 (47)	9 (19.149%)	18 (38.298%)	3 (6.383%)	0	0	17 (36.170%)	18.7	Wave 2 vs Wave 1: p = 0.000*** Wave 2 vs Wave 3: p = 0.000***
FSS Wave 3 (41)	1 (2.439%)	2 (4.878%)	1 (2.439%)	16 (39.024%)	8 (19.512%)	13 (31.707%)	64.821	Wave 3 vs Wave 1: p = 0.659 Wave 3 vs Wave 2: p = 0.000***
More and more the objective is to maximise our financial outcomes								
FSS Wave 1 (57)	3 (5.263%)	3 (5.263%)	12 (21.053%)	15 (26.316%)	7 (12.281%)	17 (29.825%)	57.587	Wave 1 vs Wave 2: p = 0.000*** Wave 1 vs Wave 3: p = 0.989

FSS Wave 2 (47)	7 (14.894%)	12 (25.532%)	6 (12.766%)	4 (8.511%)	1 (2.128%)	17 (36.170%)	31.083	Wave 2 vs Wave 1: p = 0.000*** Wave 2 vs Wave 3: p = 0.000***
FSS Wave 3 (41)	1 (2.439%)	5 (12.195%)	5 (12.195%)	13 (31.707%)	4 (9.756%)	13 (31.707%)	57.679	Wave 3 vs Wave 1: p = 0.989 Wave 3 vs Wave 2: p = 0.000***
I am NOT influenced by numerical targets								
FSS Wave 1 (57)	0	14 (24.561%)	16 (28.070%)	7 (12.281%)	3 (5.263%)	17 (29.825%)	50.300	Wave 1 vs Wave 2: p = 1.000 Wave 1 vs Wave 3: p = 1.000
FSS Wave 2 (47)	3 (6.383%)	8 (17.021%)	11 (23.404%)	6 (12.766%)	2 (4.255%)	17 (36.170%)	48.35	Wave 2 vs Wave 1: p = 1.000 Wave 2 vs Wave 3: p = 1.000
FSS Wave 3 (41)	3 (7.317%)	7 (17.073%)	10 (24.390%)	5 (12.195%)	3 (7.317%)	13 (31.707%)	49.589	Wave 3 vs Wave 1: p = 1.000 Wave 3 vs Wave 2: p = 1.000
The main thing I have to do is gain the trust of the service user								
FSS Wave 1 (57)	1 (1.754%)	3 (5.263%)	7 (12.281%)	17 (29.825%)	12 (21.053%)	17 (29.825%)	59.975	Wave 1 vs Wave 2: p = 0.000*** Wave 1 vs Wave 3: p = 0.476
FSS Wave 2 (47)	12 (25.532%)	12 (25.532%)	5 (10.638%)	0	1 (2.128%)	17 (36.170%)	21.217	Wave 2 vs Wave 1: p = 0.000*** Wave 2 vs Wave 3: p = 0.000***
FSS Wave 3 (41)	1 (2.439%)	1 (2.439%)	3 (7.317%)	12 (29.268%)	11 (26.829%)	13 (31.707%)	64.839	Wave 3 vs Wave 1: p = 0.476 Wave 3 vs Wave 2: p = 0.000***
An asterisk denotes that the change in responses is statistically significant between survey waves at the .05 level.								

Figure K. 3

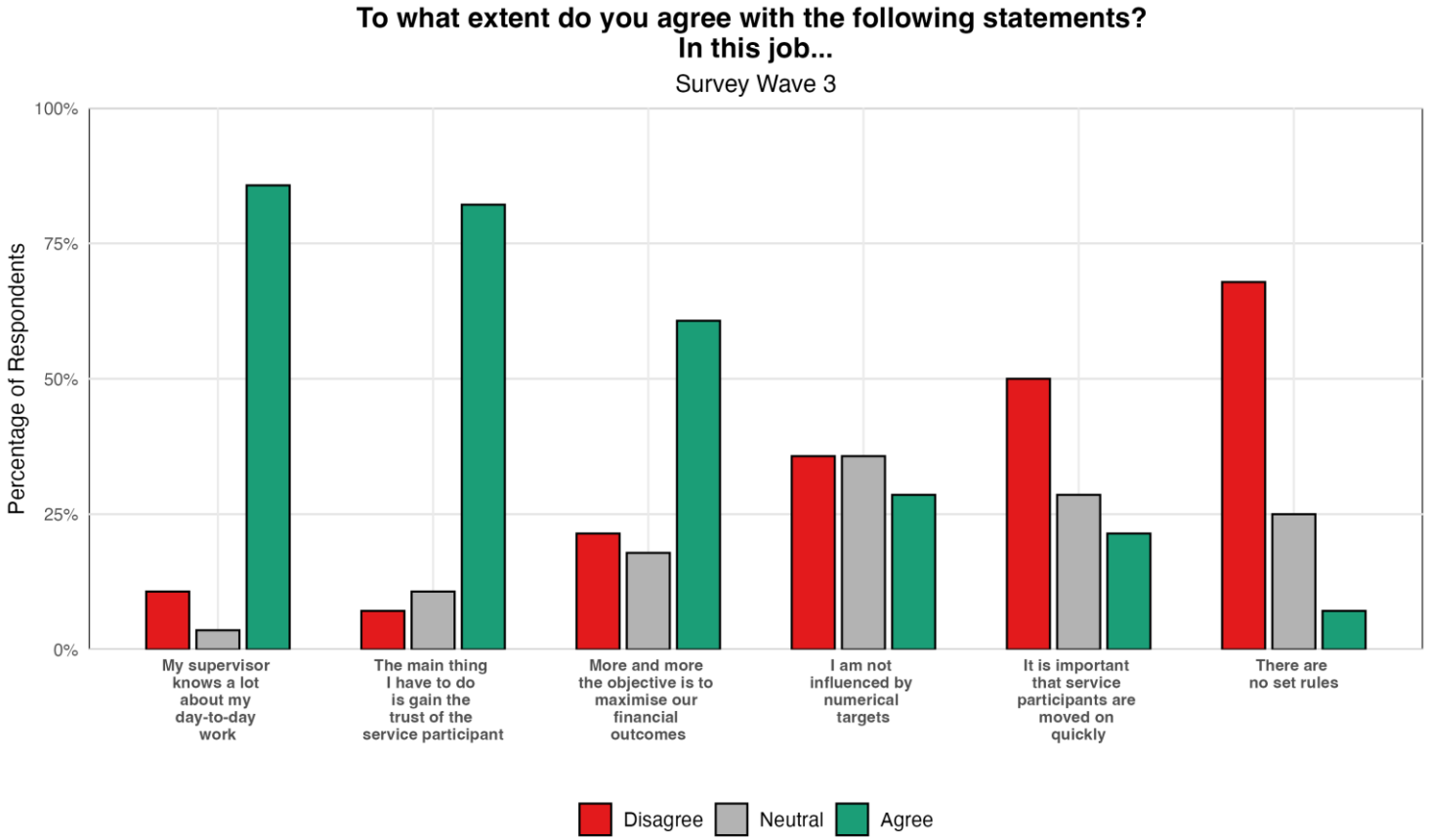

To what extent do you agree with the following statements?
In this job...
Survey Wave 3
Percentage of Respondents
100%
75%
50%
25%
0%
My supervisor knows a lot about my day-to-day work
The main thing I have to do is gain the trust of the service participant
More and more the objective is to maximise our financial outcomes
I am not influenced by numerical targets
It is important that service participants are moved on quickly
There are no set rules
Disagree
Neutral
Agree

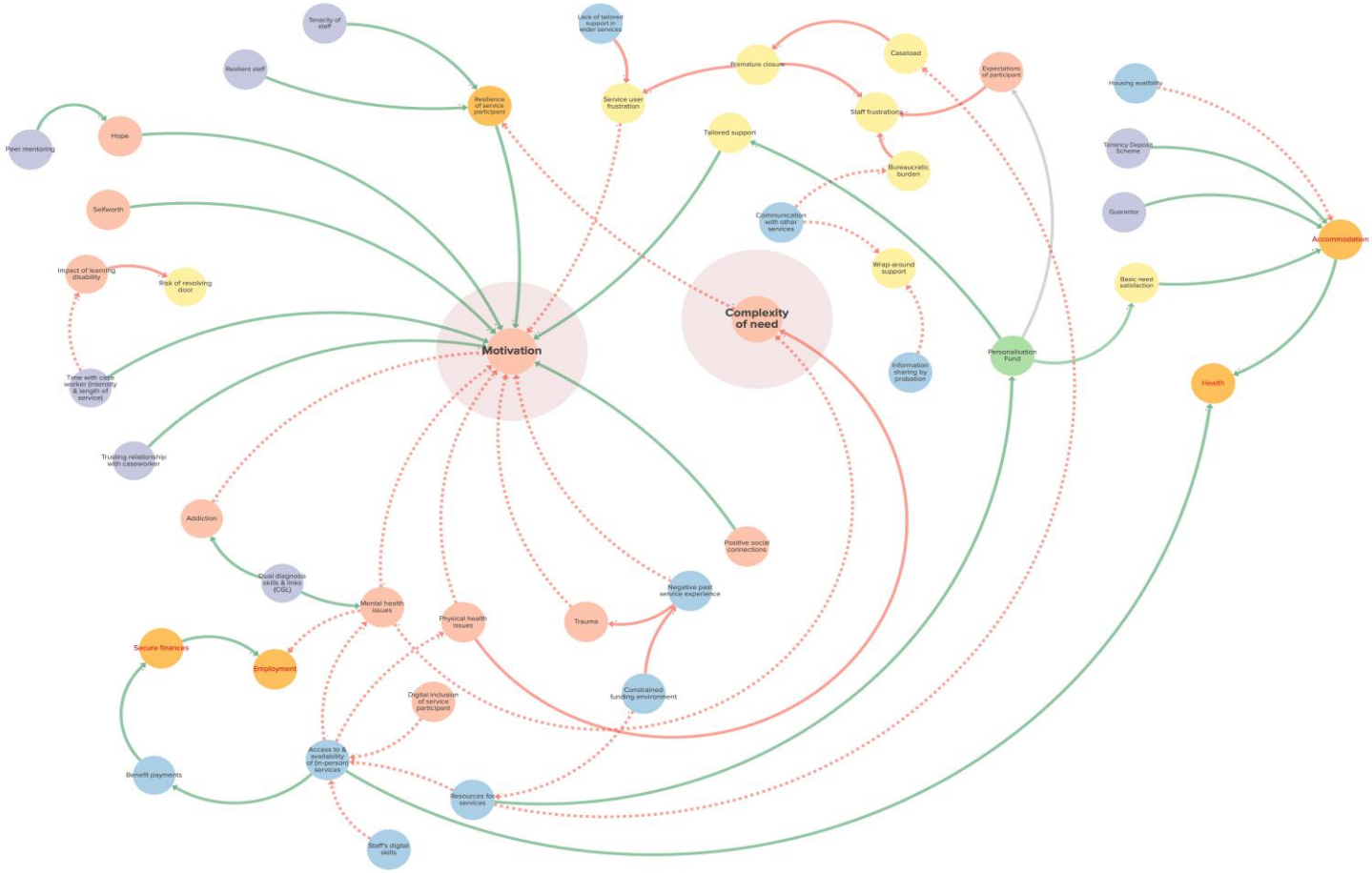
Table K.4.

In an average work week, what percentage of your time do you spend:				
Survey wave (N)	Mean % of time	Standard Deviation	N respondents	p-value
In direct contact with service users?				
FSS Wave 1 (57)	55.146	14.094	41	Wave 1 vs Wave 2: p = 0.009** Wave 1 vs Wave 3: p = 0.068
FSS Wave 2 (47)	43.833	18.326	36	Wave 2 vs Wave 1: p = 0.009** Wave 2 vs Wave 3: p = 0.505
FSS Wave 3 (41)	45.690	18.036	29	Wave 3 vs Wave 1: p = 0.068 Wave 3 vs Wave 2: p = 0.505
Working with other voluntary sector service providers?				
FSS Wave 1 (57)	8.683	5.164	41	Wave 1 vs Wave 2: p = 1.000 Wave 1 vs Wave 3: p = 1.000
FSS Wave 2 (47)	9.500	7.280	36	Wave 2 vs Wave 1: p = 1.000 Wave 2 vs Wave 3: p = 1.000
FSS Wave 3 (41)	9.655	6.747	29	Wave 3 vs Wave 1: p = 1.00 Wave 3 vs Wave 2: p = 1.000
Working with public sector service providers (eg health)?				
FSS Wave 1 (57)	7.244	4.048	41	Wave 1 vs Wave 2: p = 0.320 Wave 1 vs Wave 3: p = 0.963
FSS Wave 2 (47)	10.083	6.712	36	Wave 2 vs Wave 1: p = 0.320 Wave 2 vs Wave 3: p = 0.320
FSS Wave 3 (41)	7.759	5.636	29	Wave 3 vs Wave 1: p = 0.963 Wave 3 vs Wave 2: p = 0.320
Working with employers?				
FSS Wave 1 (57)	3.317	5.241	41	Wave 1 vs Wave 2: p = 0.042* Wave 1 vs Wave 3: p = 0.492
FSS Wave 2 (47)	7.417	10.554	36	Wave 2 vs Wave 1: p = 0.042* Wave 2 vs Wave 3: p = 0.492
FSS Wave 3 (41)	6.000	10.257	29	Wave 3 vs Wave 1: p = 0.492 Wave 3 vs Wave 2: p = 0.492
On general administration?				
FSS Wave 1 (57)	25.610	10.839	41	Wave 1 vs Wave 2: p = 0.683 Wave 1 vs Wave 3: p = 0.683

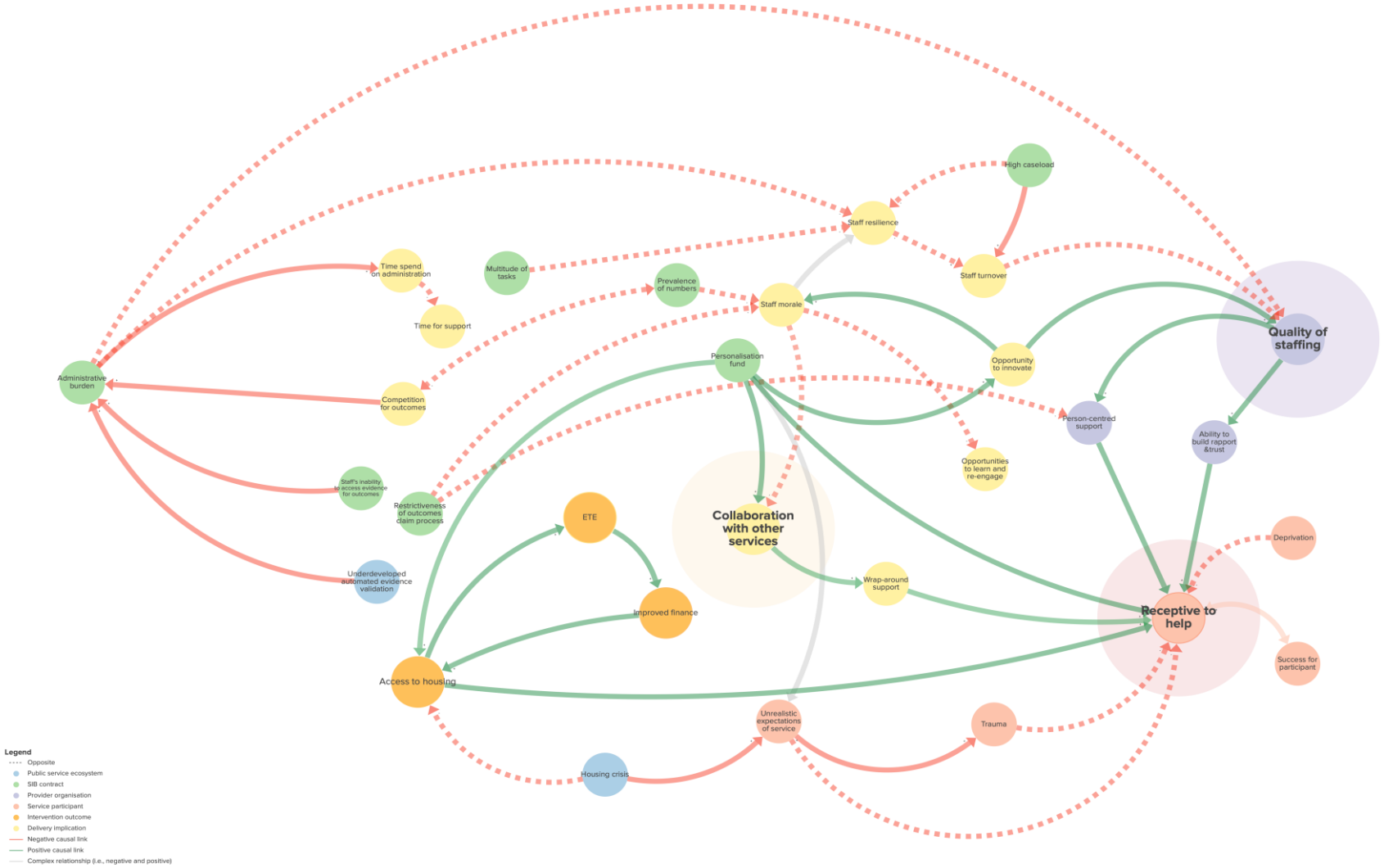
FSS Wave 2 (47)	29.167	15.834	36	Wave 2 vs Wave 1: p = 0.683 Wave 2 vs Wave 3: p = 0.867
FSS Wave 3 (41)	30.897	15.453	29	Wave 3 vs Wave 1: p = 0.683 Wave 3 vs Wave 2: p = 0.867
An asterisk denotes that the change in responses is statistically significant between survey waves at the .05 level.				

L. ADDITIONAL SYSTEM MAPS

The following system maps visualise the various interconnected factors that providers identified during the mapping workshops. They capture the relationships between key elements influencing service delivery, as perceived by both managers and frontline staff. They illustrate how contractual mechanisms, governance structures, frontline practices and external conditions interact to shape outcomes, offering a visual representation of the complexities involved in programme implementation.



Systems Map 1. Index: *circles*> blue = public service ecosystem; green = SOP contract; purple = provider organisation; pink= service user orange= intervention outcome; yellow= delivery implication; *arrows*> red= negative causal link; green= positive causal link; a *dotted* line signifies that if one factor increases, the other decreases (and vice versa). The system map was created with provider E.



Systems Map 2. Index supplement: a *dotted* line signifies that if one factor increases, the other decreases (and vice versa). The system map was created with provider H.

M. TABLE OF ACRONYMS AND GLOSSARY

Acronym	Definition
BAME	Black, Asian, and Minority Ethnic
CEO	Chief Executive Officer
DCMS	Department for Culture, Media and Sport
DWP	Department for Work and Pensions
ETE	Education, Training and Employment
GO Lab	Government Outcomes Lab
GP	General Practitioner
HMP	Her Majesty's Prison
HMRC	His Majesty's Revenue & Customs
IPS	Individual Placement and Support
KBOP	Kirklees Better Outcomes Partnership
KPIs	Key Performance Indicators
LCF	Life Chances Fund
MHCLG	Ministry for Housing, Communities and Local Government
NHS	National Healthcare Service
PIN	Performance Improvement Notice
PIP	Performance Improvement Plan
SOP	Social Outcomes Partnership
SPV	Special Purpose Vehicle
VCSE	Voluntary, Community, & Social Enterprise

Block payments: Payment are made for the service, regardless of outcomes. Block payments have been used in traditionally commissioned contracts in health and social care. It is payment made to a provider to deliver a specific yet broadly defined service, made on a regular basis. Typically, they do not provide incentives for improved care. Historically it is the most common payment system in the NHS.

Cap Social outcomes contracts often use caps to establish a maximum monetary limit on outcome payments. Caps can be designed in several forms. For instance, some social outcomes contracts include caps at the outcome level (ie: In Hounslow, Enhanced Dementia Care Service capped the payment of 'completion of integrated care plans' at 300 outcomes. Although they achieved more integrated care plans, they only got paid for 300.) Other contracts include caps at the participant level. In Midlands Regional Pause Hub, the outcome 'engagement with the Pause programme' can be achieved up to 10 times by one individual.

Cohort The targeted population of beneficiaries or service users.

Commissioning The cyclical process by which entities assess the needs of people in an area, determine priorities, design and contract appropriate services, and

monitor and evaluate their performance. This term is used widely in the UK public sector context, but less so elsewhere. It is sometimes used interchangeably with 'contracting.'

CDPSoft The 'Customer Data Platform Software' is the central referral and case management system, accessible to all parties involved in the KBOP project. It is administered by Kirklees Council.

DCMS The Department for Culture, Media and Sport (DCMS) is a department of the United Kingdom government. It hosts the Civil Society and Youth Directorate and VCSE Public Sector Commissioning Team (formerly the Centre for Social Impact Bonds), which holds policy responsibility for this policy area within UK central government. In 2016, DCMS launched the Life Chances Fund (LCF), within which it acted as the central government outcome payer.

DCMS Data Portal A dedicated data portal (created and owned by DCMS) set up for social outcomes partnerships within the LCF to capture detailed baseline and performance data for individual SOP projects. It aimed to facilitate a more streamlined application process and grant management. The portal supported outcome and payment reporting and grant management by The National Lottery Community Fund, as well as the GO Lab evaluation activity.

Fee-for-service contract In a fee-for-service (also known as fee-for-activity) model, a particular service is specified by the commissioning organisation, and providers are paid to deliver that service. Payment levels may be informed by specific inputs or activities and the accountability focus is usually the activity that service users participate in.

Intermediary Social outcomes partnerships are often supported by experts that provide specific advice. These are typically all referred to as "intermediaries" but can encompass at least four quite different roles: consultancy to develop business cases, social investment fund managers, performance management experts, and special purpose vehicles.

Investment cost Investment costs refer to the cost of items such as setting up and maintaining a Special Purpose Vehicle (SPV), expenses related with setting up the investment, the return to social investors, etc.

Investment Fund Manager Responsible for providing the project finance and managing the investment strategy on behalf of the social investors.

KBOP partnership The KBOP partnership constitutes the alliance of service providers and the social prime.

Key Performance Indicator Contractual terms – in this case between the social prime and the individual provider organisation – defining monthly targets (new starts on service, referral numbers, outcome achievements) for providers.

Legacy contract See Fee-for-Service Contract

Life Chances Fund The LCF was launched as an £80m outcomes fund committed in 2016 by UK central government (DCMS) to tackle complex social problems. It provided top-up contributions to locally commissioned outcomes-based contracts involving social investment, referred to as social outcomes partnerships (SOPs). The overall fund spend of the LCF was reduced to £70m from £80m as part of the DCMS budget negotiations in September 2020. This did not affect the ability to deliver existing commitments to projects in the Fund.

Management cost In the End of Grant Form, projects were required to report the total cost of their projects and the distribution of this cost across investment, delivery, management and evaluation and learning. In management cost, projects included the cost of items such as cost of coordination and oversight personnel, cost of performance management systems, financial management systems, cost of resources spent on governance discussions and partnership building, etc.

Outcome payment Total amount of outcome payments that could be paid to a project if all potential outcomes were achieved. Practitioners often refer to the maximum potential outcome payment as the 'contract cap' or the 'size of contract'. Also referred to as outcomes-based payments.

Outcome (outcome metrics/outcome payment triggers) The outcome (or outcome metric) is a result of interest that is typically measured at the level of service users or programme beneficiaries. In evaluation literature, outcomes are understood as not directly under the control of a delivery organisation: they are affected both by the implementation of a service (the activities and outputs it delivers) and by behavioural responses from people participating in that programme. Achieving these outcomes 'triggers' outcome payments within an outcomes contract or SOP arrangement.

Outcomes-based contract (OBC) 'Outcomes' can feature in a contractual arrangement in a range of ways. Typically, an outcomes-based contract is understood as a contract where payments are made wholly or partly contingent on the achievement of pre-defined and measured outcomes. Also known as an outcomes contract.

Outcomes fund Outcomes funds pool capital from one or more funders to pay for a set of pre-defined outcomes. Outcome funds allow the commissioning of multiple social outcomes partnerships under one structure. Payments from the outcomes fund only occur if specific criteria agreed ex-ante by the funders are met. Recent examples of outcome funds in the UK include the Refugee Transitions Outcome Fund (hosted by the Home Office), Commissioning Better Outcomes Fund and the Life Chances Fund, both administered by the National Lottery Community Fund.

Outcome metric Outcome metrics are the specific ways the commissioners choose to determine whether an outcome has been achieved. Outcome metrics often encompass a single dimension of an outcome. For example, the outcome metric for an employment outcome can be a job contract. In the Life Chances Fund, outcome metrics are referred to as 'payment triggers', as they trigger a payment for a project.

Outcome payer The organisation that pays for the outcomes in an outcomes contract or social outcomes partnership. Outcome payers are often referred to as commissioners or outcome funders.

Outcome payment Payment by outcome payers for achieving pre-agreed outcomes. Payments may be made to a special purpose vehicle or management entity in an impact bond or to service providers in other forms of outcomes-based contracts.

Payment trigger In the Life Chances Fund, projects were required to establish a list of outcomes that they would pursue. Each outcome should be attached to one or more payment triggers. These payment triggers indicate the concrete action or activity that must occur and be evidenced for a project to consider that an outcome has been achieved and should be paid. Payment triggers often include a clear timeframe for the outcome to take place. For the project Future Impact, the outcome 'young person progresses in employment and/or volunteering' is associated to the payment triggers 'individual enters into volunteering', 'individual sustains volunteering for 13 weeks', 'individual sustains volunteering for 26 weeks', among other payment triggers. Practitioners also refer to these payment triggers as outcome metrics.

Person-led service provision Service provision tailored to individual needs and wishes, enhancing user choice.

Payment by Results A way of delivering services where all or part of the payment is contingent on achieving specified results.

Provider Also known as service provider, service delivery organisation or delivery partner. A provider can be a private sector organisation, social enterprise, charity, NGO or any other legal form.

Rate Card A schedule of payments for specific, pre-agreed outcome measures that a commissioner (outcome payer) is willing to make for each user, cohort or specified improvement that verifiably achieves each outcome.

Service provider Service providers are responsible for delivering the intervention to participants. A provider can be a private sector organisation, social enterprise, charity, NGO, or any other legal form.

Service users See Cohort.

Social impact bond (SIB) See SOP

Social Investor (or investor) An investor seeking social impact in addition to financial return. Social investors can be individuals, institutional investors, and philanthropic foundations, who invest through their endowment. In UK SOPs, these assets are often managed by 'investment fund managers' rather than the original investing institutions or individuals who provide the capital

Social outcomes partnership (SOP) While there is no single, universally agreed definition of social outcomes partnerships (often referred to as social impact bonds, SIBs, or social outcomes contracts, SOCs), they are best understood as cross-sector partnerships that bring organisations together in the pursuit of measurable social outcomes. Typically, SOPs are defined as contractual arrangements that have two key characteristics: (1) Payment for social or environmental outcomes achieved (an outcomes contract), (2) Up-front repayable finance provided by a third party, the repayment of which is (at least partially) conditional on achieving specified outcomes.

Social Prime A 'social prime' is an independent organisation that coordinates and oversees service delivery by multiple service providers as an intermediary. It mediates between the service providers and the contracting authority (Kirklees Council), advocating for the providers and co-developing solutions. Responsibilities include holding the contracts, tracking performance, and ensuring outcomes are met. It can also be known as a network orchestrator or a partnership co-ordinator. This is also sometimes referred to as an ecosystem orchestrator.

Special purpose vehicle (SPV) A legal entity (usually a limited company) that is created solely for a financial transaction or to fulfil a specific contractual objective. Special purpose vehicles have sometimes been used in the structuring of **social outcomes partnerships**

Strengths-based approach This is a form of person-led service provision which seeks to increase service users' ownership of the support process by encouraging each person participating in a service to centre their strengths and ambitions as they journey beyond formal service provision.

Target When awarded funding by the Life Chances Fund, projects had to complete a 'Grant Baseline Form'. In this form, they were asked to report baseline targets for every outcome that they were expected to achieve. These targets indicate the amount of outcomes that a project could potentially achieve in a best-case scenario.

The National Lottery Community Fund (TNLCF) TNLCF, previously legally named the Big Lottery Fund, is a non-departmental public body responsible for distributing funds raised by the National Lottery. TNLCF aims to support projects which help

communities and people it considers most in need. TNLCF managed the Life Chances Fund on behalf of DCMS.

Voluntary, community and social enterprise (VSCE) sector A 'catch all' term that includes any organisation working with social objectives ranging from small community organizations to large, registered charities operating locally, regionally and nationally.

Government Outcomes Lab
Blavatnik School of Government
University of Oxford

golab.bsg.ox.ac.uk