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RESEARCH

Do Policy Implementation Support Programmes Work? The Case of the Care Act 2014

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Context: Policy implementation is an often overlooked stage when policy is introduced. Too often the result is policy failure caused by overly optimistic expectations, implementation in dispersed governance, inadequate collaborative policy-making, and the vagaries of the political cycle.

The Care Act 2014 introduced the most significant change in social care law in England for 60 years. Given the complexity of the changes, the Department of Health and Social Care and its key partners introduced an Implementation Support Programme (ISP) to increase the likelihood of smooth implementation.

Objective: To assess the impact of the ISP on local implementation of the Care Act and develop a framework for understanding the requirements of a successful ISP.

Methods: Analysis was undertaken of the relevant theoretical and conceptual literature in addition to a review of support programmes for other national policies. The empirical study of the impact of the Care Act's ISP, conducted in six local authorities, focused on three levels of activity that shaped outcomes: national, regional and local. Data were collected through interviews with key stakeholders at each level.

Findings: The ISP enjoyed several successes including: helping to secure policy legitimacy, developing stakeholder engagement, sustaining political support, and ensuring the readiness of local implementation agencies.

Limitations: The empirical research was confined to six English local authorities which limits drawing general conclusions applicable to the whole country.

Implications: Little evidence exists on the value of ISPs. The research goes some way to closing the gap and offers provisional messages on their value to policy-makers and practitioners.

Keywords: Implementation support; policy failure; social care; local government

Introduction

Once policy has been developed and agreed upon, it requires implementation. This phase is rarely straightforward – indeed it has been termed the 'Achilles' heel' of the UK political system (Harris & Rutter, 2014). The idea of simply moving from one stable state to another as a result of planned change is widely acknowledged to be at odds with work on complex systems (Williams, 2015). Explanations for how and why policy does, or does not, become implemented include everything from the initial policy design to the resistance of the local population (Spillane et al., 2006).

Rather than just let policies drift into full or partial failure, governments are beginning to take an interest in ways in which the implementation of policy can be strengthened and supported. This interest includes improved preparation of a policy, its prioritisation, better tracking of policy to assess its impact, and – the subject of this paper – implementation support. Given the relative novelty of these types of approaches, little exists by way of an established evidence base testifying to their success or otherwise.

To help tackle this deficit, an evaluation of the Implementation Support programme introduced when the Care Act 2014 was passed in England, ending in the first quarter of 2016, was undertaken. Adult social care is a devolved matter and there is separate legislation determined elsewhere by the Scottish Government and Parliament, the Welsh Government and Assembly, and the Northern Ireland Executive and Assembly. The Implementation Support (IS) programme was confined to England, therefore the arrangements elsewhere in the UK are outside the scope of this study.

Following a brief overview of the Care Act and its purpose, and a few reflections on why implementation support merits attention, we present the key findings from our study. The study was one of a suite of research projects examining various aspects of the Care Act's implementation. It

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was conducted by a team based at the University of Kent and Newcastle University. The views expressed in this paper are those of the authors and not necessarily those of the National Institute for Health Research (NIHR), the Department of Health and Social Care (DHSC), or its arm's length bodies or other government departments.

The Care Act 2014

The term 'adult social care' is commonly used to refer to personal care and practical support for older people, adults with physical disabilities, learning disabilities, or mental health issues, as well as support for those caring for them informally. The use of the term has become established in most governmental, professional, and academic writing, largely replacing the former general terms such as 'personal social services' and 'community care' (Gray & Birrell, 2013). While earlier conceptions stressed the residual nature of support for those in greatest need, more recent formulations emphasise wider ideas of individual and collective wellbeing. Indeed, it was the very fact that this policy domain had been the subject of such change that new legislation to tidy, freshen, and overhaul the sector was thought to be required.

Within England, local authorities have responsibility for oversight of their local adult social care systems within a national framework of policy and legislation. Local care systems operate as mixed markets of provision.

The Care Act 2014 introduced the most significant and ambitious change in social care law in England for 60 years, fundamentally overhauling the entire care and support system for adults, older people, and their carers. It consisted of two phases, the first phase being introduced in April 2015 with phase 2 to be introduced in 2016. However, in July 2015 it was announced that Phase 2 (introducing a cap on care costs) was to be deferred until April 2020 and has since been abandoned. New proposals are expected in a Green Paper but this has been deferred in part due to the impact of the ongoing Brexit developments on government business and, more recently, of the COVID-19 pandemic. The delay is relevant insofar as it reflects a failure of policy implementation in an area of significant public concern.

The Care Act was seen as a significant part of a new approach to supporting adults with social care needs and the delivery of adult social care services. Its overarching objectives were to reduce reliance on formal care, promote people's independence and wellbeing, and give people more control over their own care and support. The Act was generally welcomed and achieved a high degree of consensus aided by a collaborative approach among the key partners who were intent on ensuring that the policy was made to stick when it came to implementation. Central to this commitment to implementation was the development of the Implementation Support (IS) programme noted above. Whilst all changes in policy, especially those of a complex nature, might benefit from some form of implementation support, it should be easier to achieve where the key parties are in agreement over the direction and objectives of the policy. This 'collaborative policy design' (Ansell et al., 2017) is the central feature of the Care Act IS programme. Before turning to it, we briefly reflect more generally on the nature of implementation support within public policy.

Implementation Support: Why is it Necessary?

Addressing policy failure and making policy stick by paying greater attention to implementation are becoming critical concerns, especially in the face of deep-seated and stubborn policy challenges that are increasingly acknowledged to be more complex and not subject to simple, linear solutions (Holmes et al., 2017). Four broad contributors to policy failure can be identified: overly optimistic expectations; implementation in dispersed governance; inadequate collaborative policy-making; and the vagaries of the political cycle (McConnell, 2015). We have elaborated on each of these contributors elsewhere (Hudson et al., 2019). They may be regarded as the implementation challenges that would have to be met by an implementation support programme of the kind with which we are concerned here. Certainly, the Care Act required expectations to be managed; governance to be in place at multiple levels – macro (national), meso (regional and strategic local authority), and local (service provider) levels; the active engagement of many different stakeholders; and a sustained commitment over time to ensure that the changes sought were sufficiently embedded. Building on McConnell's work, we developed an overarching framework to structure our analysis (see **Figure 1**).

Implementation support can take a variety of forms, with the mechanisms selected varying widely. They may, or may not, be measurable with some taking a visible, tangible form (e.g., regional meetings), some being of an experiential nature (e.g., inspiring leadership and/or management), and others being theorised (e.g., participation in regional meetings will facilitate 'x' and 'y'). Mechanisms are not 'things' (or mediators) but part of an account of causality which only works when explaining the context within which they operate, and the outcome to which they contribute (Emmel, 2013). The identification of mechanisms shaping policy implementation support is important as it aids explanations in regard to why interconnections should occur. In addition, mechanisms can be used to describe the causal relations within a system which generate uniformity (Pawson, 2008). By linking these levels of explanation, there is the opportunity to transcend the divide between top-down and bottom-up approaches towards policy implementation (Sabatier, 1986, cited in McEvoy & Richards, 2003).

Implementation support mechanisms can be identified as having one of three main purposes: managing and regulating; problem-solving; and capacity building (Gold, 2014). All three were evident in varying degrees in the IS programme which accompanied the Care Act 2014 and to which we now turn.

The Care Act 2014 Implementation Support Programme

Given the complexity of the changes introduced by the Care Act, the DHSC – known as the Department of Health at the time of the passage of the Act – and its key partners

decided that a comprehensive programme of implementation support should be put in place both to ensure legislative readiness and increase the likelihood of smooth implementation (Hughes & Caunt, 2013). Three principles were established which underpinned the support programme:

- *Clarity of expectations and requirements*: this was to cover the new legislative framework, financial issues, and the outcomes to be achieved, all of which were to be effectively communicated to meet the needs of different audiences.
- *Flexible products*: these were to be accessible and drawn upon in a way that met local needs.
- *Collaborative infrastructure*: one that supported collaboration at local, regional, and national levels through an ongoing two-way supportive dialogue. Underpinning this infrastructure was the close relationship established between the three key partners: the DHSC, the Local Government Association (LGA), and Association of Directors of Adult Social Services (ADASS), the latter two being national membership bodies for local authorities (LGA) and Directors within them (ADASS).

The arrangements put in place to deliver on these principles involved the establishment of three key organisational innovations: a Programme Board; a Delivery Board and Programme Management Office; and a regional infrastructure. While some aspects of these features of support had been present in other policy programmes, the main innovation was that stakeholders were partners, taking on responsibility and not just giving advice. **Figure 2** provides an illustrative overview of the programme structure established for implementing the Care Act (National Audit Office, 2015).

The Programme Board was upwardly accountable to the DHSC Major Programmes Board and had beneath it a Programme Management Office, a Support Delivery Board, and a raft of work streams. It had three key functions: support, assurance, and delivery. The Delivery Board had a much more hands-on role being tasked with driving timely and effective delivery; ensuring risks and other issues were identified and mitigated; and assessing data to monitor impact and drive the delivery of anticipated programme benefits. The Programme Management Office was established to support the work of the Board and was seen as central to the fulfilment of all three Board functions. In recognition of the potentially wide gap between central government and a multiplicity of local authorities, the decision was taken to develop a regional dimension to act as a conduit between regions and the Programme Management Office. The regional tier was not another organisational layer but amounted to some modest funding being found to support the regional leads who were left free to determine their own ways of working through networks of local authorities. Regional level support was anticipated to facilitate rapid dissemination of the latest tools and advice; increase the pace of local implementation; and link into assurance mechanisms where the local pace was thought to be falling behind. Organisationally this level of support was intended to build on arrangements for existing models connected with other programmes, such as Health and Wellbeing Boards (which bring together local health and care leaders to collaboratively improve outcomes for their populations), Transforming Excellence in Adult Social Care, and NHS Vanguards (sites leading the development of new models of care, some of which are overlaps of health and adult social care).

Criterion	Relative success	Conflicted attainment	Relative failure
Helping to secure policy legitimacy	Few challenges to the legitimacy of the policy from implementing bodies	Contested legitimacy with potential for long-term damage	Policy process deemed to be illegitimate and successful implementation unlikely
Developing stakeholder support	All key stakeholders support the policy and participate in support programmes	Patchy and uneven engagement amongst stakeholders; some key groups missing	Widespread resistance to engagement
Clarity of programme contribution	Aims of the implementation support process are agreed and understood	Some of the aims and activities of the support programme are unclear and/or contested	Little understanding or awareness of the support programme
Comprehension of complexity	A reputation for understanding the complexity of 'real-world' implementation	Only a partial understanding and awareness of implementation dilemmas	Perceived and as a remote agency with little understanding of the problems facing implementing bodies
Sustaining political support	Support programme has clear and sustained backing at the highest political levels	Uncertainty as to whether political support is being sustained over the implementation period	Support programme is undermined by waning political support and interest
Contributing to attainment of policy objectives	Evidence that the support programme has contributed to the achievement of policy objectives	Some evidence of policy success but uncertainty around the contribution of the support process	Both the policy itself and the implementation support process are unable to demonstrate achievements

Figure 1: A Framework for the assessment of implementation support programmes.

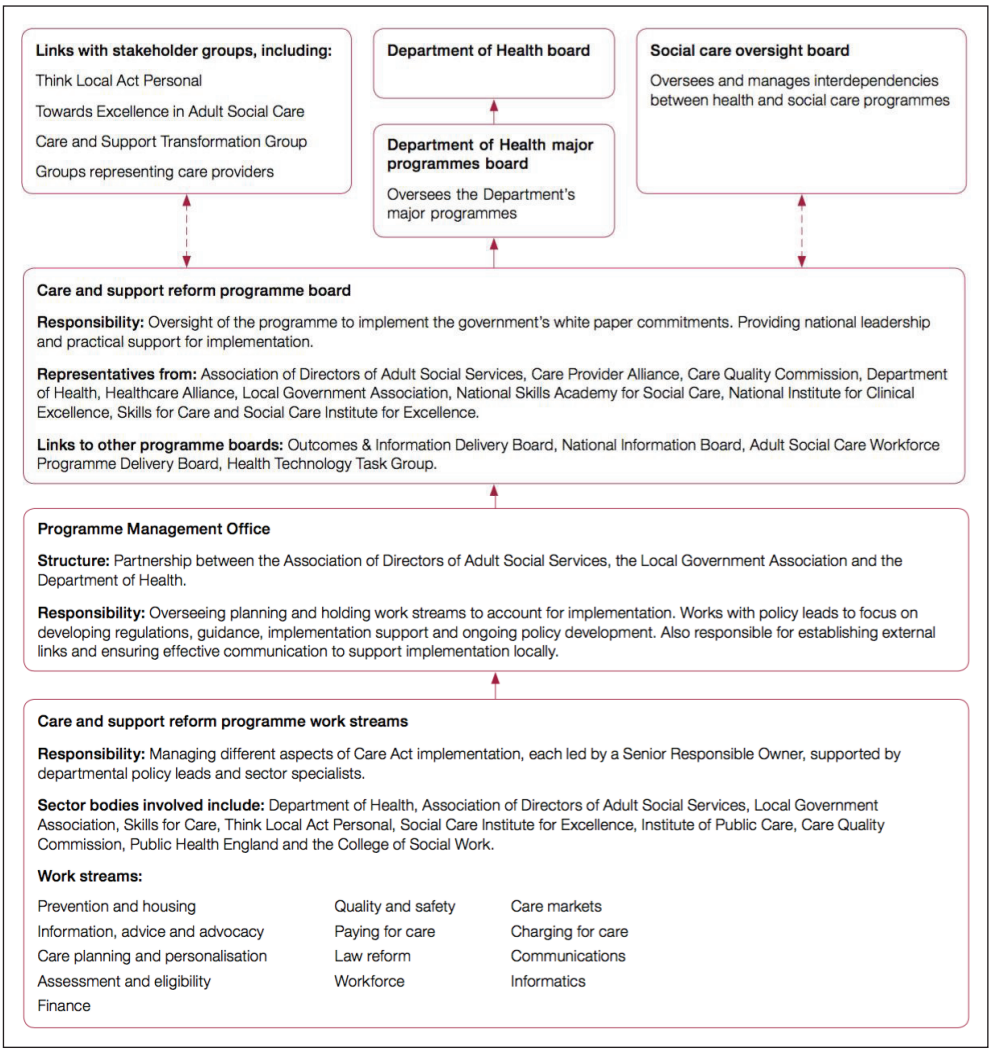

Figure 2: Programme structure for implementing the Care Act.

On the issue of the cost of the IS programme, the two stakeholders outside of the Department of Health (DH) – LGA and ADASS – funded their own input. In addition, DH made available modest funding to support the regional links. It may be worth noting, too, that the NAO (2015) raised no concerns about value for money in relation to the monitoring and support arrangements.

This brief descriptive account of the Care Act's IS programme is testimony to the seriousness with which the mission was undertaken at central level. It suggests a keen awareness of the potential danger of policy failure and a determination to avoid it in ways that could mark it out as different and distinctive. The need for implementation to be in the hands of a multiplicity of local agencies – statutory, voluntary, and independent – is a key feature of the context surrounding the Care Act. Although highly detailed statutory guidance (the epitome of a top-down approach) was produced, there was also an appreciation of the influence of local contexts and dispersed power bases and the need to take these into account.

Method

Our research, conducted between early 2017 and mid-2018 and funded by the DHSC Policy Research Programme, which comes under the auspices of the NIHR, focused on implementation support at three levels: macro (national), meso (regional and strategic local authority), and micro (local service delivery). Data were explored in three key areas: analysis of relevant theoretical and conceptual literature, a review of the support programmes (if any) for a number of previous and current national policy programmes, and an empirical study of the Care Act IS programme itself. In order to understand better the reasons for establishing the Care Act IS programme at national level, three data sources were utilised: documentary analysis of Care Act Programme Board minutes; information on Care Act Programme Board actions; and an analysis of 10 semi-structured interviews conducted with members of the Programme Board. A number of documents were produced for the Programme Board setting out 'visions and priorities' for implementation support, one of which provided a succinct explanation of the need for an IS programme:

> *A traditional approach to providing implementation support is unlikely to be able to meet the needs of all organisations given their breadth, role in providing social care and support and particular local circumstances. Similarly, those charged with implementation also have challenging financial constraints,*

> *other related policy issues such as Integration Transformation Fund, corporate requirements and/or partnership arrangements to address* (Hughes, 2013: p.1).

The document cites a number of advantages in having a distinctive implementation support programme, including collaboration among stakeholders, clarity in dialogue, and flexibility in the programme management tools. Additionally, capacity – in terms of resources and finance – is advanced as an issue that several organisations in the public sector face. There is also a recognition that '…no one single approach will be universally applicable to all involved and that a heavily directed approach would neither be well received nor taken up' (ibid:p.2).

To explore the issues arising at the meso (regional) level, interviews were conducted with five regional leads. At the micro (locality) level, six local authority case studies were undertaken which entailed interviews with senior managers, operational staff, and focus groups made up of service users and carers. The local authority areas were chosen to reflect the diversity present within English local government (see **Table 1**). Research approval was sought from the Association of Directors of Adult Social Services and granted on 21st July 2017, and HRA Social Services Research ethical approval for data collection with service users was obtained on 23rd February 2018 (Ref: 17/IEC08/0050). A final research report was published in late 2019 (Peckham et al., 2019).

Mapping Implementation Support in Other Policy Domains

As part of the preparations for the field work undertaken to assess the value and impact of the Care Act IS programme we conducted a rapid mapping exercise of other English policies with not dissimilar aims to those of the Care Act in order to understand what, if any, policy support had been made available. The aim was to establish if there were general lessons regarding how support processes may best be developed to aid the local implementation of national policy. It is perhaps notable that no published review of the issue of implementation support exists. The search strategy was guided by the knowledge and experience of the research team, and by the external advisory group which guided and informed the research. Five criteria governed the selection of policies: scale (was it a national policy applicable to local areas across the country?); purpose (was the focus on implementation support?); reach (was support extended to every locality?); learning (was there an evaluation or other evidence base?); and significance (did the policy have a statutory underpinning and guidance?). The mapping exercise initially identified fifteen policies which, after reviewing them against our selection criteria, led to a focus on five of these: the Community Care Support Force, Sure Start, Health and Wellbeing Boards, the Troubled Families Programme, and the NHS Vanguards. Although many of the policies themselves had been subject to an independent evaluation, few of the studies detailed the approaches of implementation support (if any) that had been offered. Further information about the rapid review can be found in Chapter 3 of the final research report (Peckham et al., 2019).

In the light of our rapid review of other policies, the main conclusion to draw is that implementation support has tended to be regarded as somewhat marginal to successful policy implementation – at best a useful accessory, but not thought to be central to the success of a policy. Such a finding, although disappointing, serves to underscore the importance of our study of implementation support in regard to the Care Act.

Against this context of the availability of implementation support in other policy domains, the Care Act IS programme was both unusual and distinctive. Although the other policies we examined shared some of the same approaches to implementation support, the Care Act employed a more extensive range of support mechanisms in order to address every aspect of implementation (e.g., nationally produced guidance, regional level working groups, training, stocktake reporting mechanisms). It was also widely welcomed and not considered to be burdensome or an unhelpful imposition.

Finally, and perhaps not so surprising given the limited attention it has received, our mapping of other policies, and the implementation support provided, shows

Table 1: Case studies.

Local authority case study	Population size (2017)	Urban/rural
North East metropolitan district unitary authority	200–300,000 ***percentage 65years+*** – 17%	***Urban/rural split*** – 99%/1%
Smaller northern unitary authority	100–200,000 ***percentage 65years+*** – 19.5%	***Urban/rural split*** – 68%/32%
Northern metropolitan district council	300–400,000 ***percentage 65years+*** – 17%	***Urban/rural split*** – 82%/18%
Large southern county council	over 1 million ***percentage 65years+*** – 17.9%	***Urban/rural split*** – 72%/28%
Rural eastern county council	100–200,000 ***percentage 65years+*** – 19.8	***Urban/rural split*** – 61%/39%
London Borough Council	200–300,000 ***percentage 65years+*** – 10.3%	***Urban/rural split*** – 100%/0%

negligible learning from the type of IS programme we have described in respect of the Care Act. The implementation of each policy has proceeded in separate silos, seemingly oblivious to, and unaffected by, what has happened (or not happened) in other policy areas. However, there are some glimmers of hope which suggest that this compartmentalised approach to policy implementation may be shifting with evidence of a growing interest in learning from implementation support approaches. This was especially notable in the development of the respective support programmes for the Care Act 2014 and NHS Vanguards initiative (Billings et al., 2019; Checkland et al., 2019; Coleman et al., 2020). In the case of the latter, this research commenced upon completion of our study of the Care Act IS programme and was informed by our work. Findings from our study are echoed in those emerging from the Manchester-based Vanguards study.

The Care Act Implementation Support Programme: Did it Work?

The findings from our research are structured around the six criteria set out in the assessment framework based on McConnell's work (see **Figure 1**):

1. *Helping to secure policy legitimacy*: to understand how far, and in what ways, the creation of the IS programme had itself helped to shape the legitimacy of the policy, namely, the Care Act 2014. In some important respects the quest for policy legitimacy around the Care Act was facilitated by the general view that parts of the legislation consisted of legal 'tidying', bringing together separate requirements that had accreted since the 1948 National Assistance Act. Other parts of the Act were more challenging requiring, for example, a new focus on wellbeing, prevention, self-care, and market-shaping. The most visible manifestation of policy legitimacy at a national level was the signing of a memorandum of understanding (MoU) between the DHSC, LGA, and ADASS. The MoU was proposed, in the words a senior civil servant, to '…document this vision for co-ownership of the programme'. Another senior civil servant claimed that the MoU provided legitimacy through the '…formalisation of joint working'. Finally, it also provided for a degree of transparency to the joint working arrangements between stakeholders.

   For the purposes of securing legitimacy at the meso (regional) level, the importance of the Regional Coordinator role was highlighted. It was viewed as an essential 'go-between' from the centre to the local providing, as one regional coordinator put it, the '…conduit from the centre through into the regions and out into councils' and facilitating rapid information exchange. In addition to intensive collaboration between the macro and meso levels, the funding made available at regional level, although not substantial, was crucial to the success of the implementation process. At a time of austerity which hit local government finances especially hard, the implementation funding 'made a lot of difference' according to a regional coordinator.

   At the micro (local) level, it is important to emphasise that the concepts underlying the Care Act already had widespread support within many local authorities. To that extent the Act could be regarded as going with, rather than against, the grain of organisational and professional thinking. The information flow between all three levels – national, regional, and local – was praised and viewed to be very much a two-way process. The engagement of the LGA and ADASS was especially welcomed since it meant that the messages being communicated to the local level had been developed with the wider policy field and not just within DHSC. This wider engagement from bodies with 'clout' helped to secure policy legitimacy at the local level. National communication tools were well-received in the main and avoided the need for reinvention locally.

   To some extent, the marked degree of consensus around the Care Act and its aims and objectives limit what can be learned from this particular case study about the value of implementation support programmes. However, the existence of a policy consensus should not be equated with a 'simple' implementation path. The Care Act represented a formidable challenge to established ways of working and this complexity constituted the justification for creating the IS programme. Our fieldwork suggests that the support arrangements were successful in helping to secure legitimacy for both the Care Act and for the support programme itself. Although there were some concerns about detail and practicality, there was little or no suggestion that the support programme was unnecessary, unwanted, or in any way lacking in legitimacy.
2. *Developing stakeholder support*: the nature and extent of stakeholder engagement, including whether all key partners had been involved and the terms of their engagement in the IS programme. As noted above in terms of securing policy legitimacy, our fieldwork suggested that the relationship between the three key national stakeholders (DHSC, LGA, and ADASS) was highly successful. This is not an achievement that should be taken lightly – the national, local, and professional voices in social care have often been in disagreement over the general direction of social and economic policies. A key aspect of this relationship was the decision to engage the key stakeholders in the policy *design* process as well as the policy *implementation* arrangements, thereby enabling a degree of co-production of the policy from the outset. As a Director of Adult Social Services commented, it was a '…genuinely collective effort', which heralded a new approach for social care. In the words of a local government national officer, the approach gave rise to '…more rounded thinking'. Nevertheless, this respondent made the point that the partnership was only '…collaborative up to a point and then [DHSC] ownership sometimes did kick in'.

   At regional and local levels there was a positive response to the development of stakeholder support.

An operational staff member expressed it in these terms: '...we're all learning different languages, different agendas, different roles, how can we pull all this together and do something collectively, rather than each of us having to go through the same learning process, can we speed it up because we haven't got very long to do it in...'.

Securing a workable balance between the legislative authority and the implementing agencies is a complex area. It was clear to all involved that ultimate authority lay with the DHSC and that compliance with law, regulation and guidance was the bottom line. Yet this *primus inter pares* status was rarely raised as a problem by other stakeholders. There was little or no reservation expressed about how this model had worked out in practice and we were not able to identify any comparable achievement in other policy domains. The incorporation of a regional support mechanism generally served to strengthen these achievements, especially by drawing upon networks of local stakeholders. Only a few interviewees expressed problems with the development of stakeholder support and these concerned patchy and/or uneven support and problems with bringing in external consultants who did not always understand local context. Overall, the Care Act IS programme scores highly when assessed against stakeholder engagement.

3. *Clarity of programme contribution*: to understand more about two things – whether effective use was made of the implementation 'products' commissioned by the programme, and whether there was clarity over the aims of the support programme. A battery of products – guidance, events, factsheets, and more – was rapidly commissioned by the programme and offered, or distributed to, the implementing agencies. These flows of information were widely seen as helpful in averting the need for implementing localities to create their own products for local consumption. The experience and profile of the regional lead was regarded as important in terms of the clarity of the programme contribution. Having experience of local government in order to be able to provide effective leadership was viewed as especially important.

   However, there are bound to be limits over the extent to which centrally commissioned support products and other arrangements can meet all of the eventualities likely to be encountered at local level. In view of this, and not surprisingly, concerns were raised about timeliness, customisation to local contexts, and the extent to which the products filtered down to operational staff. Across the case study sites, a mix of approaches to implementation was discernible. While some areas relied heavily on regional level support, others did not appear to engage with the region but instead opted to use the national products to provide clarification on implementation. There were also issues over the length of time support arrangements were in place. Many valued them not only in the short-term, but also felt they had value longer-term. As a local operational staff member commented: '...I think what's interesting is that the necessary resources just went up to the inception [of the Care Act]. I don't think any thought has been given to whether there are any resources you now need to ensure it's embedded'. This was endorsed by a senior manager who suggested that after a couple of years or so it would be useful to assess 'what's worked, what hasn't and what support can we do to try and shift upstream because you're all too focused downstream still'.

   When it came to clarity over the aims of the support programme, the key tension was between a perception of the programme as helping localities to solve problems and build implementation capacity on the one hand, and managing performance on the other. These two elements – carrot and stick – do not sit easily together. They conflicted most prominently in relation to the 'stocktaking' exercises where local authorities were required to self-assess their preparedness for Care Act implementation on a wide range of dimensions. From the perspective of the centre – and perhaps especially at a political level – the stocktake findings could be viewed as necessary indicators of progress that could justify investment in the IS programme. On the other hand, localities could – and often did – view them as a means of unwanted attention that could result in some form of 'naming and shaming' exercise. This led to some element of 'gaming' whereby local authorities assessed themselves as neither doing well or badly in order to avoid attracting attention. Implementation support programmes will arguably struggle to achieve their aims if the agencies they are designed to support feel uncertain about the true purpose of their intentions.

4. *Comprehension of complexity*: extent to which the support programme was felt able to get to grips with the realities of implementing a complex policy. It is well known that successful change is at least as much (if not more) about bottom-up behaviour than top-down prescription; that local contexts (history, tradition, culture, personalities) can filter out standardised expectations and requirements; and that most policies – and certainly this one – are characterised by complexity rather than simplicity. In short, there is an issue around the ways in which an implementation support programme understands and responds to the complexity of the implementation environment. This is especially evident where local government is concerned since it can lead, in the words of a senior civil servant, to a '...clash between national accountability and democratic local authority'. The issue was compounded in the case of the central team which had little experience of working with local authorities. Another aspect of the complexity surrounding the implementation of the Care Act was the dual roles of the LGA and ADASS acting simultaneously as partners and lob-

byists. A senior civil servant expressed the problem in these terms: '…there was this wonderful situation where we were working as a partnership within a programme context but outside the programme you would have lobbying…so sometimes it was difficult… for example where they are being torn in two different directions'.

It is unrealistic to expect a national government department to be in touch with, and have a detailed understanding of, around 150 local implementation agencies (councils) each with its own history, culture, and democratic governance. Indeed, when national representatives were despatched to speak to localities there were some concerns expressed about a lack of credibility. It was for this reason that a decision was taken at national level to insert a regional dimension into the national support programme. Some modest funding was found to establish this level of support and by and large the regional leads were left free to determine their own ways of working. The regional input also allowed local authorities to find out what their peers were doing and what lessons could be learned. The regional leads were well-placed to circulate knowledge and secure local authority 'buy-in'. As a regional coordinator noted: if the programme was locally developed then local authorities would be '…more willing to put the time in because they've chosen those priorities'. It helped if the regional leads understood the pressures directors of adult social services were under which could affect how far they struggled with implementation or were able to make rapid progress.

In view of the above comments, it is perhaps not surprising that our fieldwork suggested that in some localities the regional tier ended up having a significance that far exceeded expectations. Where they worked well, the regional leads were highly regarded with expressions such as 'the driving force' and 'breathing life' into the implementation process being used. With their local knowledge, for example, regional leads could be in a position to explain why some localities might be faring better or worse on the stocktake exercises; in doing so they would also be better placed to offer tailored support.

Such was the popularity of the regional support mechanism in our northern fieldwork sites that we also heard calls for its continuation into the post-implementation stage, even for consideration to be given to a permanent forum for implementation, improvement, and innovation. Much depends here upon the skills and experience of those working at this level. Working in the interstices between central government and local implementation agencies, acting as the eyes and ears of both levels, is a complex task. We heard recurring reference to some of the required personal qualities such as trust, knowledge, experience and professional credibility. We know that such skills are not in plentiful supply. There are some important issues to be unpicked here around developing the right skills for such roles to be undertaken.

At a local level, there could still be tensions between a national aspiration for a 'bells and whistles' implementation and those local authorities preferring a more minimalist approach in order to ensure 'compliance'. As a senior manager put it: '… you would get central [DHSC and LGA] talking best practice and, really, encouraging everybody to go full out. And it took quite some soul searching to say it's OK to just be compliant in some areas'.

Some of our field site local managers felt that the complexities of implementation were not fully grasped by the centre. In particular, tight timescales for understanding and implementing the reforms posed a challenge. A senior manager reflected that '…it was quite hectic for staff. There was a lot of learning that they needed to undertake, a lot of workshops that they needed to attend which were compulsory… . So, at the time I think it was quite stressful for staff. They were quite anxious…'.

It can be said that the Care Act IS programme created many issues for local authorities particularly in regard to the appropriate timing of support from the centre and how far the programme understood and was able to respond to the complexity of the implementation environment. As noted, the regional level was critical in bridging and mediating between the national and local levels.

5. *Sustaining political support*: degree to which the policy has the support (or at least the acquiescence) of legislators in order to come to fruition. Our fieldwork was limited by the absence of contact with national level politicians, though we did include the major national figures at a non-political level. It is understandable that politicians will want evidence that policies in which they have invested are producing 'results'. In the case of the Care Act, the most obvious means of such confirmation was the results of the stocktake exercises and, as indicated above, this conflation of the support and performance management roles of the support programme was a source of consternation for localities. However, more nuanced messages could – and were – sent to ministers from the Programme Board, and responses were received. To this extent the very existence of the IS programme could be said to have helped sustain political support by keeping open channels of communication between political and non-political actors.

   There was little discussion of sustaining political support at the local level for the Care Act an acknowledgement, perhaps, that it was a piece of national legislation which had already gained high level support. It was therefore taken as a given that it would be implemented at local level and did not require further political support at that level. Although we undertook fieldwork with local authority cabinet leads, we were unable to discern any clear local strategies for political support of the legislation.
6. *Contributing to attainment of policy objectives*: extent to, and the ways in, which the IS programme

assisted in contributing to the attainment of policy objectives. This proved difficult to ascertain in this case given that the IS programme was not designed to ensure the policy made progress in achieving its ends; rather it was timetabled to cease once the legal deadlines for implementation had been reached. This means the IS programme could only reasonably be assessed on the narrower indicator of ensuring 'implementation readiness' on the part of the responsible agencies.

Notwithstanding some of the difficulties identified in our fieldwork, it is fair to conclude that the programme did significantly help to ensure implementation readiness. One operational staff member commented on how the Care Act 'oiled the wheels in terms of giving us greater momentum behind those changes in terms of which we were already moving towards that emphasis on prevention, early intervention, giving people the skills so they could function more independently…'. Some of our respondents at local level felt that elements of the Care Act were better supported than others. For example, despite the centrality of prevention and wellbeing as underpinning principles of the Act, they were not always perceived to be to the fore within the support provided. No reasons were identified for these gaps.

The most commonly expressed concerns were about the mismatch between the ambitions of the legislation and the impact of severe funding restrictions on local authority spending. We encountered strong feelings that the austerity programme was rendering unattainable the key operating principles of the Care Act, such as independence, wellbeing, and prevention; rather, localities felt they were being effectively confined to responding to crisis situations. A local operational staff member put it in the following terms when talking about the impact of austerity on implementation: 'the current trick, of course, which is a very neat trick of central government, is to sort of talk about localism and say well what we think is local authorities are better placed to do this. And they'll give you the power and the responsibility and maybe a quarter of the money or a half of the money. And quite rightly people are going like well I blame the local authority. It's sort of an underhand trick that's been done on everybody'. This criticism highlights the difficulties that arise when a policy that is collaboratively designed, popular with the receiving audience, and supported by an implementation programme is not properly funded to achieve its objectives. An implementation support programme, no matter how good, may be best regarded as a necessary but not a sufficient factor in securing policy objectives.

Discussion

From the outset it was acknowledged that the Care Act was a complex and ambitious piece of legislation and that implementation would not be easy, especially being dependent on diverse contexts and the involvement of multiple stakeholders each presenting specific challenges well identified in the policy literature (Davies et al., 2008, Russell et al., 2008). The approach adopted in the Care Act IS programme built on the collaborative nature of the development of the Act itself and involved key national stakeholders working in partnership to develop and support the implementation process. The range of support mechanisms employed within the implementation approach set the Care Act apart from previous policies reviewed in this study and briefly described earlier.

Four key concerns guided the research:

- How the Care Act IS programme may support the redesign of local services and systems to improve the provision of care and support, to improve quality and reduce risks to delivery;
- How, and to what extent, centrally commissioned or developed implementation support, including the Care Act IS programme, is supporting local changes;
- Identifying effective practice in implementation, and 'what works' in terms of service redesign and provision; and
- Identifying potentially transferable lessons that may be useful or relevant to other local government reform programmes.

These concerns need to be viewed through a complex adaptive systems lens since the context, or system, within which a policy is implemented is never static. Systems are viewed as self-organising and emergent from within complex structures and there is therefore a need to comprehend and interpret the relationships between the elements which make up the 'system' in order to understand 'what works' (Westhorp, 2012). Within a complex system, interactions are generally non-linear, that is, an action does not always have the same outcome as the result is dependent on the context within which the interactions occur. In addition, emergent behaviours are often unpredictable, due mainly to the influence of people who will react differently to the same situation (Williams, 2015). This may be because they are subject to differing pressures and expectations reflecting the particular power plays operating in any given situation.

Policy sets the context within which those with a remit for its delivery must make crucial decisions on the shape of implementation. In everyday parlance it is often said that things should not be 'taken out of context'. This similarly applies to policy implementation, since there is now a growing body of evidence that an intervention that is successful in one location does not deliver the same results elsewhere (Health Foundation, 2014; Horton et al., 2018). As Dixon-Woods (2014: p.89) points out: 'History is littered with examples of showpiece programmes that do not consistently manage to export their success beyond the home soil of early iterations'.

All of this connects with the long-standing literature on 'receptive' and 'non-receptive' contexts for change pioneered by Pettigrew et al. (1992). The quintessential task

of implementation support could therefore be said to be to assist the organisational shift towards a 'receptive' implementation context. Weiner (2009) describes this as 'organisational readiness' for change – a state of being both psychologically and behaviourally able and willing to take action in a desired direction. Of relevance here is the health system transformation initiative launched by WHO Europe, which includes a self-assessment checklist to enable policy-makers to reflect upon, and assess, their readiness for change and whether or not the requisite capacities and capabilities are in place for successful implementation to occur (WHO, 2018).

It is therefore likely that the implementation support process will more easily flourish in some contexts than others – indeed a recurring theme throughout this account has been the receptive political and professional context within which the Care Act IS programme functioned. Not all policies can be expected to be characterised by such a high degree of political and professional agreement and engagement; in fact, most will almost certainly be the outcome of divisive and contentious disagreements.

A useful framework for understanding the role of context is Matland's (1995) classic work on the impact of conflict and ambiguity on implementation. The premise is that the different characteristics of policies have varying implications for the way they are implemented – and, by extension, for the ways in which implementation support programmes might best be constructed. Matland uses a distinction between issues about the extent of policy ambiguity on the one hand, and issues about policy conflict on the other, to develop the matrix below (see **Table 2**).

There are important implications arising from this analysis for ensuring the right model of policy implementation support is associated with each domain of the matrix. Broadly we can hypothesise that:

- *Administrative Implementation* is amenable to a model associated with guidance, regulation, and top-down performance management.
- *Political Implementation* is amenable to a model associated with guidance, regulation, and performance management but will also require flexibility and collaborative working.
- *Experimental Implementation* is amenable to a model associated with a bottom-up approach, sensitivity to the implementation context, and support for problem-solving.
- *Symbolic Implementation* is amenable to a model associated with the same features as experimental implementation but may also require support for capacity building.

These categories are not mutually exclusive – policies could contain several elements – but the task of policymakers and practitioners is nevertheless to determine which policies require what mix of support to give them the best chance of effective implementation.

In the case of the Care Act, the policy is probably best understood as 'experimental implementation'. Although the passage of the legislation was characterised by relatively low conflict, it incorporated some new and largely untested ideas that were always likely to be open to interpretation – high ambiguity. In these circumstances a bottom-up approach showing sensitivity to local context alongside support for problem-solving was (in line with Matland's hypothesis) the correct approach.

Limitations

A limitation of our research is that it was undertaken after the IS programme had closed and while this had the advantage of allowing time for reflection, it also meant we were, to some extent, dependent upon participants' recall of past events. A second possible limitation of our research

Table 2: Matland's Model of Conflict, Ambiguity and Implementation.

	LOW CONFLICT	HIGH CONFLICT
LOW AMBIGUITY	**ADMINISTRATIVE IMPLEMENTATION** · low ambiguity and low conflict · the pre-requisite conditions for a rational decision process are in place · an activity associated with a generally shared and straightforward objective · suitable for the application of a top-down approach · key organising concept: resources	**POLITICAL IMPLEMENTATION** · low ambiguity but high conflict · a straightforward but strongly contested activity · amenable to interaction and feedback · implementation outcomes determined by the location of authority · key organising concept: power
HIGH AMBIGUITY	**EXPERIMENTAL IMPLEMENTATION** · high ambiguity but low conflict · a complex policy domain where cause-effect mechanisms are uncertain · environmental influences likely to be important; different organisations implement different policies · bottom-up approaches likely to be important · key organising concept: context	**SYMBOLIC IMPLEMENTATION** · high conflict and high ambiguity · an absence of clarity about what can be achieved · no strong coalition to create progress · significant professional values and allegiances · neither top nor bottom stakeholders committed · key organising concept: collaborative strength

was its restricted coverage to six local authorities that may have not been typical of developments elsewhere. However, we do not consider this to be a major drawback since, given the complexity of local government, no two authorities are likely to be the same in every respect.

Conclusion

Overall, it can be concluded that the Care Act IS programme significantly helped ensure the implementation readiness of local agencies. Key successes identified for the IS programme relate to its securing policy legitimacy, the successful navigation of complex issues through stakeholder engagement, and ensuring the readiness of local implementation agencies.

Stakeholder engagement at a macro (national) level was regarded as the key feature of the IS programme. The close relationships secured between the key national stakeholders (DHSC, LGA, ADASS) were unique with no comparable example found in the other policy domains we reviewed. The approach demonstrated engagement, drawing on existing relationships, brought in external expertise as required, facilitated the sharing of ideas and avoided a traditional mechanistic and top-down way of working by seeking a more flexible and adaptive approach influenced by the needs of regional leads and local service providers.

Given the relative novelty of the Care Act IS programme with its particular features that are not replicated in other policy domains, there is correspondingly little empirical evidence to draw upon, making the evidence base for implementation support programmes thin. There are three key messages arising from the Care Act IS programme we studied:

- Ensure the common ground developed with key stakeholders at the preparation stage is also applied to those putting policies into effect in managerial and professional roles: understanding bottom-up discretion and dilemmas;
- Recruitment and development of a cadre of experienced and trusted 'implementation brokers' to offer support tailored to local contexts; and
- Offer implementation support where it is needed or requested: ongoing assistance with problem-solving and capacity-building to develop sustainable implementation skills and knowledge.

Underpinning everything the research investigated and its findings is the irrefutable evidence that the Care Act was in large part a popular piece of legislation amongst sector organisations that generated a great deal of stakeholder consensus. This cannot be said of all policy and therefore inevitably limits what can be learned from this study alone about the wider potential of policy support programmes. But if nothing else, the findings reported here demonstrate the potential value of implementation support if making policy stick is a desired outcome. It is clearly a topic that merits further investigation, especially at a time when government's ability to find lasting solutions to complex 'wicked' problems has perhaps never been so tested and under such scrutiny.

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Competing Interests

The authors have no competing interests to declare.

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