Kent Academic Repository

Peckham, Stephen, Hudson, B., Hunter, D.J., Redgate, S. and White, G. (2020) *Improving choices for care: a strategic research initiative on the implementation of the care act 2014.* **National Institute for Health Research**

Downloaded from

The version of record is available from

This document version
Author's Accepted Manuscript

DOI for this version

Licence for this version
UNSPECIFIED

Additional information

Versions of research works

IMPROVING CHOICES FOR CARE: A STRATEGIC RESEARCH INITIATIVE ON THE IMPLEMENTATION OF THE CARE ACT 2014

Final Report
August 2019

Professor Stephen Peckham[1]
Professor Bob Hudson[1]
Professor David Hunter[2]
Sam Redgate[2]
Dr Gregory White[1]

1. Centre for Health Services Studies, University of Kent

2. Institute of Health and Society, Newcastle University

0

Acknowledgements

Disclaimer

Contents

Executive Summary

BACKGROUND: The Care Act 2014 introduced the most significant change in social care law in England for sixty years, fundamentally overhauling the entire care and support system for adults, older people and their carers. Given the complexity of the changes, the Department of Health and Social Care (known as the Department of Health at the time of the passage of the Care Act) and its key partners decided that a comprehensive programme of implementation support should be put in place to ensure legislative readiness and increase the likelihood of smooth implementation. There were three interlinking principles that underpinned the support programme established by the Department of Health and Social Care:

- *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. These included for example, information, toolkits to assess readiness, good practice guidance, guidance for service users and a model contract.

- *Collaborative infrastructure:* one that supports collaboration at local, regional and national levels through an ongoing two-way supportive dialogue. Underpinning this infrastructure was the relationship between the three key partners – the Department of Health and Social Care, the Local Government Association (LGA) and Association of Directors of Adult Social Services (ADASS).

These arrangements involved the establishment of three key organisational innovations: a Programme Board; a Delivery Board and Programme Management Office; and a regional infrastructure. The approach was delivered through nine work programmes:

Prevention and housing	Prevention charging regulations (to be delivered alongside wider Charging for Care regulations); Statutory Guidance on prevention and housing
Quality and safety	Publish, consult and implement regulations on fundamental standards; Implement new system of quality ratings against the new standards

Information, advice and advocacy	Delivery of information and advice services to meet needs of population; Legal duty on local authorities to provide a universal information and advice service
Paying for care	Support for those planning costs associated with care; Design of deferred payment scheme
Charging for care	Distributing costs of care between state and individual in equitable manner
Planning and personalisation	Statutory guidance for care planning (including care planning process, reviews, and personal budgets/resource allocation
Assessment and eligibility	Assessment regulations; Statutory guidance on assessment
Care markets	Regulations for the market oversight regime (definition of business failure, entry criteria, obtaining information from group companies including organisations that are not registered providers) and local authority duty when providers fail
Law reform	Oversight across the suite of regulations and guidance to ensure policy coherence, quality and a single voice. Includes coordination, challenge and review

This intervention was felt to be innovative and was underpinned by a close and structured relationship between the responsible government department (the Department of Health and Social Care), the representative body for the key implementation agencies (the Local Government Association) and the representative body for the key professional body (the Association of Directors of Adult Social Services). The Department of Health and Social Care wished to better understand the effectiveness of this approach and accordingly invited bids to evaluate the programme. As well as a greater understanding of the Care Act programme itself, it was expected that the commissioned research would lead to greater insight into how government may support the redesign of local services and systems more widely. A successful bid was submitted by a research team from Kent and Durham (latterly Newcastle) Universities to conduct a 2-year (2016-2018) research study. This report is the outcome of the commissioned research.

METHODS: Our research proposal identified three levels of inter-dependent activity that shape outcomes – the macro (national support structures), meso (regional and senior/strategic local authority level) and micro (service management/service delivery level). 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 implementation support programme itself. For the latter we undertook fieldwork at national, regional and local levels. At the national level interviews with Programme Board members and representatives from key stakeholders were conducted. At the regional level we undertook interviews with five regional leads. At the locality level we sampled six local authority case study areas where we undertook interviews with senior managers, operational staff and focus groups of users and carers. Drawing on the policy implementation literature, we identified four broad reasons for hindering policy implementation: overly optimistic expectations; implementation in dispersed governance; inadequate collaborative policymaking; and the vagaries of the political cycle. These can be regarded as the implementation challenges that would have to be met by a policy support programme. Building on McConnell's work on policy failure, we then developed an overarching framework to structure our analysis as shown below.

A Framework for the Assessment of Implementation Support Programmes

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

FINDINGS

Other Policy Domains: Before undertaking fieldwork, we conducted a mapping exercise of other English policies with aims not dissimilar to those of the care Act in order to understand what – if any – policy support had been made available. The aims of this exercise were to:

- Identify a range of examples of policy implementation support and determine the role of government in the implementation
- Develop understanding of the mechanisms that appear to have contributed to successful policy implementation support and how they play out in different contexts.

Fifteen policies were initially identified and reviewed but using sampling criteria we then focused 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 had been subject to an evaluation, few of the studies detail the approaches of implementation support (if any at all) that had been provided. Our review suggests that implementation support has tended to be regarded as somewhat marginal to successful policy implementation. In this context the Care Act programme was seen to be distinctive. By the same token our research field could be viewed as relatively unchartered territory.

EFFECTIVENESS of the CARE ACT SUPPORT PROGRAMME

We structure our findings from data collection at the macro, meso and micro levels within the six domains of our assessment framework:

1. **Helping to secure policy legitimacy:** to understand how far, and in what ways, the creation of the implementation support 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. However, these concepts already had widespread support within many

local authorities and to that extent the Care Act could be regarded as going with, rather than against, the grain of organisational and professional thinking. To some extent this limits what can be learned from this particular case study about the value of implementation support programmes; different challenges would be faced in more controversial policy domains within which policy legitimacy is questioned.

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 implementation support 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; whether all key partners had been involved and the terms of their engagement in the implementation support programme. Our fieldwork suggests that the relationship between the three key national stakeholders 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.

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 Department of Health and Social Care 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.

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. 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 encountered at local level. Concerns were raised about timeliness, customisation to local contexts and the extent to which the products filtered down to operational staff.

In the case of 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 political level – the stocktake findings could be viewed as necessary indicators of progress that could justify investment in the implementation support 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 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.

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 each with their 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.

Our fieldwork suggests that in some localities the regional tier ended up having a significance that far exceeded expectations. Where they worked well, the regional leads were very 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 be 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 creating the right environment and developing the right skills for such roles to be undertaken.

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 implementation support programme could be said to have helped sustain political support by keeping open channels of communication between political and non-political actors. At a local level we undertook fieldwork with local authority cabinet leads but 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 implementation support programme assisted in contributing to the attainment of policy objectives. This is difficult to ascertain in this case, given that the 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 implementation support programme can 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 would be fair to conclude that the programme did significantly help to ensure implementation readiness. 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. This 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.

Conclusion/Key Messages: Given the relative novelty of comprehensive policy support programmes there is correspondingly little empirical evidence to draw upon at this stage. However the issues, literature and evidence presented in this report offer an opportunity to tease out some provisional messages for policy-makers and practitioners on how best to approach the task:

Policy Design Preparation
- Exploration of policy options and their feasibility with key implementation agencies
- Creation of forums for collaborative policy design: the more consensual the design process the less the likelihood of disagreements at the implementation stages
- Development of policy design assurance frameworks: identification of significant implementation risks and challenges along with risk management strategies
- Production of robust implementation statements: clear expectations of what should reasonably be expected to be delivered and under what circumstances
- Use of the best available evidence base to inform policy design
- Agreement on what would constitute an adequate funding stream for anchoring the policy and achieving the programme objectives
- Ensure the agencies tasked with implementation can reasonably be expected to succeed in the task

Policy Tracking
- Two-way communication processes: progress reports from implementation agencies to the policy-making centre; responses back from the centre to implementing agencies

- Use or creation of intermediary bodies between the policy-making and policy implementing levels
- Development of proportionate primary and secondary targets along with agreed timelines
- Separation of monitoring, regulating and inspecting roles from support mechanisms: use of policy support programmes to better understand the stories behind the statistics
- Realistic expectations of what constitutes 'success': policy objectives might never be fully delivered in the case of 'wicked issues'

Policy Implementation Support

- 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
- Offer implementation support where it is needed or requested: ongoing assistance with problem-solving and capacity-building to develop sustainable implementation skills and knowledge

Policy Implementation Review

- Short, medium and longer-term review landmarks: clarity on what should have been achieved by when
- Routine use of action research for formative and summative evaluations
- Political acknowledgement that complex policies need to be given time to demonstrate achievements: costs and benefits will be unevenly distributed over time

Overall, it can be concluded that the Care Act implementation support programme significantly helped ensure the implementation readiness of the local agencies. The main successes were: securing policy legitimacy, navigating complex issues through stakeholder engagement and support, and ensuring of the readiness of local implementation agencies. The relationships developed between the key national stakeholders were unusual and creative – indeed we were unable to identify comparable achievements in other related policy domains. The model demonstrated engagement, drew on existing relationships, brought in

external expertise, facilitated the sharing of ideas and balanced bureaucratic with network elements of governance.   However, the Care Act was in large part a popular piece of legislation that generated a great deal of stakeholder consensus, and this limits what can be learned from this study alone about the wider potential of policy support programmes.

1. Introduction and Background to the Research

1.1. Background

The Government set out its plan to reform care and support in the 2012 White Paper, *Caring for our future: reforming care and support* (Secretary of State for Health 2012). Following the White Paper, the Government published a draft Bill that led to the passing of the Care Act 2014 the first phase of which came into force on 1st April 2015. The Care Act 2014 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. The overarching objectives were to reduce reliance on formal care, to promote people's independence and well-being, and give people more control of their own care and support.

Despite its complexity and some measure of political disagreement over the proposed cap on care costs, the Bill was generally uncontentious and passed into law with little wider political or public debate. This consensus, both in and beyond Westminster, was sustained by the willingness of ministers to accept changes to proposed legislation during almost two years of scrutiny following publication of the White Paper. This consensus was also a product of the collaborative approach taken to develop the proposals outlined in the White Paper – an approach that is central to the focus of this report. Further public consultation on the Bill attracted around a thousand responses and involved a special joint committee of MPs and peers being established to scrutinise the draft Bill. Most of the committee's recommendations for amendment were adopted with further changes being agreed as the Bill worked its way through Parliament.

This high degree of legislative consensus and collaborative approach to drawing up the White Paper were important factors in influencing the decision to support the implementation of the Care Act through an innovative implementation support programme. Whilst it could be argued that all complex policy change requires some form of implementation support, this should be easier to achieve where most 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 support model.

Notwithstanding this high degree of consensus, it was recognised by the Department of Health and Social Care that implementation of the Care Act would be complex and a decision was taken to provide an implementation support programme. In effect, it was decided that the collaborative model that had characterised policy *design* should be extended into support for policy *implementation*. The Department of Health and Social Care, Local Government Association (LGA) and Association of Directors of Adult Social Services (ADASS) were identified as the three key stakeholders and worked in partnership to support implementation of the Care Act in order to develop a consistent and coherent approach to local implementation. The programme was reviewed during its first year by the National Audit Office (NAO) which suggested there was some evidence that the approach was proving to be effective (NAO 2015). It was noted that

> *"The Department's innovative joint governance with the sector has provided the support necessary to carry out this challenging piece of legislation. The Department is overseeing the programme, with stakeholders on the main programme board. A programme management office, set up jointly with the Local Government Association and the Association of Directors of Adult Social Services, leads implementation. The main innovation is that stakeholders are partners, taking on responsibility and not just giving advice. This has been well received by local government and stakeholders"* (p7).

The NAO's analysis of the implementation support programme was based on interviews with those involved in the support programme and research undertaken in nine case study site local authorities. The analysis of the support programme formed only one element of what was a wider assessment of the early stages of implementing Phase 1 of the Care Act 2014.

We describe the structure and operation of the support programme more fully in Section 1.3 below. The initiative was time-limited to align with the anticipated deadlines for implementation. The support programme continued until the first quarter of 2016 with the last meeting of the Partnership Board occurring in March 2016. The implementation support programme was seen as ground breaking and innovative by the key partners, with the potential to hold lessons for other policy domains and for models of implementation support more generally. It was against this background that a decision was taken by the Department

of Health and Social Care to commission further research on the effectiveness of the support programme as one of a number of projects examining the impact of the Care Act 2014.

1.2. The research

In 2016, the Department of Health and Social Care commissioned a suite of research projects examining various aspects of the Care Act's implementation. This included a project specifically to understand more about the effectiveness of the Care Act support programme as an approach to implementation support. In particular, the Department was keen to learn lessons about the extent to which the Care Act support programme might provide a model for supporting the implementation of other national programmes. The invitation to tender for this research requested proposals that understand how government may support the redesign of local services and systems, to improve the provision and quality of care and support and reduce risks to delivery. The Department was especially keen *"… to identify effective practice in implementation, and 'what works' in terms of service redesign and provision" and to identify "potentially transferrable lessons that may be relevant to other local government reform programmes. These lessons could also help to focus the approach taken to implementing funding reforms from 2020"* (Department of Health, Invitation to Tender). More specifically, the Department wanted to assess the impact of this partnership approach on local implementation.

Key questions and issues identified were:
- How this approach may support redesign of local services and systems, to improve the provision of care and support, to improve quality, and to reduce risks to delivery
- How, and to what extent, centrally commissioned or developed implementation support (including regional Care Act implementation structures) is supporting local changes
- To identify effective practice in implementation, and 'what works' in terms of service redesign and provision
- To identify potentially transferrable lessons that may be relevant to other local government reform programmes.

A successful bid was submitted by a research team from Kent and Durham (latterly Newcastle) Universities to conduct a 2-year (2016-2018) research study. The proposal identified three levels of inter-dependent activity that shape outcomes – the macro (national support structures), meso (regional and senior/strategic local authority level) and micro (service management/service delivery level). Although it is important to identify the macro factors and be aware of their significance, our approach was to regard these as 'givens' and to focus upon the ways in which actors at the meso and micro levels responded.

1.2.1 Aims and objectives of the research

The aim of the research was to assess the impact of the national and regional partnership implementation support programme on local implementation of the Care Act. In attempting to understand this approach, we also undertook a wider review of other national policy support programmes along with a review of the theoretical and conceptual literature. Our key research objectives were to:

1. Identify key lessons from other implementation support methods and improvement research.
2. Evaluate the impact and effectiveness of the national and regional level support arrangements.
3. Understand the implementation issues at local level, including cultural, organisational and operational issues.
4. Develop a framework for understanding the requirements of a successful implementation programme and improvement service.
5. Spread knowledge transfer between improvement support for the Care Act and other policy support programmes across the public sector.

1.2.2 Design and methods

 We used a mixed methods approach in order to fully address the various aspects of the support programme, situate this within a wider context of supporting policy implementation and, through researcher and data triangulation, develop lessons for national policy makers and those with implementation responsibilities. . To address these research objectives we undertook an analysis of relevant theoretical and conceptual literature, a review of the

support programmes for a number of previous and current national policy programmes, and an empirical study of the implementation support programme for the Care Act 2014. The research was pursued via a number of strands. In order to understand more generally the issues related to implementing national policy programmes at a local level we undertook a review of relevant literature including evaluations of previous policy programmes where implementation support measures had been put in place. We drew on this data to develop an analytical framework and a set of criteria associated with successful policy implementation. Alongside this, we undertook empirical research on the process and impact of the Care Act 2014 implementation support programme at national, regional and local levels.

1.2.3   Ethics and research governance

As the research involved a number of local authority Adult Social Services Departments, we were required to apply for research clearance from the Association of Directors of Adult Social Services. Approval was granted on 21st July 2017 enabling fieldwork research to commence (see appendix A). In addition, as we planned to undertake focus groups with service users we were required to obtain HRA Social Services Research ethics. This took longer than expected with ethical approval finally obtained on 23rd February 2018 ((Ref: 17/IEC08/0050 - see appendix B).

We established an external advisory group with representatives from the Department of Health and Social Care, Association of Directors of Adult Social Services, Local Government Association, Age UK, Carers UK, National Audit Office and the King's Fund. The advisory group met in person and commented on identifying national and regional interviewees, case study selection, interim and final reports.

1.2.4   Data collection and analysis

We undertook a limited search for relevant published papers on implementation support programmes in other relevant policy domains. The aim of the literature review was to help us to understand the impact of the national and regional partnership programme on local implementation by:

- identifying key lessons from evidence and practice

- evaluating the impact and effectiveness of support arrangements

- understanding implementation issues at local level

- developing a framework for successful improvement

- developing transferable knowledge

Working with our advisory group members, we also identified a number of previous national programmes that had been implemented at a local level as well as some current programmes, such as the NHS Vanguard Programme, where we could identify evidence of implementation support structures and processes associated with them. We searched for any published evidence on these programmes and unpublished reports. We focused on identifying reviews of evidence on implementation and service improvement to identify "best practice" models of implementation and improvement where there was a national programme delivered local within a layered governance framework such as central government policy being delivered through a local or sub national government. We also searched for papers that we identified as examining support for policy implementation. Searches were undertaken of key databases including Embase, ASSIA, and Web of Science. We also examined approaches developed to support the implementation of national policies and service improvement programmes. The findings of this analysis are set out in our interim report (Hudson et al 2017) and summarised in Section 3 of this report.

We undertook a detailed analysis of the work of the implementation support programme established to support local implementation of the Care Act 2014. Data collection was undertaken at three levels in order to understand the particular role and interpretation by all those involved and affected by the changes introduced by the Care Act and how the implementation support programme was enacted. Empirical data collection commenced in early 2017 and completed in August 2018. At the macro level, we undertook a review of the minutes and other documentation related to the implementation support process, and conducted interviews with senior staff involved at national level and from a sample of three of the regions within which case studies were located.

At the macro national and regional levels, we examined the roles and functions of the key support mechanisms and structures – the programme board, programme management office and work-streams and regional leads. We used a mixed-methods approach involving interviews and document analysis to examine process and impacts. We conducted 11 interviews with Programme Board members and representatives from key stakeholders. National interviews were conducted between March 2017 and September 2017. At a regional level, we undertook interviews with five regional leads between January 2018 and July 2018. We analysed all the Programme Board minutes and documents produced within the support programme. We also analysed all the stocktake survey results. Details of key decisions and actions taken at the Programme Board meetings are detailed in Appendix C. For these interviews, the data collection tools were developed by the research team and shared with our external advisory group.

As set out in our application we then collected data at the meso and micro levels through interviews with key strategy and management staff in local authorities and with frontline team leaders/managers in a number of case study sites. Case study sites were selected to provide a sample of different local authority contexts in England (data source; Office for National Statistics). Key characteristics for selecting case studies were discussed with the external advisory group with type of authority, geographical location, percentage of people over 65 and size agreed as key criteria to ensure variation:

Case study A: North East metropolitan district unitary authority
Total population (2017) – population 200-300,000   ***percentage 65years+ -*** 17%
Urban/rural split – 99%/1%
Socio-demographic breakdown: Higher managerial, administrative and professional occupations – 8%; Lower managerial, administrative and professional occupations – 18%; Intermediate occupations – 12%: Small employers and own account workers – 9%; Lower supervisory and technical occupations – 17%; Semi-routine occupations – 17%; Routine occupations – 19%; Never worked and long-term unemployed – 6%.

Case study B: Smaller northern unitary authority

Total population (2017) – population 100-200,000   *percentage 65years+ -* 19.5%

Urban/rural split – 68%/32%

Socio-demographic breakdown: Higher managerial, administrative and professional occupations – 8%; Lower managerial, administrative and professional occupations – 20%; Intermediate occupations – 10%; Small employers and own account workers – 9%; Lower supervisory and technical occupations – 16%; Semi-routine occupations – 16%; Routine occupations – 17%; Never worked and long-term unemployed – 6%.

Case study C: Northern metropolitan district council

Total population (2017) – population 300-400,000   *percentage 65years+ -* 17%

Urban/rural split – 82%/18%

Socio-demographic breakdown: Higher managerial, administrative and professional occupations – 9%; Lower managerial, administrative and professional occupations – 19%; Intermediate occupations – 10%; Small employers and own account workers – 10%; Lower supervisory and technical occupations – 15%; Semi-routine occupations – 15%; Routine occupations – 20%; Never worked and long-term unemployed – 4%.

Case study D: Large southern county council

Total population (2017) – population over 1 million   *percentage 65years+ -* 17.9%

Urban/rural split – 72%/28%

Socio-demographic breakdown: Higher managerial, administrative and professional occupations – 14%; Lower managerial, administrative and professional occupations – 24%; Intermediate occupations – 11%; Small employers and own account workers – 14%; Lower supervisory and technical occupations – 12%; Semi-routine occupations – 12%; Routine occupations – 11%; Never worked and long-term unemployed – 3%.

Case study E: Rural eastern county council

Total population (2017) – population 100-200,000   *percentage 65years+ -* 19.8%

Urban/rural split – 61%/39%

Socio-demographic breakdown: Higher managerial, administrative and professional occupations – 13%; Lower managerial, administrative and professional occupations – 23%; Intermediate occupations – 10%; Small employers and own account workers – 14%; Lower supervisory and technical occupations – 14%; Semi-routine occupations – 14%; Routine occupations – 13%; Never worked and long-term unemployed – 2%.

Case study F: London Borough Council

Total population (2017) – population 200-300,000   *percentage 65years+* - 10.3%

Urban/rural split – 100%/0%

Socio-demographic breakdown: Higher managerial, administrative and professional occupations – 13%; Lower managerial, administrative and professional occupations – 23%; Intermediate occupations – 11%; Small employers and own account workers – 12%; Lower supervisory and technical occupations – 14%; Semi-routine occupations – 14%; Routine occupations – 10%; Never worked and long-term unemployed – 7%.

In selecting case studies, we included three sites that were also included in the NAO study. This provided an opportunity to undertake some limited longitudinal comparison in these sites. At the meso and micro levels, we planned to undertake interviews and focus groups in six selected case study sites with senior managers, operational staff, local providers and run focus groups with service users/carers. In addition, we also planned to observe operational meetings. Data collection tools for case study interviews were developed by the research team and piloted with staff in a local authority not included as a case study. We were also advised and supported by our public and patient advisors in terms of developing our data collection approach and, in particular, planning the focus groups with users and carers. We were also supported by the Public and Patient Engagement Officer employed at the Centre for Health Services Studies, University of Kent. Due to the timing of the research it was not possible, as we had hoped it would be, to observe operational meetings relating to the implementation support provided by the national programme board or programme office, both of which had ceased to function by the time the fieldwork commenced.

Table 1: Details of interviews and focus groups

Case study site	Senior leader/ manager	Operational/ business staff	Providers	Total interviews	Focus groups
A	1	5	0	6	0
B	4	9	1	14	1
C	1	8	1	10	1
D	3	6	0	9	0
E	6	7	0	13	0
F	6	2	0	8	0

We planned to undertake 12 focus groups but, in the end, only carried out two. The reasons were twofold. The first two focus groups provided no real evidence of any knowledge or sense of a national implementation programme and the data obtained from participants was of very limited value in addressing our research questions. We discussed this with our PPI advisors and it was felt that it would provide little additional contribution to hold further focus groups which would require people giving up time to participate. A further issue was that recruitment was difficult with many of those approached not agreeing to participate. Local support and user groups felt that this was because of the limited engagement they and users and carers had with national implementation. Their interest was more on local implementation that affected them directly. The topic guides for the focus groups were developed together with user representatives from the CHSS patient experience and public involvement group – the Opening Doors to Research Group. This process was supported by the CHSS Patient Experience and Public Involvement lead. We also interviewed local providers but initial indications suggested little or no contact with the support programme.

All interviews and focus groups were recorded and transcribed. Data was entered into NVivo for coding. Coding was undertaken by two researchers and a sample of interviews were independently coded by the researchers and then shared with the wider research team to check and agree the coding frame. Data from the NAO study was also reviewed in relation to its analysis of the early stages of the support programme and, where relevant, local case study data. Thematic data from the documentation was also coded in a similar way.

We analysed the data from the programme documentation and empirical data collection using the framework developed in our review of the literature and previous approaches to policy support based on McConnell's analysis of policy success and failure and policy process domains (see Hudson et al 2019, and Table 3, Section 2 below). This enabled the drawing out of themes and identifying where aspects of implementation support might be more successful in some respects than others. Initially, all members of the research team read and analysed the same group of interview transcripts to ensure consistency of analysis. Once agreed, the remaining interviews were analysed by one researcher and then checked with a second member of the team. By synthesising the findings from across each strand of the research, we also provided an understanding of the multi-level coherence between the macro, meso

and micro levels for service improvement support which might be adopted in designing future support programmes.

1.3. Care Act 2014 Implementation Support Programme

This section outlines the main aspects of the Care Act itself and the Implementation Support (IS) programme. The Care Act 2014 introduced the most significant change in social care law in England for sixty 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. Even this has now been abandoned and new proposals are to be brought forward in a Green Paper expected in early 2019. This removed (for the immediate future) the most contentious part of the legislation that held serious concerns about the funding implications.

However, the proposed changes in phase one alone were challenging and complex. They included:

- providing services that prevent care needs from becoming more serious, or delay the impact of their needs;
- meeting a national minimum level of eligibility for a person's care and support needs;
- assessing carers, regardless of how much care they provide, and meet carers' needs on a similar basis to those they care for;
- offering deferred payment or loan agreements to more people, avoiding property sales to pay for care and support;
- providing information and advice (including financial advice) on care and support services to all, regardless of care needs;
- providing an independent advocate where such support is needed;
- working with care providers to get a diverse and high-quality range of local services;
- complying with a new legal framework for protection of adults at risk of abuse or neglect;
- giving continuity of care to those whose needs are being funded by the local authority who choose to move to another area;

- assessing the care and support needs of children and their carers, who may need support after they turn 18, as they move to adult social care; and
- arranging and funding services to meet the care and support needs of adults who are detained in prison.

Given the complexity of the changes to adult social care, the Department of Health and Social Care and its key partners – the LGA and ADASS – concluded that a traditional top-down, one-size fits all approach to implementation support would be an inappropriate model for achieving successful implementation across all local areas. This view was clearly set out in 2013 at a meeting of the Partnership Board that was attended by the key national stakeholders involved in the White Paper and Care Bill (Care and Support Reform Programme Board, November 28th 2013).

The Partnership Board also set out the three interlinking principles that underpinned the support programme established by the Department of Health and Social Care:

- *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. These included for example, information, toolkits to assess readiness, good practice guidance, guidance for service users and a model contract (See table 2 below).
- *Collaborative infrastructure:* one that supports collaboration at local, regional and national levels through an ongoing two-way supportive dialogue. Underpinning this infrastructure was the relationship between the three key partners – the Department of Health and Social Care, the LGA and ADASS.

In order to support the implementation programme it was agreed to establish three key organisational innovations: the Programme Board; a Delivery Board and Programme Management Office; and a regional infrastructure. The overall support programme is outlined in figure 2.

Figure 2: Programme structure for implementing the Care Act

Links with stakeholder groups, including:	Department of Health board	Social care oversight board
Think Local Act Personal Towards Excellence in Adult Social Care Care and Support Transformation Group Groups representing care providers	**Department of Health major programmes board** Oversees the Department's major programmes	Oversees and manages interdependencies between health and social care programmes

Care and support reform programme board

Responsibility: Oversight of the programme to implement the government's white paper commitments. Providing national leadership and practical support for implementation.

Representatives from: Association of Directors of Adult Social Services, Care Provider Alliance, Care Quality Commission, Department of Health, Healthcare Alliance, Local Government Association, National Skills Academy for Social Care, National Institute for Clinical Excellence, Skills for Care and Social Care Institute for Excellence.

Links to other programme boards: Outcomes & Information Delivery Board, National Information Board, Adult Social Care Workforce Programme Delivery Board, Health Technology Task Group.

Programme Management Office

Structure: Partnership between the Association of Directors of Adult Social Services, the Local Government Association and the Department of Health.

Responsibility: Overseeing planning and holding work streams to account for implementation. Works with policy leads to focus on developing regulations, guidance, implementation support and ongoing policy development. Also responsible for establishing external links and ensuring effective communication to support implementation locally.

Care and support reform programme work streams

Responsibility: Managing different aspects of Care Act implementation, each led by a Senior Responsible Owner, supported by departmental policy leads and sector specialists.

Sector bodies involved include: Department of Health, Association of Directors of Adult Social Services, Local Government Association, Skills for Care, Think Local Act Personal, Social Care Institute for Excellence, Institute of Public Care, Care Quality Commission, Public Health England and the College of Social Work.

Work streams:

Prevention and housing	Quality and safety	Care markets
Information, advice and advocacy	Paying for care	Charging for care
Care planning and personalisation	Law reform	Communications
Assessment and eligibility	Workforce	Informatics
Finance		

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 for achieving successful implementation and not just giving advice. Key priorities for implementation were identified and included: *"(a) Care Act Implementation Grant of £125,000 allocated to each local authority; (b) Strengthening of regional capacity and the recently confirmed regional training and implementation support fund; (c) National support products as follows: Workforce learning and development resources and capacity planning tools; Implementation support toolkits and practice guidance; Support for providers"* (Hughes, 2014 p1).

1.3.2 Programme Board

The Programme Board (PB) was set up in the wake of the Care and Support White Paper of July 2012 (see: 'Care and support reform programme board in figure 2). The membership was large (over thirty) with eleven representatives from the Department of Health and Social Care and the remainder from the LGA, ADASS and other agencies, including SOLACE (Society of Local Authority Chief Executives), NHS England, Skills for Care and NICE (National Institute of Health and Care Excellence). The PB was upwardly accountable to the Department of Health Major Programmes Board and had beneath it a Programme Management Office (PMO), a Support Delivery Board and nine core work streams (See table 2). The PB was seen as having three functions:

- *Support*: to provide national leadership and oversee the delivery of practical support to local authority providers and other delivery partners

- *Assurance:* to oversee delivery of the Care Act legal framework; ensure that appropriate local delivery plans were in place; provide assurance on the state of readiness and delivery confidence; ensure expected benefits and associated outcomes were being realised.

- *Delivery:* to oversee effective delivery of the national programme plan; bring together key representatives of delivery organisations; manage risks and make decisions about delivery.

1.3.3 Delivery Board and Programme Management Office

The Care and Support Reform Delivery Board's function was more operational. It was chaired by a representative of Department of Health and Social Care and 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 Delivery Board met monthly before each Programme Board. The programme Management Office (PMO) was established in November 2013 to support the work of the Board in undertaking its three core functions – support, assurance and delivery. The PMO supported the ten work streams, provided a single point of contact for progress, enabled the Board to agree and prioritise progress, identified a single senior responsible officer to sign off on plans and related issues, and supported the identification of cross-cutting issues.

Table 2: Overview of work-streams for Care Act implementation support

Work-stream	Responsibility of stream	Key implementation support
Prevention and housing	Prevention charging regulations (to be delivered alongside wider Charging for Care regulations); Statutory Guidance on prevention and housing	Care and Support Specialised Housing Fund - up to £415m used to stimulate the market for specialised housing
Quality and safety	Publish, consult and implement regulations on fundamental standards; Implement new system of quality ratings against the new standards	Evidence-based, outcome-based good practice guidance on adult safeguarding
Information, advice and advocacy	Delivery of information and advice services to meet needs of population; Legal duty on local authorities to provide a universal information and advice service	Improving online LA information; Improve access to independent advice and support for people with eligible needs
Paying for care	Support for those planning costs associated with care; Design of deferred payment scheme	Identification and sharing of best practice; Development of a 'model' pathway
Charging for care	Distributing costs of care between state and individual in equitable manner	Development of a toolkit for local authorities to support readiness; Input into training materials for local authorities
Planning and personalisation	Statutory guidance for care planning (including care planning process, reviews, and personal budgets/resource allocation	Common principles of resource allocation systems; Easy read guidance for service users that details what they can expect (and have a right to expect) from the new care system
Assessment and eligibility	Assessment regulations; Statutory guidance on assessment	Tools to support assessment – Developed through ADASS; Tools and training module to support implementation of the new assessment and eligibility framework – Delivered by Skills for Care
Care markets	Regulations for the market oversight regime (definition of business failure, entry criteria, obtaining information from group companies including organisations that are not registered providers) and local authority duty when providers fail	Principles for dealing with serious provider failure; Self-help networks of DASS's to provide mutual support
Law reform	Oversight across the suite of regulations and guidance to ensure policy coherence, quality and a single voice. Includes coordination, challenge and review	Possible model contract for delegation of functions; Integration Transformation Fund and Pioneers – financial and learning resources to make integrated health and care a reality; General information and support to local authorities on sight impairment registers

1.3.4 Regional Infrastructure

In recognition of the potentially wide gap between central government and a multiplicity of implementing local authorities, the decision was taken to develop a regional level of support to act as a conduit between localities and the PMO. It was suggested in PB minutes (November 28th, 2013) that the regional level support would: facilitate rapid dissemination of the latest tools and advice; increase the pace of local implementation; and link into assurance mechanisms where the local pace is thought to be falling behind. Funding was to be found to establish this level of support.

Organisationally this level of support was to build on arrangements for existing models connected with other programmes such as Health and Wellbeing Boards and Transforming Excellence in Adult Social Care. The key partners consisted of lead local authority CEOs, directors of adult social care and lead elected members, all supported by Department of Health and Social Care Regional Deputy Directors and LGA Principal Advisers. Regional branches of ADASS were expected to take the lead on implementation arrangements and a named contact was to act as an 'engine room' for cascading information, advice and support.

This brief descriptive account of the IS programme for the Care Act 2014 is testimony to the seriousness with which the mission was undertaken at national 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 Care Act context. Although highly detailed statutory guidance (the epitome of a top-down approach) was indeed produced, there was also an appreciation of the influence of local contexts and dispersed power bases.

The PB and PMO in effect functioned as an 'intermediary body' – an implementation support centre that attempted to bridge the gap between centrally determined legislative requirements and local implementation centres. The model consists of a clear but complex, multi-layered, time-limited intervention characterised by highly collaborative relationships and a desire for flexible local implementation facilitated by regional mechanisms. The

programme also exhibits all three of the purposes of implementation support interventions identified by Gold (2014) - managing and regulating; problem solving; and capacity building.

1.3.5 Initial assessment of the organisation and structure of implementation support

The structure and operation of the IS programme was examined by the NAO in 2014/15 (NAO 2015). They concluded that the Department's innovative joint governance with the sector had "… provided the support necessary to carry out this challenging piece of legislation." (P7). They found that generally the approach was well received by local government and stakeholders. They identified that the programme had undertaken the kinds of activities outlined above. Guidance materials and extra support were being offered local authorities and the programme management office had organised events and meetings, and commissioned tools and guidance. Importantly the NAO found that Adult Social Care departments and stakeholders had been involved in determining the content of the tools and guidance material and making sure they met the required standards.

In line with the recommendations of the Programme Board, additional funding was provided by the Department of Health and Social Care to local authorities to support their preparations for the Care Act with further support available if needed. However, the NAO noted that too tight a timetable had been provided for local authorities to act on final guidance and obtain funding allocations that had inhibited local implementation planning in some areas. The Department published its final regulations and guidance 5 months and 10 days before the Care Act was due to be introduced. The 'stocktake' surveys found that pressures on councils, compounded with uncertainty over key guidance and information, had delayed or otherwise affected Care Act preparations. For example, stakeholders and councils could not produce support materials until the Department published final regulations and guidance (paragraphs 2.12 to 2.13).

Despite the challenging timetable, 99% of local authorities said they were confident that they would be able to carry out the Care Act reforms from April 2015. Most local authorities expressed confidence in being able to meet their statutory duties such as providing information and advice and giving carers extra support. The NAO noted, however, that it would take much longer to make the culture change envisaged in the Care Act. At the national

level, and from the macro perspective, there certainly seemed to be evidence to suggest that the IS programme had been carefully developed and was being well received.

2.   Contextual and Conceptual Issues

2.1   The Nature of the Problem

Following on from the ground-breaking study by Pressman and Wildavsky (1973) there is now a burgeoning literature on the ways in which aspirations and ideas often fail to translate into workable policy (Hill & Hupe, 2014). As Hupe and Hill (2015) note the normatively attractive top-down view is predicated on three questionable assumptions: a chronological order in which expressed intentions precede action; a linear causal logic whereby goals determine instruments and instruments determine results; and a hierarchy within which policy formation is more important than policy implementation. This notion of moving from one stable state to another as a result of planned change is now widely acknowledged to be at odds with work on complex adaptive systems, where change is seen as constant and stakeholders need to be adaptable and flexible (Byrne, 1998).

Disillusionment with this top-down approach has slowly taken root as governments have recognised that more needs to be done at the post-legislative stage to try to ensure intentions are turned into results – as Harris and Rutter (2014) put it, 'implementation has become the Achilles' heel of the UK system'. At the same time, it is unclear how best to support implementation. This Part of the report aims to fill the gap in three ways: by unpicking the key factors behind policy failure; by highlighting different approaches to supporting policy implementation; and by developing a tentative framework for assessing the effectiveness of implementation support programmes.

2.1.1   The persistence of policy failure

Dunlop (2017) points out that although the likelihood of policy failure is at least as high as policy success the literature tends to focus on the latter – for example with injunctions to follow 'best practice' and centrally devised guidelines. Although there is now growing interest in the notion of 'policy failure' (Volker, 2014) the tendency is to treat failures somewhat tautologically – policy failure is equated with non-implementation, either in full or in part. In reality, as McConnell (2015) notes, 'failure' resides at the extreme end of a success-failure spectrum where it is characterised by absolute non-achievement. He observes that '*in reality*

failure is rarely unequivocal and absolute...even policies that have become known as classic policy failures also produced small and modest successes' (p231).

In the UK, the best-known study is that of 'policy blunders' by King and Crewe (2013) - a study of twelve government policies that failed in their objectives, spent and wasted large amounts of public money, 'wrecked the lives of ordinary people' and were foreseeable. The authors identify two 'structural causes' of this policy failure:

➢ *A Deficit of Deliberation:* The British system, it is said, is designed 'for decisiveness rather than deliberation'. In the cases studies selected for investigation the authors say the Government did not deliberate with the people most directly affected, with those whose job it is to apply a policy, with independent experts or with those opposed to the policy. In most cases, bills were rushed through Parliament with little time afforded for substantive debate or detailed scrutiny.

➢ *A Deficit of Accountability:* Ministers tend not to be held accountable for the outcomes of their policy initiatives – by the time a blunder becomes apparent, they have moved on or out. One consequence of this is that ministers are attracted to short-term results and to pushing through policies as quickly as possible, rather than getting involved in the messy and frustrating details of implementation.

If a more effective approach to implementation support is wanted, then the reasons for the persistence of policy failures such as this need to be more carefully unpicked. It is possible that certain policies are purposely vague or ambiguous precisely in order to delay or thwart implementation (Matland, 1995) and these largely lie outside our interest. Given the assumption of a desire to bring a policy to implementation fruition, four broad hindrances can be identified: overly optimistic expectations; implementation in dispersed governance; inadequate collaborative policymaking; and the vagaries of the political cycle.

2.1.2 Overly Optimistic Expectations

'Over-optimism' was the title given to an influential review of failure in major government projects in the UK by the National Audit Office (2013). It noted this to be:

> '*A long-standing problem widely recognised that too frequently results in the underestimation of the time, costs and risks to delivery and the overestimation of the benefits. It undermines value for money at best and, in the worst cases, leads to unviable projects.*' (p3)

The problem is not confined to the UK - a comparative study from the OECD (2015) also notes successful delivery performance to be an ongoing challenge for centres of government. This is especially the case where policies require a long-term focus. A study by the Institute for Government (2016) of four such policy areas - UK climate change, UK international development, Irish anti-poverty strategies and rough sleepers in England – identified three common features that complicated delivery: costs and benefits are distributed unevenly over time – there is a long-time lag between implementation and positive outcomes; they are intellectually contested, politically contentious and hard to deliver; and the causes and effects span government siloes.

In the case of the UK Major Projects Portfolio, the NAO study identified five interacting factors that contribute to over-optimism:

➢ *Complexity:* Public bodies too often underestimate the delivery challenges of complex projects and fail to spend time to deepen their understanding; there is a commitment to a 'solution' with insufficient understanding of the context and options.

➢ *Evidence Base:* Good decisions are based on having sufficient objective, accurate and timely information on costs, timescales, benefits and risks, but too often projects are planned and evaluated on poorly thought through data and modelling.

➢ *Stakeholders:* Successful projects are driven by the effective interaction of organisations and people who may have widely varying aspirations and requirements. Government tends to be optimistic about its ability to align these different views.

➢ *Behaviour and Incentives:* The NAO refers to the notion of 'strategic misrepresentation' – a desire on the part of individuals and groups to protect and boost their own prospects by securing investment in a project.

➢ *Challenge and Accountability:* Decision-makers may be inclined to seek short-term recognition and rewards, and are often not in the same role when a project is under way and problems emerge.

These explanations cover both the top-down and bottom-up implementation models. The top-down model focuses on how policies are communicated to lower level public administrators who are then responsible for implementation. The bottom-up explanation advanced notably by Lipsky (1980) claims that the top-down view overlooks the significance of the bottom-level of the implementation chain where front-line actors can have sufficient discretion in their work to significantly influence implementation.

2.1.3   Implementation in Dispersed Governance

Policies formulated at national level may face the challenge of ensuring some degree of consistency in delivery at sub-national level – a process that is especially fraught where the sub-national level has some separate degree of political authority. The application of knowledge is highly dependent on context and involves the '*messy engagement of multiple players with diverse sources of knowledge*' (Davies et al, 2008). Existing evidence of policy implementation suggests that there is no single 'right answer' in the world of policy-making but only '*more-or-less good reasons to arrive at more-or-less plausible conclusions*' (Russell et al, 2008) This highlights the importance of understanding the processes through which policy is implemented and how successful implementation and service improvements can best be supported. Sausman et al (2016) draw on the concept of 'local universality' to similarly describe the process whereby general rules, products or guidelines are shaped and tailored to fit into local contexts and enacted within practices.

2.1.4   Inadequate Collaborative Policymaking

What the above section implies is that whatever the requirements and expectations at central level, the local implementation process will always be in some ways unique. The implication

here is that policy design requires continuous collaboration with a range of local 'downstream' implementation actors such as end users, frontline staff and a range of local service agencies. In this way design and implementation begins to resemble an integrated process rather than discrete and distinct stages.

Ansell et al (2017) emphasise the need for policies to be designed in a way that 'connects actors vertically and horizontally in a process of collaboration and joint deliberation'. This, the authors say, 'should not be equated with a long and cumbersome search for unanimous consent'. Rather it constitutes 'a shared effort to establish a common ground for public problem-solving through a constructive management of difference that leaves room for dissent and grievance' (p475). This, it is argued, will lead to a joint commitment to, and responsibility for, the implementation of innovative policy design.

2.1.5   Vagaries of the Political Cycle

Policies of significance that involve change over a long period of time raise issues of political sustainability and support. In general, there is evidence to suggest that the political will necessary to drive long-term policy-making will tend to dissipate over time (Norris & McCrae, 2013) with Ilott et al (2016) identifying three discrete phases:

➢ *Phase 1: Rising Salience*: In this phase an issue becomes politicised, gaining the attention of ministers. It is the point at which the problem to be tackled is defined and articulated, and some indication of what success would look like is identified.

➢ *Phase 2*: *Building Blocks*: Here politicians and officials put in place the policies, institutions and targets aimed at resolving the problem. These actions should serve as a rallying point for the coalitions of support needed to sustain long-term focus.

➢ *Phase 3*: *Embedding:* This constitutes the period at risk of diminishing political interest during which the 'building blocks' nevertheless need to deliver some evidence of success.

The danger here is that policy-makers are more likely to get credit for legislation that is passed than for implementation problems that have been avoided. Indeed the latter will probably tend to be seen as 'someone else's problem' (Weaver, 2010). Ansell et al (op cit) identify five

reasons why politicians might shun engagement with implementation: policies have been adopted with high popular sentiment but little prospect of successful implementation; an unwillingness to share authority with others deemed less politically important; possession of an ideological fervour unsuited to collaborative governance; undue ties to partisan interest groups; and the perceived need to deliver unduly quick solutions to complex issues.

2.2   Developing an implementation support programme

Rather than just let policies drift into full or partial failure, governments are beginning to take an interest in ways in which the policy process – especially policy implementation – can be strengthened and supported. This interest is taking place at four sequential points in the implementation process: preparation, prioritisation and tracking, support, and, finally, review. However, given the relative novelty of these sorts of interventions, particularly where they constitute a coherent programme, there is still relatively little in the way of an established literature, let alone a framework for evaluating their effectiveness.

One generic framework open to adaptation is that proposed by McConnell (op cit) in his discussion of degrees of policy failure, where he distinguishes between three inter-linked activities – process, programmes and politics. It is the first of these that is most applicable to the role of implementation support. He further distinguishes between three degrees of failure: tolerable (where opposition and criticism is small); conflicted (where failures are matched by achievements); and total (where opposition is great and support minimal). Applying these three levels to the process domain of policy-making gives us the following framework for assessing the contribution of an implementation support programme (see Table 3).

Following some successful initial trialling of this framework with our early data collection, we concluded that it was able to provide a robust structure for our wider examination of the effectiveness of the Care Act IS Programme. The six dimensions adequately cover all of the aspirations of the Care Act programme and are also capable of being applied to comparable programmes in other policy domains.

Table 3: A Framework for the Assessment of Implementation Support Programmes

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

The framework also recognises that there is no simple dividing line between success and failure – interventions can work well in some respects but not in others. A nuanced

understanding of why some aspects of implementation support intervention seem to work while others do not can help in drawing out more general lessons.

2.2.1 Implementation Preparation

The aim at this point would be to ensure government is more alert to the practicalities of implementation by scrutinising the feasibility of policy proposals more carefully at the outset – in effect, better 'policy design' (May, 2015). Faulty policy design can stem from many causes – a poor understanding of the problem, insufficient knowledge of the implementation context, unclear and even contradictory goals, absence of political backing, amongst them. In such circumstances, any degree of successful implementation is unlikely (Hogwood & Peters, 1985).

A failure to draw upon, or be transparent about, the use of evidence has been highlighted in two recent UK reports by *Sense About Science* (2015, 2017). In these reports, the question is asked: 'could someone outside government see what you're proposing to do and why?' A framework is developed covering diagnosis (the issue to be addressed), proposal (the chosen intervention), implementation (how the intervention will be introduced and run) and evaluation (how will we know if the policy has worked?). A scoring system with four levels was applied to 593 discrete policy proposals by thirteen domestic policy departments. Although some examples of good practice were identified, there were some general shortcomings evident: sharing work done; poor referencing; unclear chains of reasoning; and a failure to consider other policy options.

Gold (2014) has noted that few countries have mechanisms in place to ensure more robust policy design. In the UK, the Civil Service Reform Plan (HM Government, 2012) requires permanent secretaries to warn before a political decision is taken if there are likely to be implementation concerns, but in practice the central machinery only tends to be activated once an established policy is off track. Again, a review of the Plan (HM Government, 2014) made a commitment to publish more of the evidence base that supports policymaking, but the *Sense About Science* reports seem to suggest only minimal progress has been made.

An interesting exception in this regard is Australia, where the Department of the Prime Minister and Cabinet has issued guidelines (Australian Government, 2014) for policy proposals with 'significant implementation risks or challenges'. These policies are defined as fitting one or more of several criteria: addresses a top Government priority; has significant budget implications; makes major or complex changes to existing policies; involves significant cross-agency issues; is particularly sensitive; requires urgent implementation; involves new or complex delivery systems; and has been developed over a very short period.

In such cases, a full implementation plan has to be developed during the drafting process covering seven domains: planning, governance, stakeholder engagement, risks, monitoring, review and evaluation, resource management and management strategy. Each of these is further broken down and made available in the form of implementation 'toolkits'. There does not yet appear to be any evaluation of the effectiveness of these arrangements. In the UK, a more modest suggestion to create a watchdog (similar to the Office of Budget Responsibility) to scrutinise the assumptions underpinning government decisions about public spending (Institute for Government/Chartered Institute of Public Finance and Accountancy, 2017) has yet to receive a positive response.

2.2.2 Implementation Prioritisation and Tracking

The emphasis here is to ensure a focus on implementation by establishing some form of central 'delivery unit' to track progress. Gold (op cit) sees the proliferation of such units as a global trend (they are now reckoned to exist in 25 countries) fulfilling several functions:

- *performance monitoring*: tracking progress against key policy priorities through analysing a constant stream of departmental performance data
- *problem-solving*: undertaking field visits to identify obstacles to delivery and flagging up where additional resources are needed to fix problems
- *progress assessing:* supplying heads of government with routine progress reports

Whilst most such units have been located at the centre of government, this does not have to be the case; others can be established in key ministries or for specific priority programmes.

In the UK, the first overt strategy unit was probably the Central Policy Review Staff (CPRS) created in 1971 to relate the policies of individual departments to the government's strategy as a whole (Challis et al, 1988; Blackstone et al, 1988). The Conservative Government of Margaret Thatcher abolished the unit but the idea was revived under Tony Blair's first Labour Government with the creation of a Performance and Innovation Unit based in the Cabinet Office in 1998, followed by the Prime Minister's Strategy Unit in 2002 and a Delivery Unit run by Michael Barber who has subsequently written about the experience (Barber, 2015). The latter - intended to ensure progress on selected priority public service targets – was in turn abolished by the 2010 Conservative Government which then set up the Major Projects Authority (MPA) to manage its portfolio of around 200 discrete high-risk projects. In 2016 the MPA merged with Infrastructure UK to form a new organisation, the Infrastructure and Projects Authority.

It is far from clear how effective these different bodies have been. In a global review of the effectiveness of delivery units in education services (Todd et al, 2014) a range of key lessons was identified. These include: focusing on a limited number of key priorities; being able to assume that budgets for each priority are adequate; developing good quality data and metrics to measure what matters; producing mutually agreed targets that are realistic and achievable; ensuring a clear understanding of delivery systems and active stakeholder engagement; and constructing an effective communications strategy.

The theory of knowledge here is the positivist tradition with its assumption that social phenomena can be divorced from their context and that objective knowledge about them can be achieved through empirical observation and quantitative expression. This constitutes a linear-rational model of decision-making in which unambiguous objectives are established, action upon them flows in predictable ways through established implementation structures and outcomes are monitored against them. It is the realisation that implementation is complex, contextual and as much a bottom-up as a top-down imperative that has led to interest in an alternative approach, that of 'implementation support' (Geyer & Cairney, 2015)

2.2.3 Implementation Support

Tracking performance delivery alone is unlikely to be sufficient to ensure effective implementation, especially where the policy is complex and long-term in nature. The question then arises as to whether some form of implementation support might be needed and, if so, what approach is appropriate. All such approaches require close liaison with, and understanding of, the position of the implementing agencies.

In a review of the components of service improvement for the Health Foundation, Allcock et al (2015) point out that those who work on the front line know more about the challenges of delivery than national policy makers; a crucial task for implementation support is therefore to tap into the perceptions and experiences of those whose behaviour will shape the implementation process. This support is not so much about understanding legal obligations or the requirements of statutory guidance than about promoting the art and craft of policy implementation. It involves assessing existing capacity to deliver, knowing what is being done well, what needs improving and how best to build new capacity.

The danger here is that such bodies try to straddle several strands of activity, some of which are at best in tension with each other, and at worst are contradictory. Three purposes can be identified: managing and regulating; problem-solving; and capacity building.

Managing and Regulating:

Here the focus is on the identification of procedures for the measurement and scrutiny of performance and ensuring required standards are met. Gold (op cit) notes that there is a risk that performance rating systems will be vulnerable to 'grade inflation'. It is an approach better suited to prioritisation and tracking than to implementation support.

Problem-Solving:

The assumption here is that a problem has been sufficiently well defined to permit a close focus on how to 'solve' it. This could be pursued in a range of ways such as through technical support, trouble-shooting, the brokering of areas of dispute, and encouraging the utilisation of research and evidence.

Capacity Building:

Whereas problem-solving focuses on 'what' questions, capacity building concentrates on the 'how'. It involves investing in skills and competencies that will be sustainable in meeting future implementation challenges. Training, peer learning, information, guidance, project management skills and other such interventions could all have a part to play.

The literature on policy evaluation is well established. When done well it can help to modify implementation trajectories and support decisions on whether or not to renew, expand or terminate an initiative.

2.3. Conclusion

Section 2 has highlighted the relative neglect of 'policy failure' as a topic of official or academic concern. 'Failure' is rarely total - typically it is a matter of degree. This in itself is part of the case for the potential value of a policy support programme – while such programmes can never hope to compensate for wholesale failure in policy design, they can make it more likely that reasonably well-designed policies come to fruition, if necessary by modifying them as experience is gained from their implementation. By identifying the most common explanations for policy failure, this section provides an important context within which to place the potential role and value of support programmes. Our framework for assessment has been designed to take account of: the reasons for policy failure; the sequential stages of implementation; and the fact that failure tends to be partial not total. This makes it possible for emerging lessons to be more nuanced, with the greatest efforts aimed at those parts of the policy process most in need of support.

We recognise that the implementation of social care has a particular context given the governance arrangements of social care in England. It provides a different context to other public policy areas such as health care where there are Arm's Length Bodies such as NHS England, which have central co-ordination and support functions and work with devolved delivery structures. However, our evolving framework provides a useful way of conceptualising delivery support in these different contexts. In this report we utilise the

framework outlined in Table 3 to structure our data analysis and presentation of our research

findings in Chapters 3 and 4.

3. Mapping Implementation Support in Other Policy Domains

3.1 Introduction

The aim of conducting a mapping of national policy implementation support initiatives introduced in other social policy areas was to establish if there are general lessons regarding how support processes may best be developed to aid the local implementation of national policy. Overall, the mapping exercise sought to:

- Identify a range of examples of policy implementation support and determine the role of government in the implementation

- Develop understanding of the mechanisms that appear to have contributed to successful policy implementation support and how they play out in different contexts.

In the absence of any established review of this issue, the research team sought to identify policy domains bearing some similarity to the Care Act, particularly those that required implementation by a multiplicity of local agencies. This included initiatives in the field of adult social care itself and wider programmes both past and ongoing.

3.2 Mapping implementation support

Fifteen policies were initially identified and reviewed as part of the mapping exercise. The search was guided by the knowledge and experience of the research team and external advisory group. While not all of the policies reviewed were closely related to the Care Act reforms, there are key-shared characteristics that are relevant to implementation support activities irrespective of the specific policy focus. Five key criteria governed the selection of policies:

1. **Scale:** was this a national policy applicable to all relevant localities across the country?
2. **Purpose:** was the focus on implementation support rather than monitoring, inspection or performance management?
3. **Reach:** was support extended to every locality nationwide?
4. **Learning:** is there an evaluation or other evidence base?
5. **Significance:** does this policy have a statutory underpinning and guidance?

The fifteen policies were assessed against these criteria – fourteen previous policy initiatives and one concurrent following NHS England's launch of the Vanguard Programme to support the development of new models of care arising from the Five Year Forward View (NHS England et al 2014). While initially little information was available, by the end of 2018 this programme was being evaluated by the National New Models of Care Evaluation team. In addition, although it had less to say about implementation support, the five North East region Vanguards had been evaluated in an earlier study by a team based at Durham and Newcastle Universities involving two members of the Care Act research team (Maniatopoulos et al 2016). We were able, therefore, to include this programme in our analysis. The policies/programmes set against the five criteria are shown in Table 4 below.

Table 4: Policies mapped against inclusion criteria for secondary synthesis of evidence

Policy	Scale	Purpose	Reach	Learning	Significance
Total Place	x	X	✓	✓	X
City Challenge	x	X	✓	✓	X
Community Care Support Force (CCSF)	✓	✓	✓	✓	✓
Cities and Local Government Devolution Act 2016	X	X	X	X	✓
Community Care Development Programme	X	X	✓	✓	X
Troubled Families	✓	✓	✓	✓	X
Ensuring the effective discharge of older patients from NHS acute hospitals	X	X	✓	X	X
Academies programme	✓	X	X	✓	✓
New Deal for Communities	X	X	X	✓	X
Health Action Zones (HAZ)	✓	X	X	✓	X
Sure Start	✓	✓	✓	✓	✓
Health and Social Care Act	✓	X	✓	✓	✓
Better Care Fund (BCF)	✓	X	✓	✓	✓
Health and Wellbeing Boards (HWB)	✓	✓	✓	✓	✓
Vanguards	✓	✓	✓	✓	✓

Grey highlight indicates policy identified for further investigation

Data was collected in regard to each selected policy to understand how the approach was implemented, the role of the government with respect to implementation, the nature of the support provided for implementation, key contextual factors influencing implementation, and whether or not the implementation approach had been evaluated.

Of these fifteen policy areas, five fulfilled all, or in one case most, of the criteria: - Community Care Support Force, Sure Start, Health and Wellbeing Boards, and Vanguards. Troubled Families, although only sharing four of the characteristics, was also included in the analysis due to its scale and reach that are in line with the Care Act 2014. The five policies selected for closer inspection were considered in relation to their commonalities, and comparisons made between each of the implementation approaches and subsequent perceived success. The implementation support approaches adopted by each policy are explored below in terms of the extent to which they reflect one or more of three identified models based on the work of Gold (2014):

- *Performance management*

  Including: articulation of required standards; identification of acceptable levels of performance; procedures for measurement and scrutiny of performance

- *Problem-solving*

  Including: focus on the 'what' rather than the 'how': working through a well-defined problem to reach a solution; implementing solutions and reviewing results (e.g. technical support; trouble-shooting; brokering disputes; utilising research)

- *Capacity building*

  Including: focus on the 'how' rather than the 'what'; investing in competencies and skills for future sustainability (e.g. training; information and guidance; peer learning).

Table 5 summarises the implementation support approaches identified within each of the five chosen policies (alongside that of the Care Act) and ranks their properties against the three models identified above. An important caveat needs to be entered relating to the paucity of detail – or indeed any data in some cases – on the nature of implementation support for these other policy domains.

Table 5: Implementation approach methods within case studies

Implementation Approach	Brief description of approach	Approach exhibited in…						Performance management	Problem-solving	Capacity building
		CCSF	Sure Start	HWB	Troubled Families	Vanguards	Care Act			
Information dissemination, learning and awareness										
Phased implementation	Phased implementation approach		✓	✓	✓		✓	In part	Yes	In part
Written support	Provision of practice guidance	✓	✓	✓	✓	✓	✓	Yes	In part	In part
Product development and information dissemination	Publication of support activities and distribution of funds, as well as the production of new products for implementation support to be disseminated to local areas	✓	✓		✓	✓	✓	In part	Yes	No
Increase public awareness	Commissioned research on regional and local variations						✓	No	Yes	No
Regional support	Appointment of regional teams to promote implementation		✓				✓	In part	Yes	In part
Provider implementation support	Provider engagement work to gain understanding of implementation support needs		✓		✓		✓	In part	Yes	In part

Stakeholder support	Providing information and resource support to key organisations and groups involved in implementation process	✔	✔	✔	✔	✔	✔	In part	Yes	No
Stock-take support	Providing regional and LA support for conducting stock-takes of resources						✔	In part	In part	In part
Training courses and workshop support	Aiding the dissemination of information	✔	✔		✔	✔	✔	In part	Yes	In part
Dedicated support	Individual area Officer/Advisor made available		✔		✔			In part	Yes	In part
Targeted support	'Support Force' targeting specific authorities	✔						Yes	Yes	Yes
Risk management, mitigation and risk registers										
Risk management	Identifying risks in the implementation process and producing guidance on mitigation strategies						✔	Yes	Yes	In part
National programme coordination and delivery										
Translating products from national to local	Production of local guidance		✔				✔	Yes	In part	In part

Individual lead areas	Local areas taking the lead to develop new aspects of care models					✓			In part	Yes	Yes
National coordination	National coordination of funding and resources for regional and local implementation	✓	✓		✓			✓	Yes	No	No
Payment by results	Detailed financial framework illustrating payment by results				✓				Yes	No	No
Adaptation of delivery models	Local level delivery models able to be adapted to meet local need	✓	✓	✓	✓	✓	✓		In part	Yes	Yes
Coproduction and collaboration											
Joint production of operating models	Authorities working together with National Government to refine and implement operating models		✓		✓	✓		✓	In part	Yes	No
Relationship management	Continual evaluation of relationships between partnerships of implementation partners, and, the public and private providers of care							✓	No	Yes	No
Collaboration, using and developing strategic partnerships	Linking relevant organisations in order to streamline implementation			✓				✓	No	Yes	Yes

Although many of the policies have been subject to an evaluation, few of the studies detail the approaches of implementation support provided. This in itself is an important finding although a somewhat frustrating one from the point of view of our study. The main exception is the Vanguard Programme where the national evaluation team mentioned earlier were explicitly requested to examine the support programme. Given this was the only evaluation to include a component to examine the programme support structures, and that it overlapped with this study, it suggests that implementation support has tended to be regarded as somewhat marginal to successful policy implementation. It also underscores the importance of our study of implementation support in regard to the Care Act.

Notwithstanding these drawbacks, common themes emerged from the exercise, suggesting that performance management and problem solving were the dominant characteristics of implementation support approaches. Performance management as a dominant characteristic is perhaps not so surprising given that in order to be included within the sample policies needed to be of a national nature and have statutory underpinning guidance. Likewise, problem solving as a dominant characteristic could be argued to be an expected element of an implementation support approach as it is a means of assisting recipients in implementing the policy/guidance in question.

A key feature of all the policies reviewed was the level of locally developed delivery models to meet the identified need presented by national requirements.   Locally developed implementation guided by national performance management allowed local areas the flexibility to implement their own solutions to national requirements. Capacity building was evident in around two thirds of the identified implementation approaches and was accorded greater prominence within those which focused on support (i.e. through provision of Advisors/Support Force) and where local areas were granted greater autonomy to deliver models of service that met local needs. The Vanguard programme aimed to provide a more comprehensive support as detailed in table 6. The support package was informed directly by issues highlighted by local Vanguards and their stakeholders (including clinicians and patients) over time and aimed to build on local experience sharing practice and developing common opportunities for radical care redesign and remove barriers to change.

Table 6: Vanguard support programme features

Areas of support	Description
Designing new care models	working with the Vanguards to develop their local model of care, maximising the greatest impact and value for patients
Evaluation and metrics	supporting the Vanguards to understand – on an ongoing basis – the impact their changes are having on patients, staff and the wider population
Integrated commissioning and provision	assisting the Vanguards to break down the barriers which prevent their local health system from developing integrated commissioning
Governance, accountability and provider regulation	helping the Vanguards develop the right organisational form and governance model, as well as understand the impact on how they are regulated
Empowering patients and communities	working with the Vanguards to enhance the way in which they work with patients, local people and communities to develop services
Harnessing technology	supporting the Vanguards to rethink how care is delivered, given the potential of digital technology to deliver care in radically different ways. It will also help organisations to more easily share patient information
Workforce redesign	supporting the Vanguards to develop a modern, flexible workforce which is organised around patients and their local populations
Local leadership and delivery	working with the Vanguards to develop leadership capability and learn from international experts
Communications and engagement	supporting the Vanguards to demonstrate best practice in the way they engage with staff, patients and local people

While priorities for support were driven from the bottom up, i.e. by what Vanguards specified they wanted in terms of help and support, the national evaluation identified two key concerns:

- In some cases the infrastructure required was not fully established to provide the support required
- Different types of support were needed at different times (technical aspects initially for example e.g. design) in the process and evolved over time.

The programme also tried to provide a balance between national and more local support respectively with local "account managers", regional level management and a national new care models team at NHS England.

NHSE has facilitated bringing Vanguards together via communities of practice, network learning calls, webinars, connecting sites to arm's length bodies, providing access to data, learning materials and tools and provided bespoke local support, e.g. quarterly progress reviews, solution-focussed coaching and dedicated account management support (NHS Providers et al., 2018). Recognising that different people learn in different ways, a wide variety of mechanisms to support learning were employed during the programme. However, as with other programme there were concerns about the timing and usefulness of support and the balance between support and performance management (Checkland 2018 personal communication).

A key feature of all the policies was the requirement to equip local users of support within local agencies with the information required to implement the policy. A wide range of approaches was evident across the policies although features such as 'increasing public awareness', 'regional support', and 'stock-take support' were accorded greater prominence within the Care Act and did not feature so heavily in other policies.

In terms of national coordination, all policies reviewed placed significant emphasis on the adaptation of delivery models to ensure that local needs could be met. However, only the Sure Start initiative followed the Care Act example by supplementing this approach with local guidance. 'National coordination' was an integral element in the majority of policies whereby direction was given at a national level in taking policy implementation forward – very much a traditional top-down model. Finally, several policies placed an emphasis on co-production and

collaboration with 'joint production of operating models' present in the Sure Start, Troubled Families and Vanguards initiatives, albeit to a lesser degree than the Care Act.

3.3   Conclusion

Although the other policies we examined shared some of the same approaches to implementation support, the Care Act employed a wider variety of support mechanisms in order to address every aspect of implementation (e.g. nationally produced guidance, regional level working groups, stocktake reporting mechanisms and so on). To that extent, in comparison with the other policies, it has proved distinctive and has also demonstrated a determination and commitment to providing implementation support that was welcomed and perhaps lacking from other policy areas.

From our mapping of other policies and the implementation support provided around the same time as, or soon after, the Care Act (notably in the case of HWBs and Vanguards which also fall within the remit of the Department of Health and Social Care), there appears to have been little learning from the approach adopted by the Care Act. The implementation of each policy seems to have proceeded in silos, oblivious to, and unaffected by, what has happened (or not) in other policy areas.   However, given the clear intent in developing support programmes for both the Care Act 2014 and the Vanguard programme, and interest in learning from these processes, there appears to be an increasing interest in the role of policy implementation support. Whether these support processes have been successful and what aspects of policy implementation support may be more successful than others is, therefore, important in relation to providing policy makers with valuable insights to improving policy implementation in the future.

4. Study findings

4.1   Introduction

This section is in two parts. In part one, at a macro level, data obtained from the document analysis along with interviews with Programme Board members and representatives from key stakeholders are presented to provide a background to the topics identified for inclusion in the subsequent interviews at the meso and micro levels. In part two, data from interviews at the macro, meso and micro levels undertaken is presented alongside document analysis from the NAO, set within McConnell's framework (see table 3, p25).

4.2   Why was implementation support needed?

The following three key data sources were utilised to better understand the reasoning behind the establishment of an implementation support programme for the Care Act: documentary analysis of Care Act Programme Board minutes; information on Care Act Programme Board actions; and an analysis of ten semi-structured interviews. For the interviews, we approached members of the Care Act Programme Board and explored the following questions with them: (1) Why was it considered necessary for an implementation support programme to be devised? (2) What were the aims and objectives of the programme? (3) How was the programme structured, and who was involved? (4) What were the main perceived achievements of the programme and what were the ongoing dilemmas? Three key issues were identified:

1. Inviting greater collaboration – involving a range of organisations in the planning and execution of the Act, as well as providing infrastructure to support implementation

2. Reducing the impact of risk – thorough planning for any risks that might occur during the process of policy implementation in order to aid smooth delivery of the Care Act

3. Providing clear information and guidance – using the knowledge and skills base of organisations outside of government to produce information relating to all aspects of the Care Act

A series of documents were produced setting out 'visions and priorities' for implementation support. Hughes' (2013) paper – presented to the PB – provides 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 the Integration Transformation Fund, corporate requirements and/or partnership arrangements to address* (p1).

The paper cites a number of advantages to a distinctive implementation support programme including collaboration amongst stakeholders; clarity in dialogue; and flexibility in the programme management tools. Additionally, capacity – in terms of resources and finance – is put forward 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"* (Hughes 2013, p.2).

4.2.1 The aims and objectives of implementation support

For the implementation of the Care Act, a number of documents were produced by the PMO, and members of the PB, in order to streamline and coordinate an approach to policy implementation. The initial documentation indicated that the programme should follow a cooperative and collaborative approach. On this matter, the paper by Hughes (2013) notes specifically that the implementation support vision is: *"… [a] wide range of activities, products, communications and infrastructure that facilitate a local approach to implementation. It envisages a national and local approach to developing products that are supported through regional and local networks that encourage sharing, collaboration and mutual support"* (Ibid, p.1).

Of these themes, the presence of a co-production approach has been central. Several meetings of the PB indicate that an insistence on collaboration was at the centre of the approach. The meeting on 28th November 2013 recorded that:

> *[A] collaborative approach was welcomed by the Board, and there was general agreement that using existing resources and engagement groups would be key. Linking to the earlier discussion on financial risks, the Board asked we be mindful of the demands of implementation on a local level in terms of already stretched resources, so any work that can be done nationally for everyone's benefit is to be welcomed. On the point of using the capacity of regional networks, the Board agreed this would be useful as part of a general 'smarter' approach to ways of working.*
>
> Programme Board meeting, 28/11/2013

The evidence from the national level interviews broadly supports the findings from the PB minutes. Participants were in agreement that the inclusion of multiple stakeholders in the planning process had been critical to developing specific guidance for the Care Act.

> *There's a group that you'll consistently find were involved throughout: Skills for Care, ADASS… There's a number of umbrella organisations like Care England, UK HCA, National Care Forum, which is charitable care providers. There would have been Carers UK or Carers Trust because of the carers' angle being crucial. TLAP for the voice of the sector and service users. I'm pretty certain [they] were involved all the way through to develop the national policy. What I do regularly hear from the sector and from various places is that it was perhaps the best example they had come across of genuinely co-producing legislation, genuinely not top down and done to. And that I've heard from various people right across the sector*
>
> (N10: Social Care Institute for Excellence)

A second key aspect was risk mitigation. The minutes from one PB meeting give an indication of one type of risk management used in the process of delivery:

CS informed the Board that a new risk register template (08/01/06) has been developed by the PMO following a risk identification workshop with SRO's. Once finalised, this will be shared with Board members for their approval. The register will include newly identified risks relating to finance, lack of provider readiness and changes in current political consensus

Programme Board meeting, 15/07/2014

Flexibility in delivery support with support at a sub-central level emerged as another key consideration. The programme aimed to produce flexible support arrangements that helped provide clarity and certainty at the earliest opportunity, without constraining local approaches or innovation would be of most value. The PB identified a need to provide infrastructure and capacity at a regional level, consistent with other regional mechanisms, to support local implementation activity by sharing practice, through communications, organising mutual support and identifying and seeking to remove barriers.

Analysis of the PB minutes and actions indicates that a number of implementation support methods were used, as well as details of how such methods were developed. The types of development and implementation support have been broadly categorised in table 7 below. Primarily, the PB minutes indicate that:

1. Public awareness was a key feature of the implementation process – it was seen as paramount that information was accurately disseminated to the regional and local level;
2. Stock-takes at the local level were a concern, and the tools to understand preparedness were developed quickly;
3. Elements of risk at all levels of implementation were considered thoroughly.

Our national level interviews included representatives from the Department of Health and Social Care, NHS England, Skills for Care, ADASS, Social Care Institute for Excellence, and, the LGA. Drawing upon these interviews we have further identified a range of support practices to better understand and categorise the data shown in table 8 below.

Table 7: Description of Care Act development and implementation support methods

Phased implementation using scenario analysis	Scenario planning workshops – i.e. coordinating implementation at the national and regional level, using comparison of scenarios
Translating products from national to local	Production of new guidance from the PMO
Identifying risks using a risk register template	Risk identification workshops with regional and local coordination
Public awareness strand	Commissioned research on regional and local variations of social care
Product development	Publication of support activities and distribution of funds, as well as the production of new products for implementation support
Collaboration	Use of existing resources and engagement groups on national and regional level
Provider implementation support	Provider engagement work to gain understanding of implementation support needs
Distribution and allocation of funding	Government allocations methodology – consultation with regional implementation offices and local authorities

Table 8: Implementation support typology from national interview data

Categories of support	Brief description
Stakeholder support	Providing information and resource support to key organisations and groups involved in implementation process
Risk management	Identifying risks in the implementation process and producing guidance on mitigation strategies
Funding management	Central and regional management of funding for implementation support
Relationship management	Continual evaluation of relationships between partnerships of implementation partners, and, the public and private providers of care
National coordination	Using PMO and PB to coordinate funding and resources for regional and local implementation
Information dissemination	Using PMO and PB to coordinate information dissemination in local authorities
Stock-take support	Providing regional and LA support for conducting stock-takes of resources
Strategic partnerships	Linking primary care organisations, care groups, third sector organisations and private sector groups in order to streamline implementation
Training courses	Courses run for the benefit of local authorities in updating own knowledge base on details of Care Act and its implications
Work-stream approach	Organising different work-streams for components of implementation – i.e. finance stream, workforce stream
Workshop support	Organising workshops at a regional and local level to aid dissemination of information

4.2.2 Perceived problems and achievements

As with the wider issue of policy implementation *per se*, there is always the possibility that implementation support arrangements themselves might fail to change behaviours and outcomes. From the perspective of the national level interviewees, speaking with the advantage of hindsight, the process was felt to have been largely well received and successful along several key dimensions.

4.2.3 Clarity of information and guidance

One of the primary goals of the programme was to provide a suite of information for dissemination at the regional and local level – explaining the legal aspects of the Care Act, and setting out plainly new terminologies associated with the Act such as the 'wellbeing' principle. The primary goal here was to provide a standardised set of information for local authorities to aid training and learning for staff and professionals. Broadly, our national level interviewees felt that the programme had succeeded in producing clear guidance on the Act. According to one respondent:

> *We produced a whole load of learning materials around each aspect of the Care Act [and] we worked very closely with the sector and the civil servants to ensure that the all the right material was fitted with the practice guidance that they were giving for each part of the Care Act… We also then alongside that developed a hosting mechanism for e-learning units around the Care Act. The other piece of work we did alongside that is we produced a workforce capacity-planning model [and] fitted that within our workforce planning model so it wasn't something that local authorities found was suddenly new. But it fitted in with what they were doing but we tweaked it specifically to fit with the Care Act*

> (N7: National Level Partner Organisation)

The materials produced at the national level were generally felt to have provided the necessary frame for regional leads and local authorities to inform and advise their own workforce. This element was seen as crucial in the delivery of a national level programme.

4.2.4 Collaboration and infrastructure

A further major perceived achievement was the programme management approach to delivery of the Care Act. It was frequently mentioned that the inclusive approach to design and execution helped to aid policy delivery – in other words that collaborative policy *design* is an essential precursor to collaborative policy *implementation*. Indeed, this was seen as holding the potential for future institutional learning and other major policy programmes:

> *The thing I really like about it was the strong programme management approach, and I think if you use that and then as part of that think how widely you involve stakeholders and, you know, are there restraints then you can measure that then, then I think that's a really good way of doing policy. And we are using that kind of technique more and more, actually, this whole programme management approach to policy.*

> (N4: Local Authority Chief Executive)

The success, in this case, is identified as national coordination and delivery, which sought to provide 'on-the-ground' support in local authorities through workshops, meetings and presentations – situated either locally within the authority, or centrally at the Department of Health. Those that reflected on this approach also commented that the involvement of organisations at all levels aided policy delivery and implementation. One respondent went as far as to describe the experience as '*the most involving process I've come across, and I've been involved in policy research and government work for a long time'*

> (N10: Social Care Institute for Excellence)

4.2.5 Products and programme management tools

The programme was not understood by our national respondents to have been without delivery flaws. One was around the knowledge base.

> *The department had some civil servants who had a social care background and they had seconded in one or two people specifically for their social care knowledge. With the last set of changes, that's changed entirely. There are very few civil servants with any great understanding of social care policy and they don't have any secondees into the department to fill those gaps*

> (N1: Local Government National Officer)

In effect the intention was to deliver the Act under a set of implementation support arrangements that it was felt had previously not been employed for major policy shifts.

4.3 Helping to secure policy legitimacy

4.3.1 National perspective (Macro level)

There was a strong sense of the importance of co-production with key national stakeholders, which was viewed to give the policy legitimacy. Comments regarding the securing of legitimacy were overall positive with a number of illustrations of how this had been achieved put forward.

Policy legitimacy was most visibly secured through the formal establishment and signing of a memorandum of understanding (MOU) between the Department of Health and Social Care, the LGA and ADASS. The strength behind the formation of this partnership is also explored through the second component of the framework, 'developing stakeholder support'. However, one of its key features was the promotion of the legitimacy of the policy through key organisations coming together to ensure the successful implementation of the Care Act. The MOU was suggested to '… *document this vision for co-ownership of the programme.'* (N5: Senior Civil Servant). In addition, it *'…set out that involvement and influence would be at both of those levels* [Senior management and PB], *seats at the programme board, yes, but also, you know regular reviews with the SRO and joint sign off of recommendations that the SRO would make to ministers who would ultimately would have made decisions on the Care Act 2014'* (N5: Senior Civil Servant).

The MOU also provided a degree of transparency to the joint working arrangements between stakeholders and provided legitimacy through the *'…formalisation of joint working…'* (N8: Senior Civil Servant).

Another key aspect in helping to secure policy legitimacy was the establishment of the PB. The PB formalised the joint working arrangements between stakeholders and had representation from a number of areas including professionals. This link to professional occupations directly connected to the Care Act, notably social workers, gave the opportunity

for experienced minds to comment on the developing guidance being overseen by the board. The co-production endorsed by the formation of the PB was intended to help to identify the big issues and risks, and to aid communication between stakeholders, whilst providing a legitimate framework within which stakeholders operated.

The involvement of the Major Project Authority (MPA) was also commented to provide credibility and policy legitimacy through the provision of independent views. The MPA works with HM Treasury and other government departments in order to provide independent assurance on major projects and assures support and reporting on the Government Major Projects Portfolio. Finally, project legitimacy was also evident through the decision to set up regional activity (see later sections for discussion on local activity).

The main concerns with regards to securing policy legitimacy were queries around the completion of stocktake reports where some at a national level felt that a number of authorities may have been *'…projecting a rosier picture than was actually the case.'* (N9: Local Government National Officer).

4.3.2   Regional perspective (Meso level)

In terms of securing policy legitimacy, the importance of the Regional Coordinator role was highlighted. The role was viewed as an essential 'go-between' from the centre to the local, providing the, *'…conduit from the centre through into the regions and out into councils'* (R3) and facilitating rapid information exchange. The Regional Coordinator was described as having 'privileged access' to information coming from the centre, and through contacts built in the region was able to disseminate this information to relevant staff. This approach was reported to alleviate the potential for information/emails to get 'stuck' in inboxes (of Directors for example) or not be passed on to the right people. At the same time the regional coordinator was in a position to feed into the centre the views of those in local implementing centres – a two-way conduit of information exchange.

Policy legitimacy was also seen to be secured through a process of intensive collaboration and coproduction of knowledge, secured through: 'a mixture of training, support, facilitating peer support, making sure we [the regional contacts] were engaged in consultation'. It was also

made clear that the funding made available at the regional level (although far from substantial) was crucial to the implementation process:

'The approach the civil servants took to coproduction of policy guidance was I think innovative and should be repeated. The implementation funding [funding made available from national to assist with implementation at the local level] *was critical. It was critical then. It would be even more critical today when we all have a lot less day-to-day resource than we had in 2013. Another five years of austerity and, you know, we just don't have the same numbers of people to divert to stuff. So, I think that made a lot of difference.'* (R5: Regional co-ordinator)

The stocktake process was highlighted in relation to conflicted attainment of securing policy legitimacy. It was thought as a process to lack supporting evidence and instead of being used as originally expected, the exercise developed into a performance management tool with the risk of becoming counterproductive as people distrusted the process.

Mixed views on the availability of Care Act guidance were also given, both during and leading up to implementation giving rise to a feeling of conflicted attainment. The national level information on the Act, as provided by Department of Health and Social Care, had been delayed a number of times in 2013, leading up to the full implementation of the Act.

4.3.3 Local perspectives (Micro level)

Relative success

Information flow was highlighted as a key concept in securing policy legitimacy with specific emphasis placed on the importance of information coming from the centre, through regional leads and appointed internal leads, into the local authority. This hierarchical information dissemination flow was viewed as providing credibility to the changes being incorporated at the local level given that the messages had been developed with the wider policy field and not just within the Department of Health and Social Care. The LGA, ADASS, Department of Health and Social Care and Public Health England were all named as being visible both through active engagement at national and regional events and through email communications in

connection with the Care Act. This wider presence helped to secure policy legitimacy at the local level as the organisations were viewed to have *'clout'*.

Overall information flow was praised and viewed to be very much a two-way process with information being able to be fed back to the centre on local needs and interpretations. The significance of the Regional Leads was highlighted as a key driver for enabling the information flow between national and local level, acting as a 'go-between' providing an accessible vehicle to promote information exchange (see section 4.4 'Developing stakeholder support' for further discussion on the role of Regional Leads).

National communication tools were, overall, well-received. However, some discussions regarding the lack of local input into such materials were raised. In particular, one area queried how household distribution lists and radio advertising slots had been formulated, as local knowledge input could have ensured that more relevant distribution channels were used. However, those that used the national tools often reported that they were a cost-effective solution to disseminating information, for example:

'We used the leaflets and information. Because things were slow to come out in terms of the care and support statutory guidance and the detail of things, it's very difficult to produce that locally, and very costly, especially if the messages are changing slightly some of the time. So it makes sense to use the national publications. So we used quite a lot of the national messaging and websites and linked to national information so it was very useful.' (D3, Operational staff)

Following the effect of having clear national leads for implementation, many local authorities identified internal leads to secure legitimacy of implementation at a more local level. These leads typically developed local delivery plans and identified relevant in-house resources to aid implementation. Comments were also made by some operational staff and management in relation to the stocktake process as aiding implementation through providing useful information regarding what was currently happening within the authority and what still needed to be done.

For users and carers the availability of information on the Care Act was a fundamental issue and one where local authorities and national government have been – in the opinion of the focus groups – unsatisfactory. Further to this, the treatment of carers, in terms of funding arrangements, was deemed to be poor under the Care Act:

> [You] *can't get your pension and you can't get the carers' allowance at the same time and I know some areas, we're lucky in* [area] *we've got Carers Together, but I've got a sister in* [neighbouring area] *and since the new Care Act, they get nothing and I mean nothing…*

Respondents in our group discussions with users and carers, in the main, were negative about the availability – and delivery – of information.

> *It was mentioned [the Care Act] at my wife's annual assessment, but it wasn't mentioned the first year as something that sounded important, if you know what I mean. The fact that I already knew about it because Carers Together had told us about it, I was ready for it coming and I said, oh yeah, I want an assessment, and she said, I'll do it now, and I said, no you won't, I've already made arrangements for Carers Together to do it for me.*

The above respondent is typical of the responses received during the focus groups. Most commonly, participants would speak about their experiences of receiving information through the use of external or third-party organisations – not via the local authority or national government. This view was reflected by several participants in the focus groups:

> *We're lucky, because, as I said, we can go to people, we can go to Carers Together and the people that we go to give us the information. Now, if we didn't have the arm of Carers Together around us, can I put it, if we were doing it through the social worker, whether we would get the same information and feedback I think is highly unlikely, but that's only a personal point of view, but it's these people that are around us and help us and support us that really know the score.*

Furthermore, on this point, participants tended towards speaking about general awareness regarding the Care Act, or, a lack of awareness, which stemmed from a perceived scarcity of information as well as a distrust of the source -the reasons given were, more often than not, due to preconceptions about the national government, and the treatment of carers as being 'unfair'.

> *There are an awful lot of people out there that know nothing about anything and in a way it's not fair. We're saving the government that much money a year and I think we're treated pretty shoddily.*

Conflicted attainment

As alluded to in the above 'relative success' section, information flow at the local level came under criticism whereby the implementation support programmes effects did not always reach all connected staff groups. With different authorities adopting different internal structures and information flow paths, there was an inequity in terms of the effectiveness of localised information flow. Each appeared to be very local context specific and reflected the needs and capacities of the authority.

It appeared that there was a perception by many that information within local authorities would cascade throughout staff teams in a similar fashion to the flow from the national, through regional, to local information flows. However, issues were raised in relation to 'who' was in receipt of the information coming down from national sources. It was a matter very much linked to internal organisational structures and communication channels within the local authority. Identified Care Act Project Managers and Senior Managers in general had no issues with the information coming into the authority. The perception was rather different in the cases of middle managers and operational staff who sometimes queried the information flow. In some instances this perceived lack of information from national sources was felt to have hindered implementation support:

> *'...I think there's always a bit of an issue there about either it goes to a lead or it goes to someone and then while they share it in that little pocket...'* (E9, Operational staff)

Due to this perceived lack of national level information providing the steer for implementation, operational level staff often found themselves in situations where they had to make their own interpretations of policy implementation. This could result in operational confusion:

'…it just didn't filter down to me, but something about some kind of steer or guidance around for implementation about what we need to be checking and what we need, because nobody said make sure your recording systems are up to date, look at your paperwork, look at what leaflets you've got, look at your communications, look at your policies. Nobody actually gave us the steer to do all that. We were going oh that's going to say the wrong thing now, quick, we better update that.' (E9, Operational staff)

In addition to the overall comments on information flow, the timeliness of implementation support guidance was frequently cited in terms of conflicted attainment of securing policy legitimacy. Guidance documentation was viewed as being issued late in the day, with feeling rushed being a frequent observation. Concerns about timeliness of guidance were identified in the NAO Phase I review:

'[Local authority] *feels that some guidance missing from DH on key issues – e.g. assessments for those in residential care; DH made misjudgement over money for deferred payments; major risk going forward is workforce capacity'* (Note from NAO Interview)

Following up on this point, using data from our own study, there is clear evidence to show that little had changed in terms of confidence in the Department of Health and Social Care. Data from the same case study site (as that presented above) shows that one participant expressed the view that the outstanding issues on models of financial support, and of guidance on the Act itself, had been detrimental to the implementation process.

If they'd [the DH] *been upfront about well we're actually not sure how to do this so let's bring people together from different councils and talk that through, then that's fine. You know, develop something amongst ourselves. But the fact there was these different models going around and so you weren't quite sure well which one should we do, and is*

this going to be replaced two weeks down the line by something else, you know, well it was a bit frustrating and probably duplicated effort in some ways. So being upfront about it would have been much better. (E12)

In this case, the evidence presented on both counts indicates that there were real issues with the level of support from the Department of Health and Social Care and the associated implementation support process. In respect of this particular case study site, much of the internal work had already been produced, and could have been used to ease implementation. However, uncertainties about guidance on the Act had created more work for council staff than was necessary and it was not felt that sufficient time was provided to implement all elements of the Care Act properly.

'I think when you're implementing such a large piece of legislation such as the Care Act, I mean that was huge, massive. It may be better to implement it in blocks over a period of time. So elements of the Care Act over a period of time so that, you're leading up to a go live date when all staff have been trained up to an acceptable level.' (E12, Senior Manager)

As already noted, reactions to the stocktake process were mixed. Some found the process useful in helping to identify work still required. However, some were very negative, highlighting a tension between having support and performance management functions sitting within one implementation support model. It was stated by some that results were used as a performance management controlling mechanism rather than a supportive approach to assist with identified areas of need. Accordingly, subsequent stocktakes were filled out with information which it was thought the Department of Health and Social Care wanted to hear rather than the reality of the local situation. This is an important consideration in assessing the likely effectiveness of implementation support measures.

Relative failure

The only real failure acknowledged in terms of securing policy legitimacy was in respect to uncertainty over phase 2, which in turn was felt to have impacted on most aspects of

implementation for phase 1. This might best be regarded as a failure of policy design rather than of the support arrangements.

4.3.5 Helping to secure policy legitimacy: A summary

For this component we wished to understand how far, and in what ways, the creation of the implementation support programme had itself helped to shape the legitimacy of the policy, namely, the Care Act 2014. This is about more than simply bringing legislative requirements to the attention of those responsible for putting them into effect; rather it is about helping to demonstrate that the policy design is robust and that key implementation implications have been properly taken into account.

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. However, these concepts already had widespread support within many local authorities and to that extent, the Care Act could be regarded as going with, rather than against, the grain of organisational and professional thinking. To some extent this limits what can be learned from this particular case study about the value of implementation support programmes; different challenges would be faced in more controversial policy domains in which policy legitimacy is questioned.

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 implementation support programme. In terms of securing policy legitimacy, two key sources needed to be accessed by the programme - expertise and governance. In the case of expertise there was an explicit recognition at the national level that the experience and understanding needed to make the Care Act work was held not by the centre but by the multiple local implementation bodies. Some means therefore had to be found to access this experience and expertise in order to lend credibility to a support programme. In the case of governance, local authorities – although largely funded by central government – retained their own democratic legitimacy

and would be free to decide how best to make use of their resources in relation to their Care Act responsibilities. Co-opting key representative bodies of the implementing agencies – the LGA and the ADSS – into the support programme offered a means of linking national and local levels of governance.

Our fieldwork suggests that these arrangements were successful in helping to secure legitimacy for both the Care Act and for the support programme. 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. On the contrary, where reservations were expressed at local level about the programme these tended to be about the need for greater support rather than its removal. Our conclusion on this dimension of the framework is that the Care Act implementation support programme was successful both in securing its own legitimacy and in reinforcing the legitimacy of the legislation.

4.4   Developing stakeholder support

4.4.1   National perspectives (Macro level)

Stakeholder support is viewed as the greatest strength of the programme and therefore runs across all the domains comprising our framework. It was highlighted that the collaborative approach associated with the Care Act was a continuation from the white paper, *Caring for our future: Reforming care and support,* and the Responsibility Deal. The white paper in particular was complimented for the way in which it engaged the wider stakeholder community. This collaborative approach then followed through to the way in which the Care Act was to be implemented. The importance of the collaborative approach was identified in the NAO's Phase I review. The NAO report concluded that, as a result of 'joint working', objectives were achieved sooner than might have been the case in a different setting.

It was also acknowledged that all local authorities had to implement Care Act changes in order to deliver expected outcomes and therefore *'...you could not do that without a partnership with the organisations that represent those local authorities, which is the LGA and ADASS'*. It was also commented that *'...the department* [of Health] *got a lot more in terms of an*

understanding of the system, how the system works and what it needed to do to achieve its policy objectives than if it had done it solely on its own.' (N3: Senior Civil Servant)

At a national level the PB gave formality and structure to the partnership arrangements. The PB was described as very much a joint policy team and there was an acknowledgement that the individual strengths of the partners needed to be identified and determine how such strengths could be employed to best effect change.

Through the interviews there emerged a strong sense among all parties of wanting to make the policy implementation work and, from this belief, strong commitments to ensuring its success were made across the board. This may have been because the Care Act, although complex, was aligned with the pre-existing aspirations of the stakeholders. It was this belief in the partnership that allowed for productive conversations between organisations that may have more commonly been adversarial. The partnership approach was believed to make people feel that they were *'…genuinely co-producing legislation…'* and that it was *'…genuinely collective effort'* (N6: Director Adult Social Services). This was viewed as a new approach for social care.

Comments were also made on the processes being perceived as very open with a lot of stakeholder support influencing decisions. This openness was commented on as bringing a sense of ownership and buy-in to those involved and was therefore thought to reduce the likelihood of subsequent failure. It was highlighted that *'…anything that does away with this and them mentality, particular at the moment in the current context of pressures, is hugely helpful'* (N9: Local Government National Officer).

These arrangements even had the effect of introducing some co-location of stakeholders that would not have otherwise occurred. It was reported, for example, that ADASS and LGA staff shared work spaces in some instances through a 'joint office programme'. This approach was thought to facilitate joint working and develop *'…more rounded thinking.'* (N9: Local Government National Officer).

Stakeholder support was not only commented upon as being strong at a national level, but also at the local level by national representatives. Local government was reported to have a level of trust in what was being done and *'...a huge amount of influence over it'* (N5: Senior Civil Servant). There was said to be a clear plan of co-ownership between central government, local government and adult social care leadership. The introduction of regional resources and capacity to shape regional activity was also felt to be a popular development by national level stakeholders as it allowed for people to take responsibility for their own future.

Although, overall, comments towards developing stakeholder support were positive a few concerns were highlighted through the interviews alluding to tensions between organisations involved. Conflicts appeared to centre on being part of the partnership and the role of the organisation – for example the LGA's role as a membership and support organisation and it being part of a central government policy implementation partnership. Sometimes the two did not fit, with examples such as communications coming out from only one partner where another partner did not agree with the messages being distributed, *'…you know, if it was ultimately being driven by DH and we weren't happy with the message, yet we're in a joint project team, how does that work? So there were occasions when some of the communications came just from DH, I think, and just from us particularly around the delay for instance...'* (N9: Local Government National Officer). It was also reported that although work was undertaken as a partnership, ultimately it was the Department of Health and Social Care that was accountable for the actual delivery of the Care Act and that the partnership was *'…collaborative up to a point and then DH ownership sometimes did kick in.'* (N9: Local Government National Officer).

It was also suggested that perhaps insufficient time had been allowed for the setting up of the partnership as the range of stakeholders meant that not everyone understood each other's contribution to the group. This lack of understanding was perceived to be a cause of tensions: *'So I was being commissioned by colleagues at DH who understood workforce development. But then working alongside the programme office who did not understand workforce development at all in any way whatsoever could cause significant tensions.'* (N7: National Level Partner Organisation).

4.4.2 Meso Level: Findings from the Regional interviews

One of the key benefits of the regional role was the promotion and development of stakeholder support through the region. The coordinators role seemed to be very much connected to fostering and facilitating stakeholder support at the regional level between stakeholders across the local authorities within their area. This facilitation was primarily undertaken through the establishment of regional groups, some of which already existed for other purposes. These groups were commented on as promoting peer learning and mutual support between the stakeholders. At the heart of this approach was the building of trust between stakeholders which was said to have facilitated a *'…huge amount of sharing informally'* with a *'...lot of personal investment in supporting and sharing good practice.'* (R2, Regional Coordinator. The groups were believed to have developed and facilitated collaborative cultures through the promotion of inclusion. It was also noted that the groups provided a focal point for local authorities in terms of asking questions and gaining information:

> *...a lot of people were very nervous about the new legislation and very concerned about what they had to have in place and really were looking for an opportunity to find out what other councils were doing and what they should be doing and to get some kind of peer support around that, so a lot of relief really that there was somebody in place that was a sort of focal point for their questions, their queries and to circulate good effective knowledge.* (R4, Regional Coordinator).

The use of regional groups was not new. For many, the implementation groups built on existing infrastructure:

> [We] *did have, or we do have a structure of networks and groups. I mentioned workforce but we also have a performance group, a carers group, and informatics and safeguarding. A lot of the discussion and consultation was with those groups as well. So, it was individual Care Act leads but it was also the existing structure of networks and groups within the* [Region] *within an overall framework of governance which was the Care Act programme board reporting to* [Region] *ADASS…* (R4, Regional Coordinator).

Examples were provided of groups containing a mixture of local representatives from Assistant Directors down to Team Managers. However, it was stated that there was no hierarchy in the room, just people interested in the implementation of the Care Act.

It was not only within the region that stakeholder support was evidenced. At national level also, Regional Coordinators met with their peers and national colleagues to share ideas, promoting the ethos of collaborative working throughout the structure.

Most Coordinators highlighted that they were given 'free rein' in terms of approaching support activity in the regions. This appeared to be an important aspect to the role as it allowed the Coordinators to address the individualised nature of each region and respond to emerging themes without being constrained by a nationally imposed framework.

4.4.3   Local perspectives (Micro Level)

Relative Success

Overall there was a very positive response to the development of stakeholder support. The findings demonstrated that participants found the 'collective' nature of the implementation process integral to successful policy delivery. Using data from our case studies, and mapping it against the NAO information, we found a clear continuity of views in terms of stakeholder and partnership working:

> *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…* (C5, Operational staff)

In particular, in terms of developing stakeholder support, we were able to identify from the case studies included in both the NAO and our study that the workforce benefited from a partnership approach. Stakeholders also mentioned in relation to success, that collaborative working included approaches internal to the local authority, consisting of staff from across a

number of departments and those external to the authority but working in similar positions where regional groups were used to bring people together.

Internal implementation support procedures were also evident and too many were seen as a better option than bringing in a range of external consultants. Within the authority such approaches were fostered through the utilisation of staff from different teams to provide specialist knowledge, as well as through the formation of project teams. This use of existing networks was often preferred to setting up a specific implementation support function within the authority. For example, some authorities reported using existing project management staff to lead implementation, while others reported using existing meeting structures to assist with information flow throughout the authority. In addition, local authorities established their own local support networks and accessed/commissioned their external support. This included establishing internal teams, working with other authorities, and commissioning specialist expertise and training.

Overall, there was strong support for the regional implementation support approach provided for the Care Act. This approach was thought to create a *'team ethos... across the region'* (B3, Senior manager) and a sense of shared purpose, *'…we all felt very much in the same boat'* (C7, Operational staff) thereby reducing feelings of isolation. However, regional networks and the importance placed on them was found to vary across the case study sites, with some finding the function vital whilst others were not even aware of their existence. This variation highlights the importance of the influence of different local contexts in the development of implementation support mechanisms.

In many instances, regional networks were not new. Existing meeting structures were re-shaped to reflect the needs of the Care Act. Interestingly, there seemed to be a North/South divide with the Northern case study sites placing a greater emphasis on the collaborative approach fostered through the use of regional leads and attendance at regional groups than the Southern sites. Also within organisations, some members perceived the regional approach to be more significant than others did. Project manager and senior management were often much more positive in their responses to the input of the regional lead approach than less senior members of staff. This could be due to more senior staff members and project

leads being the key links to the regional Leads and groups and thus viewing them more favourably and also being in receipt of first-hand national communications rather than having information fed back to them through local internal communication channels.

The regional meeting approach was praised in terms of its ability to share information across the region which allowed for a place to discuss ideas and to identify and then share best practice. Information was also received directly from national sources through regional meetings, providing opportunities to *'…share, hear from centre, hear from DH, share practice what are other boroughs doing, and just a useful check.'* (F7, Senior manager).

The opportunities for peer support and networking at regional events was noted by many to be more beneficial than the formal information-giving. The perceived benefit of having a range of authorities within regional forums was to enable discussions with a good 'cross-section' of ideas: *'...superb ideas came through from lots of different authorities who were just approaching things in a slightly different way but going away from that and looking to see what would best fit.'* (B6, Operational staff).

As well as stakeholder support during implementation, comments were also made regarding the relative success of the involvement of implementing agencies in the policy design and not just presenting them with a policy fait accompli.

> *It was a lot of the pre-consultations that we did about these are the proposed outcomes, these are the proposed needs, this is the proposed eligibility, what do you think of it?* (F3, Senior manager)

Conflicted attainment

Only a small number of interviewees discussed conflicted attainment (patchy and uneven support and/or with some key groups missing) of developing stakeholder support. When they did discussions often related to external providers (such as IT), where there was a general feeling that bringing in external consultants was not successful as they did not always understand the local impact and context.

There were some comments that particular elements of the regional support were too forthcoming with information and that there was uncertainty over what needed to be done due to the amount of information received. In contrast, there was a perceived lack of support/guidance by some in terms of more specific areas such as prisons, safeguarding and housing compared to the more general principles of the act.

As highlighted previously, queries arose over who was in receipt of the information coming from both regional and national sources which led to questions regarding the accessibility of the programme for those who needed to make it work 'on the ground'. Internal local structures may have a part to play in clearer information dissemination. However, comments were also made on the potential benefit having of a closer face-to-face relationship with external stakeholders in terms of implementation support, as well as a feeling that although national level events are held they are often too far away to travel to and so attendance cannot always be guaranteed.

Relative failure

There was no deemed relative failure in relation to developing stakeholder support where it was utilised. However, the fact that some localities made little or no use of the regional facility has to be better understood.

4.4.5 Developing stakeholder support: A Summary

For this second component we were interested in the nature and extent of stakeholder engagement in the implementation support programme; whether all key partners had been involved and also the terms of their engagement. Our fieldwork suggests that the relationship between the three key national stakeholders – the responsible government department (Department of Health and Social Care), the representative body for the implementing authorities (the LGA), and the representative body for the implementing profession (the ADASS) – was a key feature of the support arrangements.

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. Often these will be treated as distinct domains, one the preserve of policy makers and the other of those tasked with putting policy into practice. The literature on the 'policy-implementation gap' has long since shown this distinction to be false and unhelpful but it is nevertheless unusual to see a structured attempt at national policy level to address this issue.

The ways in which these arrangements are structured are also vital. Any attempt to engage key stakeholders in a superficial and cosmetic manner would have led to charges of co-option without cooperation. And even if there is a genuine wish to fully involve all partners there are critical decisions to be made about the extent to which this should be formalised. In the case of the Care Act support programme a balance was drawn between a formalised agreement (a Memorandum of Understanding), complex organisational arrangements with a wide membership (the creation of a Programme Board, Programme Office and a multiplicity of work streams) and network governance based in long-standing high trust relationships.

Securing a workable balance between the legislative authority and the implementing agencies is an achievement not to be underestimated. It was clear to all involved that ultimate authority lay with the Department of Health and Social Care and that compliance with law, regulation and guidance was the bottom line yet this 'primus inter pares'[1] status was rarely raised as a problem by other stakeholders. Stakeholder engagement at national level was regarded as perhaps the key feature of the implementation support programme. It was a model of engagement that drew upon existing relationships, sought out external expertise, encompassed the sharing of ideas on policy design as well as on implementation, and balanced both bureaucratic and network elements of governance. 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. When assessed against the "developing stakeholder engagement" element of our framework, the Care Act implementation support

---

[1] first among equals (Collins dictionary)

programme scores highly given the way in which arrangements were developed and understood at national level.

4.5   Clarity of Programme Contribution

4.5.1   National perspectives (Macro Level)

It was suggested that the relative size and scale of the Care Act warranted a different implementation approach to previous social care policies. Building upon the partnership approach adopted, there was a desire for rapid cross-sector learning and development. This cross-sector learning was focused through a communications strategy that included a range of materials coordinated through local authorities in order that they had the tools required at their disposal to organise their own delivery in respect of the Act and communicate with the public as they saw fit. National guidance was reported to be well received with the Programme Management Office viewed as distributing good quality information. Helpful information was also noted to be coming out from the local government sector itself such as the National Association of Financial Assessment Officers where expertise was being drawn on in order to produce relevant information guidance. In addition, Skills for Care was formally engaged to provide guidance documentation for distribution in relation to workforce training.

In addition to the production of communication materials, the approach taken was also a mechanism providing clarity to the programme. As stated throughout, the approach taken to the implementation of the Care Act was viewed to be different to previous projects. It was stated that normally there is a clear separation between government and project; however, this structure saw involvement of stakeholders and decision makers all the way up to government. As previously highlighted, the 'co-ownership' structure was reported to assist with the clarity of programme contribution through the incorporation of specialists within established task and finish groups identified to look at specific elements of the Care Act implementation.

There was an acknowledgement that without this specific professional input, guidance documentation would have been too generic. In addition, the MOU which gave the policy

legitimacy, also served as a formal guide establishing management approaches and a level of transparency to developed work streams.

4.5.2 Regional perspectives (Meso Level)

Regional coordinators were generally positive about their own contributions and the work of colleagues in regional lead roles during implementation:

> *I would say there was a great willingness to share intelligence and for people to want to do that and that made the job much easier really. I would say that the support was good. It was well organised, it was responsive. And I suppose the indication of its value is that after the Care Act was implemented my role continued from funding within, there was no more specific funding available from DH to support the Care Act but they felt that there was a reason for the role of the regional lead…* (R4, Regional Coordinator)

As previously highlighted in regard to developing stakeholder support, the approach of regional groups was not deemed to be 'new' and so the clarity and structure of the programme contribution was well received by many. It was commented that there was a sense that the implementation approach was more of a *'[national] would like you to do… not a, you will do'* (R1, Regional Coordinator). This more relaxed, less top-down, directive approach encouraged 'buy-in' from both regional and local level stakeholders and allowed for a more operational role in assisting implementation at the regional level. Each region was set up slightly differently, however, with most having a number of regional level work streams around specific elements of the Care Act requirements. These were often those identified as challenging or completely new. This approach allowed for more focused discussions to take place in relation to these elements of the Care Act.

The experience and profile of the regional lead was regarded as important in terms of the clarity of the programme contribution. It was felt to be important that they had experience of local government in order to be able to effectively lead the region and disseminate important, relevant information.

One of the few negative points relating to conflicted containment of the clarity of the programme contribution was linked to the resource available at the regional and local level. This was thought to impact on capacity issues.

4.5.3 Local perspectives (Micro Level)

Relative Success

Overall, the Care Act was a welcomed piece of legislation and as such was not really contested. It was described as a *'consensual synthesis of a policy direction'* rather than a *'policy shift'* with the accompanying support programme on the whole valued:

> *Part 1 was a codification, synthesis of legislation policy into something which wasn't particularly either contested or particularly if you like ideological, although it clearly is ideological it wasn't ideologically contested. So the model of support actually worked pretty well for that. The bit that was more anxiety creating was a fork in the road, which was Care Act Part 2... The Care Act broadly we've been there before. Part two we hadn't.* (F4, Senior manager).

In terms of ensuring the aims of the programme were agreed and understood, comments again related to the establishment of feedback loops between local, regional and national bodies in disseminating information.

As highlighted earlier in relation to stakeholder support, the regional implementation support approach was again praised. The approach was deemed to help shape local resources through the provision of information and ensured consistent approaches across the region whilst also allowing for verification of information:

> *So initially it was are we doing it right, what's happening? So it was good to get other councils' opinions, and when you were hearing the same things, the same issues, it was sort of just backing that up to say well everybody's in the same boat with this. It's sort of suck it and see how it goes.* (A1, Senior manager).

The Regional Lead role within this support approach was held in very high regard and was identified as the *'driving force'* behind the implementation. *'…the fact we had someone like* [Regional Lead] *who was living and breathing it, it was ideal'* (B2, Senior manager). The Regional Lead was viewed to bring everything together and provide focus for the region. There was a concern that without the role there may have been a lack of focus due to competing priorities and the national voice would probably not have been heard at the local level. However, as already noted, this viewpoint was much more evident in the North than the South of the country. Linked to this, one of the Northern regions made a number of references to having a strong local identity and that this facilitated the regional approach.

National guidance produced alongside the implementation of the Care Act was regularly cited as a means by which to gain information and understanding of the Care Act implementation. Factsheets in particular were considered to provide easy to understand bite size information. Positive comments were also made in relation to the guidance provided through attendance at seminars.

National level information was usually taken by authorities and customised in order to inform local implementation. This process was stated to create a shared sense of understanding which was easier to engage with than centrally produced guidance. At a local level, pre-existing structures were used to facilitate information sharing with regards to implementation of the Care Act.

Between the national 'products' and regional level support there emerged an additional layer of information dissemination linked to clarifying the programme contribution. This related to the role of national level advisors being brought in to offer advice on specialist areas of support such as new legal requirements arising from the Act.   Opinions of external training brought in were mixed with some commenting that availability of such training was 'patchy'. All case study sites had a training plan in place to ensure all staff were fully up to date on the implementation of the Care Act. For some this was organised completely in-house using nationally available resources, whilst other areas brought in external specialist subject matter experts to facilitate the training.

Across the case study sites, a mix of approaches to implementation was evidenced. Some areas relied heavily on regional level support in order to confirm and clarify process that should be adopted whilst some did not appear to engage with the region, but instead opted to use the national products to provide clarification on implementation. Individual staff behaviours as well as previous ways of working were claimed to influence the approach adopted.

Conflicted attainment

Conflicted attainment on the clarity of programme contribution largely related to information/guidance produced and disseminated. Three key concerns were raised in relation to this: the changing of information and guidance, the need for local interpretation of the guidance and the late distribution of the information and guidance.

As understanding regarding the requirements of the Care Act was being explored, it was reported that guidance information was changing. This created a pressing need to keep up to date with guidance being published. For some this was described as causing 'information overload' with numerous documents produced and information distributed with a level of uncertainty over what needed to be adhered to. This links to the complexity component of the framework where questions were raised in relation to whether or not communications were as clear and succinct as they could have been. In addition, it was felt that some parts of the published guidance were contradictory and confusing, again contributing to the uncertainty over what information to take away from such guidance materials.

It was acknowledged by many that there was a need to locally interpret the national guidance produced. This approach was not always welcomed with some feeling that guidance needed to be more explicit to avoid having to constantly adapt locally produced guidance as a result of learning. This need for adaptation of the guidance was perceived to lead to variation between authorities which could lead to questions being raised by residents '...*well that's not done in* [County]' (A1, Senior manager). In addition, differences with Scotland were highlighted when referrals are made into adult social care, i.e. '*it's free in Scotland*' (A1, Senior manager). Overall there was a general feeling of inconsistency due to the amount of local

adaptability of the Care Act. This inconsistency resulted in a perceived lack of detail which was also stated to hinder communications strategies being put into place.

Following on from comments relating to helping secure policy legitimacy, timing was once again brought up as an issue. Late issue of information regarding practical aspects of the Care Act resulted in concern over the logistics of implementation. Due to the short timescales imposed by some aspects of the Care Act, some staff training had to be completed after 1st April. Overall it was perceived that there was a disconnect between when resources for workforce development were produced and when they were needed, with an example given that it was a year after implementation before specific Occupational Therapist guidance was issued. As well as being late, one respondent also commented on training being put in place too early:

> *…so badly delivered because it was too early on, there were still too many unknowns, or the guidance was just published and the training courses were the next stage, that all she was doing was reading from the guidance... So there was something about timing for us thinking we were getting some guidance that could have been interpreted and then put into something a little bit more interesting for a training course rather than it being so fresh just reading off what was published.* (D6, Operational staff)

The outsourcing of training was commented upon by a number of people, and was viewed at best as a mixed experience. However, there was a sense that external organisations delivering Care Act training were generally a waste of money due potentially to the fact the Care Act was so new combined with a lack of, or late, dissemination of guidance to inform training.

For some respondents the support arrangements were not only valued in the short-term but were felt to be a useful longer-term intervention:

> *What we might need now is ongoing support coming back and saying OK we've had a couple of years now, 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.* (F3, Senior manager)

…I think what's interesting is that the resources just went up to the inception. I don't think any thought has been given to are there any resources you now need to ensure it's embedded? (C4, Operational staff)

Although a number of respondents commented on the Care Act becoming 'business as usual' questions may need to be asked over when the national programme should cease, if at all, and whether some alternative 'step down' arrangement could be offered once legislation takes effect as there is evidence of a desire for continued support.

Relative failure

There was only one direct mention of relative failure in relation to clarity of programme contribution and that was an acknowledgement that there was a skill shortage relating to providing staff training for the changes that were coming into effect. An external provider therefore had to be commissioned to fill this gap.

4.5.4   Clarity of Programme Contribution: A summary

On this dimension of the framework our interest shifts away from understandings and aspirations at the national level and focuses on the implementing agencies that the support programme was designed to assist. In particular, we wished 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.

Use of Programme Products

On the first aspect, a battery of products – guidance, events, factsheets and more – was rapidly commissioned by the programme and offered, or distributed to, the implementing agencies. It is doubtful if this could have been achieved by the Department of Health and Social Care alone without the stakeholder engagement described in the previous section. These flows of information were widely seen as helpful in averting the need for implementing localities to create their own products for local consumption. 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 encountered at local level. Several recurring difficulties were identified during our fieldwork:

- *Timeliness:* The flow of information needed to match the implementation timetable imposed upon local authorities by the Care Act legislation; concerns were frequently expressed that the two were not well synchronised and this led some localities to seek external support, especially in relation to uncertainty around their legal obligations.

- *Customisation:* Standardised products commissioned and developed centrally were sometimes seen as insufficiently sensitive to local contexts and hence in need of local 'customisation'. Again this could involve external consultants (the experience of which was – at best – mixed) or in-house project management teams whose availability was limited in the wake of funding cuts to local councils.

- *Penetration:* While information flows between the centre, regions and senior managers in localities seemed good, there were frequently expressed concerns that messages had failed to penetrate through to middle management, front-line staff and users and carers. The situation with front line staff is significant since as 'street-level bureaucrats' they can be in a position to determine their own implementation priorities. The position of users and carers is critical. Given that the central premise of the Care Act is around user/carer wellbeing it is concerning that our focus group fieldwork revealed them knowing little about the Act other than what had been supplied by third sector agencies; more significantly they generally felt little difference had taken place in their lives.

Clarity over the aims of the support programme

The earlier discussions on policy legitimacy and stakeholder support describe a high degree of clarity at national level on what the support programme was aiming to achieve. This was not always matched at local level. The key tension here 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.

Arguably a national implementation support programme requires a high level of trust with the implementing bodies; a relationship within which those needing to put policy into effect can be frank and honest about what has and has not been achieved, and on realistic prospects for progress. From the perspective of the centre – and perhaps especially at political level – the stocktake findings could be viewed as necessary indicators of progress that can justify investment in the implementation support programme. On the other hand, localities can – 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 nor 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 purpose of their intentions.

4.6   Comprehension of Complexity

4.6.1   National perspectives (Macro Level)

Comprehension of complexity at the national level mainly focused on measures put in place to understand the complex nature of the local authority operational environment within which the Care Act would be implemented. At the time of implementation there were considerable changes (for example staff structures) within local authorities due to depleting budgets, resulting in pressures on the system that could impact on implementation; this was thought to create a need for a national support structure in order to promote successful implementation.

Part of this complexity relates to the different levels of governance and accountability. It was stated that there was a need to understand the *'…clash between national accountability and democratic local authority.'* (N8: Senior Civil Servant). In addition there were issues about lack of operational expertise - the central team had little experience in working with local

authorities, therefore professionals were brought in to comment on guidance who understood the complexities of specific sectors with a requirement for guidance produced to *'…actually work…'* (N2: Senior Civil Servant) in practice. Complexity was also addressed in relation to the multiple roles of the key partners, the LGA and ADASS. These organisations had to be part of the programme whilst retaining their core function, *'…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.'* (N3: Senior Civil Servant). None of these issues were simple to address.

One national respondent interviewed for the NAO review also highlighted that as a result of developing pilot local authority Care Act Frameworks and a separate national model there was a degree of duplication and confusion:

> *One of the things we could have done is actually been up front and said [local authority work E] is our Care Act framework... People are getting confused between why are we having a new practice model, signs and safety, when we've got [local authority work E]. And so, I think it would have been helpful if we'd said [local authority work E] is our Care Act framework* (E13, Senior Manager)

4.6.3   Regional perspectives (Meso Level)

Overall it was felt that having the regional post allowed for complexities of the Care Act implementation to be addressed. There was an acknowledgement that without the post a lot of time would have been spent from the centre chasing up local authorities to understand what they were doing over implementation. With the post, more time was able to be spent on programme implementation at the centre.

In terms of comprehension of complexity, the regional leads offered a positive account of dealing with the practicalities of implementation. By way of recognising that implementation of the Care Act would be inherently multifaceted, the regional leads were keen to demonstrate that several levels of support had been considered and applied.

[A] lot of people were very nervous about the new legislation and very concerned about what they had to have in place and really were looking for an opportunity to find out what other councils were doing and what they should be doing and to get some kind of peer support around that, so a lot of relief really that there was somebody in place that was a sort of focal point for their questions, their queries and to circulate good effective knowledge (R4, Regional Coordinator)

In the main, the assessment given by the regional leads was one of confidence in the implementation plan. One participant added that the success of implementation of the Act was continuing to demonstrate the efficacy of regional collaboration, and indicated that such an approach would be replicated in future.

I think we're still reaping the benefits from that because how can I say, it showed or I think it showed what the benefits of collaborating regionally on a bespoke piece of work and what can be achieved… (R6, Regional Coordinator)

It was noted by most of our interviewees that it was better that a regional rather than a national approach to implementation was taken as the differences between local authority areas are 'vast'. Therefore, priorities will be different and with limited resources some authorities would possibly not engage. However, if the programme was locally developed then local authorities would be *'...are more willing to put the time in because they've chosen those priorities'* (R1, Regional Coordinator).

It was thought that it was important for the coordinator post to be both strategic and operational. There was a need for the post to understand what was going on at the centre in terms of political influence, and how it related to integration at the local level. Regional Coordinators with a background of working in local authorities and already knowing a number of local directors gave the position credibility and meant they could understand the complexity of the issues faced and local challenges encountered.

You needed to understand the pressures that directors and adult social services were under in terms of, not only in terms of budgets, but in terms of demand and staff churn and manager churn. All of those things you had to understand because that would help inform you as to why council A was really slow and struggling with implementation; whereas council B were a little bit quicker off the mark. (R3, Regional Coordinator)

It was felt that Regional Coordinators needed to have a strong understanding of the local landscape and the pre-existing meeting structures and groups in order to facilitate discussions with these groups as and when required. In addition, the post had to be able to *'...translate the national policy stuff into what it might mean on the ground...'* (R2). In doing this there was also a requirement to identify and understand that all councils are different and that they therefore require different approaches. Examples were given of some councils being very forthcoming when it came to submitting implementation plans while others were not seen at Regional meetings due to capacity issues based on their small size.

4.6.4   Local perspectives (Micro Level)

Relative Success

Overall there was a feeling that the implementation support provided demonstrated awareness of the complexities of the implementation task. There was a general acknowledgement that training materials, including written information and guidance, recognised complexities within the authorities. There was a feeling of preparedness put down in part to the provision of relevant training materials and there was positive feedback on handouts provided from national sources and the website content.

It was pointed out that the voluntary sector organisations produced Care Act guidance which was thought to highlight the main themes of the Care Act and was subsequently easier to interpret: '*…not having to wade through 140-odd pages to find that one section that you need.'* (D6, Operational staff).

At a local level, authorities responded to the complexities of implementation by setting up implementation or steering groups to enable local judgements to be made and subsequently

addressed regarding the complexity of implementation. It was noted that a number of different work streams from this group were required. These were often evolving in response to a need to meet all the demands of Care Act implementation that often meant staff being involved from across the authority.

It was viewed as a positive where there was an acknowledgement that there is always a need to be flexible in approach to implementation as populations across authorities look very different. It was perceived to be useful to have a national template, while retaining the ability to be flexible in order to:

…make it suit you…Because that makes, it's more resonant to you isn't it because you know the locality, you know the nuances of that area, but still doesn't mean to say we couldn't learn from a [other area] *Council.* (C4, Operational staff).

Many areas brought in external consultants and specialists in order to assist with some of the complexities the Care Act implementation. . As highlighted in the Clarity of Contribution section, views concerning this experience were mixed. However, legal assistance training was highlighted by a number of people as a complex area that required specialist support to be provided. Some of this training was facilitated through the regional groups, whilst other training was purchased independently by authorities in order to meet their needs. Overall, legal training was well received.

Generally, with regard to addressing complexity national level support was viewed positively and was felt to be responsive when issues were raised by local authorities. One example given was in relation to foreign nationals, for which a prompt response was provided.

Conflicted attainment

Many of the comments regarding conflicted attainment of the comprehension of complexity related to the context within which the Care Act was being introduced. There were concerns that the importance of the context of austerity needed to be highlighted, and a recognition of the need to make the Care Act work with reducing finances and resources. Austerity had already resulted in local authorities stripping out the more 'luxury' services such as

implementation support/project management and this had led to an increased dependence on other sources both national and external:

There was a very strong I think message from our chief exec in relation not to the Care Act but to the austerity that we protect the frontline. So other places hadn't gone quite so root branch protecting the frontline, and you could still see that they had got policy and development teams, and those were the people doing the work, that might have been an easier ask. (F7, Senior manager).

Tension also became apparent between a national aspiration for a 'bells and whistles' implementation and councils wanting a more minimalist approach ensuring 'compliance':

So were they [national IS] *helpful? I guess no. Because what happened was you would, central, DH and LGA were talking best practice, and really encouraging everybody to go full out. And it took quite some soul searching things to say it's OK to just be compliant in some areas.* (F7, Senior manager).

Although there was praise for the guidance produced to go alongside the Care Act, there were also some more negative comments where it was not felt that it was able to fully grasp the complexities of the implementation. There was felt by some to be a misalignment between what was being asked of authorities and reality:

I don't think that they probably understood what it actually meant on the ground so to speak... some of the policies that were written, and the practice and what they wanted us to implement, were not necessarily going to be able to be implemented in a way that they expected, and achieve what they expected. Because I think they'd got all these ideas that it was going to achieve certain things... And what we couldn't see as practitioners on the ground, and managers on the ground in doing that, that that wouldn't necessarily come to fruition. But that would then be an impact for us as a council, and a burden to us further down the line. (C1, Operational staff).

There was a feeling that parts of the published guidance demonstrated a lack of understanding about the marketplace, particularly in relation to carers. It was further stated that some aspects of the guidance contradicted each other and that case law would be required to clarify these aspects.

IT systems posed a number of issues, mainly relating to the fact that they were slow to be set up due to the late distribution of guidance and so they were not always up and running in time for the 'go live' date. Some described how time-consuming manual procedures had to be employed to supplement the IT system until it was ready.

A couple of interviewees questioned the legitimacy of national presenters at a particular regional event as not understanding social care within a local authority and ultimately not understanding the complexities faced:

> *... it was quite obvious that the people who were dealing with the focus groups and were presenting were civil servants who haven't practiced in the real world... they weren't necessarily able to answer the more technical questions... there was a feeling that... it was all written by graduates who don't really understand the ins and outs of social care.* (B1, Senior manager).

There were a few criticisms that the complexities of local landscapes were not entirely comprehended by the centre. It was suggested that people 'on the ground' would have been best placed to feed into decisions on implementation as they are more aware of local contexts:

> *But at the same time there are some of us on the ground who do that every day for a living and who could say well actually you might want to think about this or this might actually help you to think about how you're going to do it or to help you with the advice you're going to give. But I don't think they talk to the people who deliver it on the ground early enough in that development.* (D3, Operational staff)

For our user and carer respondents there was more interest in understanding the complexity of the legislation and legal aspects of the Care Act. When the question of whether the specific legal aspects of the Act had an impact on the situation of carers or service users, respondents were either ambivalent or negative:

> *I guess the Act just formalised and made certain things legal and in some areas people were already having carer's assessments and organisations before it, but maybe in some areas they weren't, so therefore there'd be more of a noticeable change.*

Participants discussed the fact that any formal or legal aspects of the Act – which were intended to benefit them – were not fully realised, and in some cases had been diluted in the process of policy implementation. This was either due to specific problems with the local authority, or a more general distrust of the political system.

Relative failure

The main aspect of comprehension of complexity that could be termed as relative failure related to Phase 2 on the care cost cap, which was perceived to be unworkable and based on fundamental misunderstandings about the way the social care market is constructed:

> *What I did struggle with was what impacted most on my role, which was basically phase 2, and whilst there was quite a lot of discussion and involvement in what phase 2 might look like, it didn't really give a lot of information centrally about how that would work. So I think generally in terms of the implementation for* [area] *we did quite a robust project planning in being able to implement it, probably a little too robust in some cases, but maybe that's just me and the level I was at hearing all of these changes a lot and then doing a training* (D6, Operational staff).

However, where complexity is concerned, the experience of one local authority – in terms of preparations for the Act – was shaped in part by an existing piece of internal work on adult social care. The work, discussed earlier, was duplicated in efforts to prepare the case study site for Care Act implementation. The data from the NAO is clear: the additional labour pressures placed on the workforce were costly in terms of the time spent.

CA reforms being implemented as part of wider transformation [within local authority] but have cost 100s of hours of officer time (Note from NAO interviews)

To follow up on this point it is very clear that – using our own project data – this was an unresolved issue. During our investigations, one participant in the study gave an account of the complex preparations prior to, and during, implementation, with reference to internal preparatory work developing a framework for implementation of the Care Act completed by the local authority. The essential point in this comparison is that in undertaking internal preparatory studies a lot of Care Act implementation work had indeed been duplicated which cost the organisation considerable amounts of time. The duplication of work, and surplus efforts of the workforce, had impacted on the local implementation of the Act. This is partly about the issuing of guidance, but it also reflects on the levels of communication from the centre – i.e. government and the Department of Health and Social Care.

As highlighted earlier, good timing in terms of policy implementation for the Act was clearly an issue that cut across several of the case study areas in our research. Looking back to the data collected for the NAO study we can draw parallels with our own interview data. The experiences of the workforce in one study site show that the timing of implementation was clearly a hindrance in terms of achieving locally set targets:

Tight timescales for understanding and implementing reforms has been a challenge; the earlier introduction of a transformation programme has meant that the timescale is achievable. Without prior work the implementation timetable would be very difficult. (Note from NAO interviews)

The results for our own investigation confirm that, following implementation, interview participants reaffirmed their concern about aspects of delivering the Act on time:

On reflection it felt at the time probably 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 in order for them to practice in a different way. So, at the time

> *I think it was quite hectic, quite stressful for staff. They were quite anxious, they were quite worried…* (E11, Senior Manager)

The key point here is that, in terms of timeliness, the implementation programme created many issues for local authorities. Reflecting on the evidence from our study, and comparing it with the NAO data, the conclusion is that the successful delivery of policy depends on well-timed support from the centre.

4.6.5 Comprehension of Complexity: A summary

Our interest in this dimension of the framework is with the 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.

Reference has already been made to the issue of penetration – the difficulty of reaching beyond senior management level to the front-line and then to users and carers themselves. Other concerns arose about specialist areas about which there seemed to be relatively little information and support, such as housing and the prison service, as well as some concern and confusion around legal obligations. These all required local action over and above national support, often involving the use of expensive and sometimes poorly received management consultancies.

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 each with their own history, culture and democratic governance. Indeed, when national representatives were despatched 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. As noted earlier in the report, this tier was meant to

serve as a conduit between regions and the Programme Management Office. It was anticipated that this would: 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.

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. Our fieldwork suggests that in some localities the regional tier ended up having a significance that far exceeded expectations. The benefits of a regional tier included: reducing implementation isolation – localities were able to learn from each other; peer support and networking – forums were created that encouraged the sharing of achievements and problems; two-way communication – messages were received from the centre to localities but implementation concerns were relayed back through the same channels.; and organisational effectiveness – regions set up their own work streams to grapple with common problems.

Where they worked well, the regional leads were very 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 be also be better placed to offer tailored support. Localities saw this as a much better approach than a negative, and possibly punitive, response from the centre to a below average stocktake ranking. The overall experience was felt to be one of collaboration rather than command and control.

Such was the popularity of the regional support mechanism in our northern fieldwork sites that we 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. Given that the forthcoming Green Paper on adult social care is likely to usher in challenges as demanding as those contained in the Care Act, there may be some important lessons to be learned here.

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 from the literature what a crucial role can be played by these 'reticulists';[2] we also know that such skills are not in plentiful supply. There are some important issues to be unpicked here around creating the right environment and developing the right skills for such roles to be undertaken.

4.7 Sustaining political support

4.7.1 National perspectives (Macro Level)

Political support was retained throughout the implementation period via close links with central government. This took the form of ministerial involvement which is not normal practice. In addition, the Cabinet Office and Major Project Authority were also involved, again providing links to senior level political support. This strong political leadership from the centre was commented on as being different to previous projects, whereby there was visible involvement of stakeholders and decision makers all the way up to government arising from identified roles within the implementation support process.

As highlighted in the stakeholder development framework component, there was a strong commitment to the collaborative approach adopted by the Care Act. It is uncertain if this was due to the personalities involved or stemmed from the shared values of the organisations or was a combination of both, however the approach did demonstrate a shared understanding at a senior national level between the major organisations which gained strong political support.

---

[2] Reticulist: Someone who possesses skills in creating, servicing and manipulating communication networks, and is astute at identifying where in an organisation a decision in which she/he is interested would be made (Power, 1973)

4.7.2 Regional perspectives) (Meso Level)

In terms of sustaining political support, very little comment was forthcoming. One aspect that did come up concerned the links to the centre. Regular meetings were reported to be held with senior representatives from Department of Health and Social Care, LGA, ADASS and the Regional Coordinators. These were primarily used as planning and information giving groups.

4.7.3 Local perspectives (Micro Level)

Relative Success

Although the Care Act was a piece of national legislation, very little was discussed regarding sustaining political support at the local level, with the exception of some references made to information papers being prepared for elected members to take to local cabinet meetings. This may be because the Act had already gained high level support and as such it was taken as a given that it would be implemented at the local level. Considerable references were made to strong internal senior management support, often with senior managers making up part of the project/implementation team. Clear information channels, including the feeding of reports up to senior management, was also mentioned as a mechanism by which to sustain support.

Political support was seen at a national level through distribution of communication materials.

Conflicted attainment

There was very little conflicted attainment for the sustaining of political support. Some mention of little knowledge relating to national level support was stated by operational level respondents. However, links with national support were evident elsewhere within the authority.

Relative failure

There was no deemed relative failure in relation to sustaining political support.

4.7.4 Sustaining political support: A summary

All policies will have political origins and all will require the support (or at least the acquiescence) of legislators in order to come to fruition. Our interest in this dimension of the framework relates back to our earlier discussion of the vagaries of the political cycle and the ways in which the political will necessary to drive long-term policy-making can dissipate over time. The issue is whether an implementation support process can help to sustain the political commitment needed for seeing a policy through to implementation.

Our fieldwork has been 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 implementation support programme could be said to have helped sustain political support by keeping open channels of communication between political and non-political actors. At local level we undertook fieldwork with local authority cabinet leads but were unable to discern any clear local strategies for political support of the legislation.

An important consideration in this context is the extent to which the policy being supported is politically contentious. As already indicated, Phase 1 of the Care Act was largely seen as uncontentious, either because it consisted of legislative tidying or because it was consistent with the flow of professional opinion. This was not true of Phase 2. Phase 2 proposals, in relation to resolving the respective financial contributions of individuals, families and the state to the costs of long-term care were highlighted as being contentious by a number of respondents with comments relating to the perceived unfeasibility of the phase. Key partners to the implementation support programme – LGA and ADASS – repeatedly warned the lead agency (the Department of Health and Social Care) of the dangers of proceeding with Phase 2 in the absence of improved funding and a more realistic timetable. In the event, Phase 2 was initially postponed and then abandoned. On the one hand this can be interpreted as a

case of faulty policy design; on the other as an indicator of a successful implementation support programme within which effective communication resulted in appropriate political adjustments.

4.8 Contributing to attainment of policy objectives

4.8.1 National perspectives (Macro Level)

There was a mixture of responses in relation to the contribution to attainment of policy objectives. The PB was thought to contribute through the provision of clear policy objectives setting out what was required. The provision of local level funding to assist implementation at the local level was highlighted to be an important aid to local implementation. Again, the strength of the collaborative approach in ensuring successful implementation came through, with comments made regarding the passion, determination and willingness to engage with the policy across organisations. Commitment from the centre was also thought to inspire local level implementation. However, there could only be robust evidence of the contribution of the process (the implementation support programme) to the policy objective (implementation of the Care Act) once implementation was underway. Our fieldwork in six localities and their regions was intended to explore this relationship between process and outcome.

4.8.2 Regional perspectives (Meso Level)

Where policy objectives are concerned, the initial findings clearly show that, at the regional level, there was a lot of preparation involved in ensuring implementation of the Act was smooth. Participants broadly gave positive assessments about their own role as well as the role of existing networks and organisations in delivering the implementation programme. Specifically, participants were very direct in pointing to the benefits of a regional lead – particularly where the regional leads had specific knowledge:

> *Well they saved time and money ultimately. So, they didn't for example have to buy their own training on the law because we provided that for them. They didn't have to, we helped them a lot with policies and procedures, so then they could customise.* (R6, Regional Coordinator)

In relation to contributing to the attainment of policy objectives it was stated by one that although the role of the Regional Coordinator was to support the region in order to implement the Care Act, '…the bottom line was always compliance' (R1).

The role of acting as a mediator between the centre and the local was about managing the 'tension' between information coming out from the centre and local interpretations, i.e. they were aware of local operational issues and how the information would affect these. This therefore meant that the information being distributed within the region would be relevant.

The Regional Coordinator was also able to provide a focus for the implementation of the Care Act:

> *I also raised the profile of the Care Act … I think the Care Act would have passed most councils by, and it probably has in some ways … the Care Act hasn't passed managers and senior managers by. But it may have passed some of the staff by because of some work that hasn't gone on that should have gone on. But I think had we [Regional coordinators] not been in place the whole Care Act would have just came, come and gone.* (R3, Regional Coordinator)

4.8.3 Local perspectives (Micro Level): Findings from the Local interviews and focus groups

Relative Success

There was a strong sense overall, that implementation of the Care Act was a success. It was perceived as being aligned with the direction of travel local authorities were going in and was stated to provide the mechanism for driving through changes:

> *I would say the Care Act oiled the wheels really in terms of giving us greater momentum behind those changes in terms of we were already moving towards that emphasis on prevention, early intervention, giving people the skills so that they could function far more independently of statutory services. So yeah, this was the means to do it, if you like, or the confirmation of the means to do it.* (B8, Operational staff).

The fact that the Care Act (part 1) had few critics may limit the lessons learnt from the Care Act support programme as implementation may be expected to be more straightforward when there is a consensus of support for the policy.

For many, implementation of the Care Act built upon existing systems and resources, which were re-worked and transferred where appropriate rather than starting again:

> *...it was about taking our existing systems and changing them and developing and adapting them, it wasn't completely new, it wasn't just a blank slate, but it felt in some ways almost like you had to develop stuff from scratch* (C5, Operational staff).

Comments regarding the additional funding to assist implementation at the local level made available highlighted the importance of this resource in providing the ability to bring project resources together and funding training. In addition, it was thought to be useful as it allowed authorities to be creative and use it as they needed it rather than it being ring-fenced to prescribed uses.

Many now regard the Care Act as 'business as usual' with it becoming '…part of everyday' and '…embedded in practice.'

Conflicted attainment

As highlighted in relation to the comprehension of complexity, the local context was also seen to impact on the attainment of policy objectives with the external environment (austerity) being seen as impeding implementation. Indeed, arguments were even made that external factors (austerity) had rendered the support programme 'useless':

> *There's no area of care that isn't increasing as far as I can see. There is a demand. And everybody's getting more - they're not getting less siloed in the way that they work, they're getting more siloed, more gatekeeping, more thresh-holding, which kind of, that's not really what the Care Act has said* (F8, Operational staff).

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. I it's sort of an underhand trick that's been done on everybody (F8, Operational staff).

A small number of mixed responses exhibited conflicted attainment to the attainment of policy objectives. Lack of available tools was highlighted due to delays in system changes coming into effect which impacted on staff as they didn't have the tools required to implement required changes. Other aspects included a dislike of the new terminology to be used in line with the Care Act, a disjointed interpretation of responsibilities between the local authority and health colleagues, and the impact on brand reputation of the authority regarding sending out messages for phase 2 of the Care Act which never came into effect.

Comments were also made in respect of some elements of the Care Act being better supported than others. For example, prevention and wellbeing are the central underpinning principles of the Care Act but were not always perceived to be centrally located within the support provided. No reasons were identified for these gaps. For users and carers there were two important themes related to policy objectives: care work and support. On care work specifically, some carers chose to direct their frustrations at national government, pointing out that their labour was very cheap:

If you're a carer, and you get £62 a week because you're earning less than £101 a week, 35 hours and it's taxable. That's a job. I asked for minimum wage, they laughed at me. I'm retired, so I couldn't get £62, I got £34, which I told them where to put politely. I said, I'm not desperate for £34 a week, you can, and we're a cheap army, but carers want organising just like a union.

The tendency to speak to the social and political and ramifications of caring was evident with the responses of both of the focus groups. Participants (carers) were clear that they were undervalued and underpaid for the work they were undertaking.

In terms of support, participants voiced concerns that their voices were not being heard, and, that the Care Act legislation has done little to 'empower' people. Where policy objectives are concerned, this is a crucial point:

> *If the council aren't going to take seriously when carers, who are the frontline people there, are actually ringing and saying, look, this isn't working, then they're not empowered at all, are they, as carers and the Care Act, where does it come into play? If you're actually saying, well, you're providing a service that isn't working and nothing changes, then what difference has that Care Act made to empower people?*

Following from the point of 'empowerment', some participants made more explicit comments about the level of support and individual effects of the Care Act on their work for patients/partners/service users.

> *Well, it [the Care Act] did give the carers a voice, but it had no effect on me and who I looked after, my husband, anything, because we get no support. The only support we get is from Carers Together. We get no support at all from the authorities, because when he became 65 they decided, when they changed him from on the Young Onset Dementia Team where we had the social worker and that, when he was changed over to the Adult Onset Dementia Team, they decided he hadn't got dementia anymore and we were told that we weren't entitled to a social worker or anything.*

The respondents from the focus groups were clear in this regard: support arrangements after the Care Act have had little perceived benefit. Combined with the funding arrangements and perceived lack of care by local authorities, the only possible conclusion is that of *relative failure*, in terms of attaining policy objectives.

Relative failure

There was no deemed relative failure in relation to contributing to attainment of policy objectives.

4.8.4 Contributing to attainment of policy objectives: A summary

This final dimension of the framework concerns the extent to, and the ways in, which the implementation support programme assisted in contributing to the attainment of policy objectives. This is difficult to ascertain given that the 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 implementation support programme can 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 would be fair to conclude that the programme did significantly help to ensure implementation readiness. The most significant 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.

It has been beyond the remit of this study to make any assessment of the impact of the implementation support programme on the subsequent attainment of the policy objectives of the Care Act; there are too many other variables that will have shaped the outcome. However, it does highlight 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, is best regarded as a necessary but not a sufficient factor in securing policy objectives.

4.9   Key messages

The key messages arising from this section are summarised in relation to seven McConnell's criteria:

Helping to secure policy legitimacy:

- The implementation support programme was able to build upon an established policy consensus
- It secured access to professional expertise
- The support programme linked national and local governance
- It did not challenge to legitimacy of the policy
- There was no challenge to desirability of the support programme
- Implementing phase 2 of the Act would have constituted a sterner test to the arrangements

Developing stakeholder support:

- This was a hallmark feature of the support programme
- The support programme developed strong and effective relationships at national level
- There was stakeholder involvement in both policy design and policy implementation
- It involved a careful balance of governance styles, formal structures and high trust networks

Clarity of programme contribution:

- Successful dissemination of a wide range of valued products
- There were concerns at locality level about timeliness and specificity; some use of external consultants to try to bridge the gap
- There was difficulty in reaching below senior management level in implementing agencies
- There was a generally positive view of the support role of the programme
- However, users and carers were largely unaware of the policy, the legislation and the programme

- There was a tension between the support and performance management roles of the programme

Comprehension of complexity:

- The regional level support was seen as vital in some localities
- Perception of regional actors as critical friends rather than national emissaries
- Regional leads helped to promote effective learning networks
- Regional leads were an effective conduits between the national and local levels: a two-way communication flow
- The knowledge, experience and attitudes of regional 'entrepreneurs' were important factors

Sustaining political support:

- The Programme Board served as a conduit between stakeholders and ministers
- Regular stocktake exercises provided some reassurance on progress to politicians
- There was little apparent engagement of local political leaders with the support programme
- The decision to remove Phase 2 of the Act could be regarded as a 'negative success'

Contributing to attainment of policy objectives:

- Support programme was designed to ensure 'implementation readiness' not to pursue implementation impact
- Implementation readiness was generally thought to have been achieved
- The programme was time-limited and there was some wish in localities for a continuation of the support role into later stages of implementation
- There were strong concerns that factors in the external environment undermined the attainment of policy objectives

5   Discussion: Key Overarching themes

In this final section of the report we pull out some of the recurring themes from our investigation that hold significance for the development and application of implementation support programmes more generally. We depict these as the '5Cs' – context, closeness, complexity, collaboration and clarity.

5.1   Context

It is a mistake to think that policy drives innovation. Rather it sets the context within which those with a remit for policy delivery must make crucial decisions on the shape of implementation. In everyday talk 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) 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'* (p89).

All of this ties in 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 a focus on subtle, incremental changes and an awareness of what needs to be in place for change to happen without which more prominent achievements cannot be attained or sustained. This is precisely the approach that was taken in relation to the Care Act 2014 and its associated improvement support programme.

It is likely that the implementation support process will more easily flourish in some contexts than others – indeed a recurring caveat throughout this report has been the receptive political and professional context within which the Care Act support programme functioned. Not all policies can be expected to be characterised by a high degree of political and professional agreement; in fact, most will almost certainly be the outcome of divisive and contentious disagreements. Health and Wellbeing Boards (HWBs), for example, have been described as enjoying 'overwhelming support' from a political perspective (Humphries et al, 2012). However, professionally, potential tensions were found with the role of the board, relating to their functions spanning public health, local government, the local NHS and the third sector (Humphries et al, 2012). A more recently published evaluation of HWBs funded by the Department of Health Social Care Policy Research Programme led by one of us (Hunter) concluded that while they had the potential to become system leaders, since they were the one place where the system came together, they were under-powered to perform such a role satisfactorily (Hunter et al, 2018). In particular, HWBs had no powers to hold partners to account and were in danger of being eclipsed by new national initiatives, notably Sustainability and Transformation Programmes and more recently Integrated Care System partnerships. No amount of implementation support could compensate for HWBs being viewed generally as 'talking shops' which added little of value. It was also felt that, as bodies established by local government, they were not well understood or valued by the NHS and therefore risked being marginalised.

The importance of the external environment was also evident in the Vanguard Programme. The NHS England implementation programme, while generally welcomed, was to some extent handicapped by various contextual factors which were dominant. This was evident in an evaluation in the North East of England for which two of us (Hudson and Hunter) were co-investigators (Maniatopoulos et al, 2017). It found that despite the support available and the attempt to avoid Vanguards being viewed as another top-down initiative, those responsible for designing and operating the new care models felt under intense scrutiny and pressure from NHS England to deliver positive results. There was pressure to deliver within unrealistically tight timescales when complex changes involving transforming the culture and behaviour of the workforce took time to succeed and become embedded. Under such

circumstances there was a tendency to overlook the initial welcome emphasis on encouraging and valuing local flexibility and context. Resisting the tendency to interfere and micro-manage from the centre became a preoccupation of, and distraction for, many Vanguards. Ensuring the requisite mix of skills and capabilities, as well as investment in these, was another major factor determining success and while limited transformation funds were made available to lubricate the change process, it is arguable whether they were sufficient to bring about the changes required and to ensure that these were sustainable in the longer term. A final key message is that for changes of the type Vanguards were introduced to undertake to have a chance of becoming embedded over time requires both a continuing commitment to invest in support and development and the creation and protection of space to enable change to occur and prosper. Achieving such an outcome proved to be a delicate balancing act in regard to Vanguards and one that was difficult to achieve or maintain. These findings are echoed in a study of eight Vanguards conducted by a team from the Health Foundation (Starling, 2017).

In order to develop a wider understanding of the potential role and shape of implementation support strategies it is therefore also necessary to consider other sorts of contexts.

A useful framework for understanding the role of context is Matland's (1995) classic work on the impact of conflict and ambiguity on implementation. Matland's premise is that the different characteristics of policies have varying implications for the way these policies are implemented – and, by extension, for the ways in which implementation support programmes might best be constructed. He 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 shown in Table 10 below.

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.

Table 10: 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 conflict and ambiguity no strong coalition to create progress significant professional values and allegiances neither top nor bottom stakeholders committed key organising concept: collaborative strength

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

The Troubled Families initiative could be described as 'Administrative Implementation'. There was relatively low ambiguity and conflict with clear guidance produced setting out the terms for payment by results for implementation success. At the opposite side of the model, 'Symbolic Implementation' can be used to describe the implementation approach of the Community Care Support Force. The approach taken consisted primarily of 'leading edge' practitioners being brought in to work alongside localities in enabling them to meet the requirements of the policy (Henwood & Wistow, 1993). The approach was very much bottom up with elements of capacity building within local teams.

HWBs could best be described as a clear example of 'Experimental Implementation' combined with some elements of 'Symbolic Implementation'. The introduction of new forms of partnership working to promote health and wellbeing occurred in a context of low conflict but one in which there was considerable ambiguity over exactly what HWBs would and could do with their limited powers.   There was also variable commitment to HWBs among the partners, many of whom displayed a number of the components of 'Symbolic Implementation'.

In regard to the NHS Vanguards initiative, this was another example of 'Experimental Implementation' although with some features of 'Political Implementation' visible given the importance of the initiative and its high-risk political profile. The national support programme accompanying the Vanguards displayed elements of 'Administrative Implementation' and 'Political Implementation' given the tensions between a desire for top-down control and performance management of outcomes on the one hand and a recognition that complex cultural change of the kind envisaged demanded flexibility and finding local solutions to long-standing problems.

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.

Our research was not able to properly explore the role of other types of implementation support in other policy domains, chiefly because of a paucity of information and research exploring this dimension, but the fact that we were unable to discern any clear and sustained interventions comparable to that associated with the Care Act 2014 is a matter of concern. Further work is needed to understand the relationship between policy implementation and policy support in other domains.

5.2 Closeness

One of the most striking – and perhaps unexpected – findings of this research has been the importance in some of our local sites of the role of the Regional Coordinator. Where the responsibility for implementation of a national policy largely lies with a multiplicity of local agencies in a system of 'dispersed governance', there needs to be some way of linking the national and local levels. One way is for the centre to simply pass down instructions to local implementing actors but there is now incontrovertible evidence of the limitations of this sort of remote 'hands off' approach.

All of this implies the need to find some way of bridging the understanding of national and local narratives via some intermediary body. One approach is the formation of what has been termed 'implementation support centres' (Pew Charitable Trust, 2017) – entities of various types that work alongside and often at the direction of government to support effective implementation. Franks and Bory (2015) develop a similar concept in their exploration of 'intermediary organisations' which, they conclude, 'appear to play a critical role not only in implementing model programs, but also in developing the necessary capacity for systems change' (p54).

In the case of the Care Act, the Regional Coordinator undertook precisely this sort of role. As we have already noted, this very lightly funded regional tier ended up having a significance that far exceeded expectations. The benefits included: reducing implementation isolation – localities were able to learn from each other; peer support and networking – forums were created that encouraged the sharing of achievements and problems; two-way communication – messages were received from the centre to localities but implementation

concerns were relayed back through the same channels.; and organisational effectiveness – regions set up their own work streams to grapple with common problems.

This raises the more general issue of our second 'C' - 'closeness' – the existence or creation of some form of local presence to support implementation. Geographically remote support at national level in the form of guidance, toolkits and information-giving events can only be expected to deliver marginal results. One option is for each locality to develop its own implementation support unit (which some of our localities effectively decided to do) but this is likely to be expensive, duplicative and runs the risk of being unduly inward-facing. An alternative is to consider the case for a domain-specific policy implementation support unit that is available to the field. In effect, this is the model that was used in the 1990s with the Community Care Support Force and the Community Care Task Force, both outlined earlier in this report. The approach here is one of making available a cadre of experienced and trusted 'implementation entrepreneurs' with the skills and capacity to tap into the perceptions and experiences of those whose behaviour will shape implementation. It is likely to require a flexible staffing model able to respond to different needs and demands along the lines of the Joint Improvement Team in Scotland (Petch, 2011; Hendry, 2016) and the Change Agent Team in England (2004).

All of this presupposes the availability of a cadre of such individuals with the necessary experience, skills and attributes to engage with local implementing agencies. Whilst much attention is given to issues such as governance and budgets in policy implementation, much less is given to the role and behaviour of those who could undertake a dedicated responsibility to create and sustain a range of complex connections in pursuit of implementation support activities.

As we have noted above, acceptance of the role and contribution of the Regional Coordinator hinged in good part upon their ability to establish a personal reputation. Getting behaviour right can make all the difference between successful support and a doomed intervention, indicating a more general issue concerning the importance of relationships over and above structures and levels of governance. The strongest card that can be played is personal skills and credibility; the weakest is to seek to impose authority. Roberts and King (1996) go so far

as to suggest that such 'policy entrepreneurs' appear to have a unique identity with certain innate personality characteristics. These include being highly intuitive, critical analytical thinkers, instigators of constructive social action, well-integrated personalities, highly developed egos, high level of leadership and above average creative potential. It also has implications for the style of leadership adopted with engaged and adaptive leadership being most appropriate in complex settings involving a diversity of stakeholders (Heifetz et al, 2009). There is also a need to avoid an obsession with competences. As an alternative, the idea of capability has been advanced – the extent to which individuals and groups can adapt to change, generate new knowledge and continue to improve their performance in situations where there is little certainty or agreement (Edmonstone, 2013). This points to the crucial importance of relationships both within and between organisations. It is an understatement to say that finding the requisite combination of experience and skill will be challenging but one of the key tasks of a new approach to implementation support will be to identify, nurture and institutionalise such behaviours and leadership styles.

5.3   Complexity

Traditional analyses have concentrated on separating out individual parts of the system from their context and environment. These 'closed systems' are seen as characterised by 'equilibrium' such that problems can be analysed without reference to the external environment. Best and Holmes (2010) use the term 'linear models' to describe this approach which they characterise as a one-way process in which knowledge, guidance, toolkits and so forth are disseminated to end users and are then in turn expected to be smoothly incorporated into local policy and practice.

Our investigation into implementation support for the Care Act raises the issue of when it is more sensible to acknowledge and work with complexity. Rather than make assumptions about linearity. It is fair to say that the majority of health and social care system change initiatives mistakenly attempt to control or manipulate context rather than foster emergent solutions (Holmes et al 2017). It echoes the claim of Pawson (2013) that a support mission to provide an overlay of uniformity and stability on unstable and endlessly evolving social systems will – other than in the case of Matland's 'administrative implementation' – be of limited effectiveness. In the case of the Care Act support programme there was a paradox.

Although the programme was acknowledged to be reasonably sensitive to the complexity of local contexts, it was seen as insufficient to take account of wider environmental turbulence. This led some to suggest that although the support to attain implementation readiness had been successful, the impact of austerity and funding cuts to local councils had made it difficult, if not impossible, to implement the principles of the Act.

5.4   Collaboration

The growing enthusiasm within the UK for whole system working has arisen from a recognition that many of the problems that public services now deal with are too complex to be addressed by one agency acting in isolation – they are 'wicked' problems (Rittel and Webber, 1973). Cross-cutting problems like health inequalities and social exclusion are frequently cited examples, but issues like reducing unplanned hospital admissions and delayed hospital discharges would also be included. The place of adult social care within a wider inter-agency system was also a central feature of the Care Act 2014, especially in the case of relationships with the NHS. All of this requires an administrative system capable of focusing on 'place' rather than on separate – and often competing – organisational priorities.

Addressing fragmentation through a collaborative and coordinated approach to policy design and policy implementation was perhaps the defining feature of the Care Act support programme. This report has detailed the formal structural arrangements (the Programme Board and Programme Office), the legal Memorandum of Understanding, the multiplicity of work streams bringing in a wide range of expertise where it was needed and the high levels of trust and mutual respect at national level between the three key stakeholders – the Department of Health and Social Care, the Local Government Association and the Association of Directors of Adult Services. This constituted a remarkable degree of partnership working and one that resulted in the creation of a successful – and possibly unique – programme of implementation support.

Effective horizontal collaboration has to be matched by successful vertical collaboration. This too could be regarded as successful, especially where use was made of the Regional Coordinator role – communications between the centre and the localities remained open and constructive. However, two weak links in the collaborative chain were identified in the

fieldwork. First, vertical collaboration at local level too often stopped at the level of senior management. Operational staff working at the front-line, and users and carers themselves were the groups most likely to feel untouched by the efforts of the support programme. And, secondly, there was relatively little coordination between the prime local implementing agency – local authority adult social care – and other partners with a role in the promotion of health and wellbeing. The prison service, housing agencies, public health and others often seemed to be left on the outside of the support arrangements. Conversely, where the NHS is taking the lead, as with the current 'new models of care' initiative, it can be social care that is left on the outside of shared arrangements. It is a reminder that despite over forty years of official exhortation for inter-dependent public agencies to work together in partnership, progress has been at best patchy (Exworthy and Hunter, 2011).

5.5 Clarity

While the most valued aspects of the Care Act implementation support programme tended to be the regional links (an intervention seen as supportive), perhaps the least helpful was the stocktaking exercises (an intervention seen as regulatory). Although there is certainly a case for both types of intervention to be part of any implementation process, it does raise the issue of the appropriateness of combining compliance and support within one agency or programme. There seems to have been relatively little attempt to explore these tensions in contemporary institutions and policies but there is still much to be learned from Henkel's seminal study of the Audit Commission, Social Services Inspectorate and Health Advisory Service (Henkel, 1991). In all three cases attempts were made to straddle compliance and support to change, sometimes with a degree of success. In the case of the Audit Commission it was the perceived independence from government that was vital, allied to credibility within the relevant policy communities. Henkel notes that:

> '*The auditors had to combine rational-technical approaches to managerial problems with recognition of the complex structure of political, professional, managerial and industrial relations.*' (p64)

The evolution of the Social Work Service (SWS) into the Social Services Inspectorate (SSI) was more fraught. The *leitmotif* of the SWS was to serve in a professional and advisory capacity

and attempts to recast it as an inspectorate were seen as unwelcome. In 1985, this resulted in the conversion of SWS into the SSI with a sharper interventionist focus on obtaining value for money. Henkel concluded that the tensions between compliance and support in this new incarnation were not successfully resolved. Much the same fate befell the Health Advisory Service (HAS) which was conceived as a multi-professional advisory service committed to achieving improvement by persuasion, but was soon reshaped by the era of managerial control. Henkel again concluded that HAS ended up 'pleasing neither managers nor powerful professionals' (p177).

All of this suggests that the way in which offers of implementation support are couched and perceived is vital in understanding their likely effectiveness. It is appropriate that local implementation agencies should be required to demonstrate probity in the ways in which public money has been used and effectiveness in terms of delivering on policy objectives. However, if the implementation of a policy is also thought to require sensitive, localised support that works with the grain of complexity then it would be circumspect to separate out this role from that of regulation and performance management.

5.6   Tactics for Supporting Implementation

Alongside these broad messages for selecting a *type* of support programme, there is the further question of developing a repertoire of *tactics* – practical measures to aid policy practitioners in their activities and decision-making. The starting point for this analysis was the notion of 'policy failure' discussed in section 2:1 where it was suggested that through a better understanding of how policy can go wrong, it is possible to develop a better appreciation of the potential role of policy support programmes. Such an understanding could determine the point at which support might be most helpful (if at all) as well as the most appropriate mode of support and its potential duration.

Four broad causes of policy failure were identified – overly optimistic expectations, dispersed governance, inadequate collaborative policymaking and the vagaries of the political cycle. Each of these can be roughly equated with the four chronological phases of preparation, prioritisation and tracking, support and review (discussed in section 2:2) as shown in Table 11 below.

Table 11: Policy Failure and Policy Support Programmes

Type of Policy Failure	Mode of Policy Support
Overly Optimistic Expectations	Implementation Preparation: Better Policy Design
Dispersed Governance	Prioritisation and Tracking: Better Policy Monitoring
Inadequate Collaborative Policy-Making	Implementation Support: Better Policy Impact
Vagaries of the Political Cycle	Implementation Review: Better Policy Learning

Although aspects of each of these elements can be routinely found, it is not usual for all of them to be combined in a comprehensive manner to address all four stages. The most common mode of intervention tends to be around performance tracking, with policy-making bodies keen to unearth some evidence that their efforts are bearing fruit. Much less attention is being given to the other three elements identified in Table 11.

The rise of post-modernism and the era of 'post-truth' politics (Baron, 2018) arguably makes it more important than ever to establish a more robust evidence base for the design and delivery of policy. Although there is now a substantial literature on the policy-implementation gap and on discrete aspects of implementation support, such as policy design or performance monitoring, there is relatively little evidence on the use or effectiveness of coherent and comprehensive policy support programmes. Indeed, we know little about their very existence. A first useful step would be to commission wider research into the role of policy support programmes themselves, to better understand what works for whom and in what circumstances. It is not enough to be aware of the policy-implementation gap; we need better ideas on how to fix it.

6.   Conclusion

From the outset it was recognised that the Care Act was a complex piece of legislation, introducing the most significant change in social care law in England for sixty years. It was also recognised that implementation would not be easy and dependent on context and the involvement of multiple stakeholders presenting specific challenges well identified in the policy literature (Davies et al, 2008; Russell et al, 2008). This highlights the importance of understanding the processes through which policy is implemented and how successful implementation and service improvements can be supported. The approach taken in the implementation support approach to the Care Act 2014 built upon the collaborative nature of the development of the Care Act and involved key national stakeholders - the Department of Health and Social Care, LGA and the ADASS - working in partnership to develop and support the implementation process. This collaboration sought to embed partnership working as a coherent approach throughout local implementation of the Care Act. The range of support mechanisms used within the implementation approach set the Care Act apart from previous policies reviewed in this study.

This research has looked to *"… identify effective practice in implementation, and 'what works' in terms of service redesign and provision" and to identify "potentially transferrable lessons that may be relevant to other local government reform programmes. These lessons could also help to focus the approach taken to implementing funding reforms from 2020"* (Department of Health, Invitation to Tender). Four key concerns have guided the research:

1. How this approach may support redesign of local services and systems, to improve the provision of care and support, to improve quality, and to reduce risks to delivery
2. How, and to what extent, centrally commissioned or developed implementation support (including regional Care Act implementation structures) is supporting local changes
3. To identify effective practice in implementation, and 'what works' in terms of service redesign and provision

4. To identify potentially transferrable lessons that may be relevant to other local government reform programmes.

Overall, it can be concluded that the Care Act implementation support programme significantly helped ensure the implementation readiness of the local agencies. One of the main successes identified for the implementation support programme relates to its securing of policy legitimacy, the address and successful navigation of complex issues through stakeholder engagement and support, and its ensuring of the readiness of local implementation agencies. Stakeholder engagement at a macro, national level was regarded as the key feature of the implementation support programme. The relationships presented between the three key national stakeholders (Department for Health and Social Care, LGA and ADASS) at a national level were somewhat unique with no comparable achievement able to be found in other policy domains. The model demonstrated engagement, drawing on existing relationships, brought in external expertise, facilitated the sharing of ideas and balanced bureaucratic and network elements of governance. This was a feature absent from the other policies reviewed for this study and may be difficult to replicate in full as the approach was developed from the approach taken to policy development for the Care Act.

As highlighted throughout this report, regional leads, although not a new support approach, were seen to have a significant impact on supporting local changes. These appointments were seen as a conduit between regions and the Programme Management Office. In some localities this regional tier had significance which far exceeded its expectations (particularly true in the northern case studies). Benefits of the regional tier included; reducing implementation isolation – localities were able to learn from each other; peer support and networking – forums were created that encouraged the sharing of achievements and problems; two-way communication – messages were received from the centre to localities but implementation concerns were relayed back through the same channels; and organisational effectiveness – regions set up their own work streams to grapple with common problems. This approach may be particularly significant in relation to the implementation of policy within situations of dispersed governance.

6.1 Key messages

Three principles were identified to underpin the support programme established:

- *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 supports collaboration at local, regional and national levels through an ongoing two-way supportive dialogue. Underpinning this infrastructure was the relationship between the three key partners.

Given the relative novelty of such comprehensive policy support programmes there is correspondingly little empirical evidence to draw upon at this stage. However the issues, literature and evidence presented in this report offer an opportunity to tease out some provisional messages for policy-makers and practitioners on how best to approach the task. We outline these below.

Policy Design Preparation

- Exploration of policy options and their feasibility with key implementation agencies
- Creation of forums for collaborative policy design: the more consensual the design process the less the likelihood of disagreements at the implementation stages
- Development of policy design assurance frameworks: identification of significant implementation risks and challenges along with risk management strategies
- Production of robust implementation statements: clear expectations of what should reasonably be expected to be delivered and under what circumstances
- Use of the best available evidence base to inform policy design
- Agreement on what would constitute an adequate funding stream for anchoring the policy and achieving the programme objectives
- Ensure the agencies tasked with implementation can reasonably be expected to succeed in the task

Policy Tracking

- Two-way communication processes: progress reports from implementation agencies to the policy-making centre; responses back from the centre to implementing agencies

- Use or creation of intermediary bodies between the policy-making and policy implementing levels

- Development of proportionate primary and secondary targets along with agreed timelines

- Separation of monitoring, regulating and inspecting roles from support mechanisms: use of policy support programmes to better understand the stories behind the statistics

- Realistic expectations of what constitutes 'success': policy objectives might never be fully delivered in the case of 'wicked issues'

Policy Implementation Support

- 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

- Offer implementation support where it is needed or requested: ongoing assistance with problem-solving and capacity-building to develop sustainable implementation skills and knowledge

Policy Implementation Review

- Short, medium and longer-term review landmarks: clarity on what should have been achieved by when

- Routine use of action research as well as more traditional evaluative methods

- Political acknowledgement that complex policies need to be given time to demonstrate achievements: costs and benefits will be unevenly distributed over time

Future research

This study specifically aimed to examine the implementation support structures and processes established by central government to support local authorities' implementation of the Care Act. As such, the research focus did not address the local implementation of the Act itself and what impact this had on users and carers of social care. In undertaking interviews and focus groups at a local authority case site level it was often difficult to separate people's views about local delivery from whether the support programme provided sufficient preparatory support. This was particularly an issue when interviewing frontline managers and staff and users and carers where locally there was limited awareness of the central support programme.

In future research it may be useful to explore whether those authorities that felt better prepared in terms of implementation were more or less successful in local implementation. Some of this data may be available from other research projects within the wider research programme commissioned on the Care Act by the Department of Health and Social Care of which this study was just one.

This research also only related to phase one of the implementation of the Care Act given the postponement of phase two of the reforms. It is possible, as identified by some respondents in our study, that different findings may have resulted if phase two had been followed through in line with the original timeframe. Further research may be useful in examining the implementation of this aspect of reforms to the social care system.

Our work suggests that the Care Act support programme was relatively successful – and probably unique – in preparing the implementation agencies for legislative readiness. The support programme was widely welcomed by respondents in our case study sites. However, to understand the value of support programmes of this nature it would be necessary to look at other policy domains more closely in order to take account of different contexts and challenges. The Care Act arrangements were able to build upon established collaborative structures that had shaped policy design and built a consensus about the content of the legislation and accompanying guidance. The challenges facing support programmes in more

contested policy domains would be different and greater. Our research carries some important messages for securing effective policy implementation but these messages do need to be further tested in other policy contexts.

References

Allcock, C, Dorman, F, Taunt, R and Dixon, J (2015), *Constructive comfort: accelerating change in the NHS*. London: The Health Foundation.

Ansell, C, Sorenson, E, Torfing, J (2017), Improving Policy Implementation through Collaborative Policymaking, *Policy and Politics*, 45(3), pp 467-86.

Australian Government (2014), *Policy Implementation*, Canberra: Department of the Prime Minister and Cabinet

Baron, I.Z (2018), *How to Save Politics in a Post-Truth Era: Thinking Through Difficult Times*, Manchester University Press.

Barber M (2015) *How to Run a Government So that Citizens Benefit and Taxpayers Don't Go Crazy*. London: Allen Lane.

Bate, A & Bellis, A (2018) *The Troubled Families Programme* (England) House of Commons Library Briefing Paper CBP 07585, 18 July 2018

Best, A and Holmes, H (2010), Systems thinking, knowledge and action: towards better models and methods. *Evidence & Policy,* 6(2)

Blackstone, T and Plowden, W (1988) *Inside the Think Tank: Advising the Cabinet 1971-1983*, London: Heinemann

Byrne, D (1998), *Complexity Theory and the Social Sciences*. London: Routledge

Challis, L, Fuller, S, Henwood, M, Klein, R, Plowden, W, Webb, A, Whittingham, P and Wistow, G (1988), *Joint Approaches to Social Policy: Rationality and Practice*. Cambridge University Press

Davies, H, Nutley, S and Walter, I (2008), Why 'knowledge transfer' is misconceived for applied social research, *J Health Serv Res Policy*, 18(3), pp188-90

Department for Communities and Local Government (2015) *Financial Framework for the Expanded Troubled Families Programme*

Department for Communities and Local Government (2016) *The first Troubled Families Programme 2012-2015, An Overview*. London: DCLG

Department of Health (2012) *White Paper Caring for our future: reforming care and support*

DfES *Sure Start: National Evaluation, Getting Sure Start Started* (2002) Nottingham: DfES Publications

Dixon-Woods, M (2014), *The problem of context in quality improvement.* London: The Health Foundation

Dunlop, C (2017), Policy learning and policy failure: definitions, dimensions and intersections, *Policy and Politics*, 45(1), pp3-18

Edmonstone, J (2013), What is wrong with NHS leadership development? *British Journal of Healthcare Management*, 19 (11): 531-538.

Exworthy, M & Hunter, DJ (2011), The challenge of joined-up government in tackling health inequalities, *International Journal of Public Administration* 34 (4): 201-212.

Franks, R and Bory, T (2015), *Who supports the successful implementation and sustainability of evidence-based practices? Defining and understanding the roles of intermediary and purveyor organisations*, New Directions for Child and Adolescent Development, 149, Fall 2015, pp 41-56.

Geyer, R and Cairney, P (2015), *Handbook on Complexity and Public Policy*. London: Edward Elgar Publishing.

Gold, J (2014), *International Delivery: Centres of government and the drive for better policy implementation*, Mowat Centre/Institute for Government

Harris, J and Rutter, J (2014), *Centre Forward: Effective Support for the Prime Minister at the centre of Government*', London: Institute for Government

Health and Social Care Change Agent Team (2004) *Avoiding and diverting admissions to hospital: A good practice guide*. London: Department of Health.

Health Foundation, (2014), *Perspectives on Context.* London: The Health Foundation.

Heifetz, R, Grashow, A & Linsky, M (2009), *The Practice of Adaptive Leadership*. Boston: Harard Business Press.

Hendry, A (2016*),* Creating an Enabling Political Environment for Health and Social Care Integration, *International Journal of Integrated Care*, 16(4)7.

Henkel, M (1991), *Government, Evaluation and Change*, London: Jessica Kingsley.

Henwood, M & Wistow, G (1993), *Evaluation of the Impact of the Community Care Support Force. Community Care Division*, Leeds: The Nuffield Institute for Health.

Hill, M and Hupe, P (2014), *Implementing Public Policy* (Third Edition), London: Sage.

HM Government (2012), *The Civil Service Reform Plan*. London: The Stationery Office.

HM Government (2014), *Civil Service Reform Plan: Progress Report.* London: The Stationery Office.

Hogwood, B and Peters, G (1985), *The Pathology of Policy*, Oxford: Oxford University Press.

Holmes, B, Best, A, Davies, H, Hunter, D, Kelly, MP, Marshall, M & Rycroft-Malone J (2017), Mobilising knowledge in complex health systems: A call to action, *Evidence & Policy* 13(3): 539-560.

Horton, TJ, Illingworth, JH & Warburton, WHP (2018) Overcoming challenges in codifying and replicating complex health care interventions*, Health Affairs* 37 (2): 191-197.

Hudson,B, Hunter, DJ & Peckham, S (2019), Policy Failure and the Policy-Implementation Gap: Can Policy Support Programmes Help?, *Policy Design and Practice* (forthcoming)

Hudson, B, Peckham, S, Hunter DJ, Redgate S and White G. (2017) *Improving choices for care: a strategic research initiative on the implementation of the Care Act 2014* Interim Report. CHSS: https://www.kent.ac.uk/chss/docs/Care%20Act/Improving%20choices%20for%20care%20%20-interim%20report.pdf

Hughes, A. & Caunt, M. (2013), *Care and Support Reform Programme Board: Programme Scope: work-streams, projects and enablers*, London: Department of Health.

Hughes, A. (2013) '*Implementation Support: Vision and Priorities'* London: Department of Health.

Hughes, A. (2014) *'Implementing your programme – list of support'* London: Department of Health.

Humphries, R & Galea, A (2013) *Health and Wellbeing Boards: One year on.* London: The King's Fund.

Humphries, R, Galea, A Sonola, L & Mundle, C (2012) *Health and Wellbeing Boards: System leaders or talking shops?* London: The King's Fund.

Hunter, DJ, Perkins, N, Visram, S, Adams, L, Finn, R, Forrest, A, Gosling, J. (2018) *Evaluating the Leadership role of Health and Wellbeing Boards as Drivers of Health Improvement and Integrated Care Across England*. Final Report. Durham: Durham University.

Hupe, P and Hill, M (2015), 'And the rest is implementation'. Comparing approaches to what happens in policy processes beyond Great Expectations*, Public Policy and Administration*, 31(2), 103-121

Ilott, O, Randall, J, Bleasdale, A and Norris, E (2016), *Making Policy Stick: Tackling long-term challenges in government*, London: Institute for Government.

Institute for Government/Chartered Institute of Public Finance and Accountancy (2017), *Performance Tracker: Autumn 2017: A data-driven analysis of the performance of government.* London: Institute for Government

King, A and Crewe, I (2013), *The Blunders of Our Governments*, London: Oneworld Publications

Lipsky, M (1980), *Street-Level Bureaucracy*, New York: Russell Sage Foundation

Maniatopoulos G, Hunter D, Erskine J, Hudson B, Gray J, McMeekin P, McCarthy A (2017) *North East Vanguards Programme. Final Evaluation Report*. Newcastle: Newcastle University.

Matland, R (1995), Synthesising the implementation literature: the ambiguity-conflict model of policy implementation, *Journal of Public Administration Research and Theory*, 5(2), pp145-74

May, P (2015), Implementation failures revisited, *Public Policy and Administration*, 30(3-4), pp 277-299

McConnell, A (2015), What is policy failure? A primer to help navigate the maze, *Public Policy and Administration*, 30(3-4) pp 221-242

National Audit Office (2013), *Over-optimism in government projects.* London: The Stationery Office.

National Audit office (2015), *Care Act first phase reforms.* HC 82, Session 2015-16

NHS England (2015) *The Forward View into Action: New Care Models support for the Vanguards.* NHS England

NHS England (2016) *New Care Models: Vanguards and developing a blueprint for the future of NHS and care services.* NHS England.

NHS England (2017) *The Local Evaluation of the New Care Models Vanguards: Our Expectations and Offer of Support for 2017/18*. NHS England

NHS England, the Care Quality Commission, Health Education England, Public Health England, Monitor, the NHS Trust Development Authority (2015) *The forward view into action. New care models: support for the vanguards.* Leeds: NHS England.

Norris, E, & McCrae, J (2013), *Policy That Sticks: Preparing to govern for lasting change*, London: Institute for Government.

OECD (2015), *Delivering From the Centre: Strengthening the role of the centre of government in driving priority strategies.* Paris: OECD.

Pawson, R (2013), *The science of evaluation: a realist manifesto.* London: Sage.

Pettigrew, A, Ferlie, E and McKee, L (1992), *Shaping Strategic Change.* London: Sage.

Pew Charitable Trust/MacArthur Foundation (2017), *Four ways implementation support centers assist in the delivery of evidence-based programmes.* A fact sheet from the Pew-MacArthur Results First Initiative

Power, J. 1973 The reticulist function in government: Manipulating networks of communication and influence, Public Administration (Australia), 32(1), 21-27.)

Pressman, JL and Wildavsky, AB (1973), *Implementation: How Great Expectations in Washington are Dashed in Oakland*. Berkeley, CA: University of California Press.

Rittel, H. and Webber, M. [1973], Dilemmas in a General Theory of Planning. *Policy Sciences,* 4: 155-169.

Roberts, NC and King, PJ (1996), *Transforming Public Policy: dynamics of policy entrepreneurship and innovation,* San Francisco: Jossey-Bass.

Russell, J, Greenhalgh, T, Byrne, E and McDonnell, I (2008), Recognizing rhetoric in health care policy analysis, *J Health Serv Res Policy*, 13(1), pp 4046

Sausman, C, Oborn, E and Barrett, M (2016), Policy translation through localisation: implementing national policy in the UK, *Policy and Politics*, 44(4), pp563-89.

Sense About Science (2015), *Assessing how the government uses evidence to make policy* London: Sense about Science

Sense About Science (2017), *Transparency of Evidence: an assessment of government policy proposals, May 2015 to May 2016* London: Sense about Science

Starling A (2017) *Some assembly required: implementing new models of care. Lessons from the new care models programme*. London: The Health Foundation.

Todd, R, Martin, J & Brock, A (2014), *Delivery Units: can they catalyse sustained improvements in education service delivery?* Cambridge Education: Aid Effectiveness

Volker, P (2014), Vision without execution is hallucination*, Public Administration Review*, 74 (4), pp 439-41

Weaver, K (2010), But will it work? *Issues in Government Studies*, 32, pp 1-17

Weiner, B (2009), A Theory of Organisational Readiness for Change, *Implementation Science*, 4:67.

WHO (2018) *Leading Health System Transformation to the Next Level*, Expert Meeting, Durham, UK, 12-13 July 2017. WHO: Copenhagen.

Appendix A: Ethical approval

Professor Stephen Peckham MA
(Econ)
George Allen Wing
University of Kent
Canterbury
CT2 7NF

Layden House
76-86 Turnmill Street
London
EC1M 5LG

Date: 21 Jul 2017

Our Ref: RG16-18 (phase 2)

Dear Stephen,

Improving choices for care: a strategic research initiative on the implementation of the care act 2014 RG16-18 (Phase 2)

I am writing on behalf of the Association of Directors of Adult Social Services Executive Council and am pleased to tell you that the Executive has decided recommend your project to its members; directors and assistant directors of adult social services. A circular advising directors of this decision will shortly be in their hands.

In the interests of ensuring that adult social services departments receive the maximum benefit from co-operating in research projects such as your own, the Executive places great importance on disseminating findings and conclusions. It encourages researchers to find ways, including (but not exclusively) formal publication of a report, of feeding back the results of their research to participating departments. It would welcome a short summary of the findings of this project, once you have completed it, in a form suitable for distribution to adult social services departments. We would appreciate knowing your expected publishing date.

The Executive Council has also requested that researchers involved in specific recent applications liaise with each other, to avoid duplication and to consider the timetabling of calls on local authority time. I emailed details of the other relevant projects to you previously, on 19th June 2017.

Please can you email me if you have any further questions?

Yours sincerely

Hilary Paxton, ADASS Assistant Director
Sent on behalf of the ADASS Executive Council

Appendix B: Ethical approval

NHS
Health Research Authority

Social Care REC
Ground Floor
Skipton House
80 London
Road
London
SE1 6LH
Telephone:
0207 972
2568 Fax:

23 February 2018

Professor Stephen Peckham
Centre for Health Services Studies
University of Kent
Canterbury, Kent
CT2 7NF

Dear Professor Peckham

Study title: **Improving choices for care: a strategic research initiative on implementation of the care act 2014**
REC reference: **17/IEC08/0050**
IRAS project ID: **237177**

Thank you for your letter of 19 December 2017, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact hra.studyregistration@nhs.net outlining the reasons for your request.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research (apart from that already taken place, the staff research as detailed in our letter dated 08 January 2018) on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

The Committee would like to remind you, as stated in our letter dated 08 January 2018 and our
Standard Operating Procedures (added below), that if you are submitting an application in the
future which involves staff and service users, the whole study needs to be submitted for an ethical review before any of the research is commenced, including the research with staff.

The Health Research Authority's (HRA) Standard Operating Procedures state that for dual staff and patient studies - Studies which include both NHS and social care provider staff who are recruited through their professional capacity and NHS patients/service users, should be reviewed by a REC and an opinion given on the study as a whole. There is no REC requirement to ensure that the staff element of the study has been reviewed by a non NHS REC prior to giving a decision.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

1. Although you have submitted an amended participant information sheet, letter of invitation and consent form in response to point 7 our letter, there is mention of observations in them which was not explained. Either delete the reference to observations or explain them – what is being observed and when. Is it just during the focus group?

You should notify the REC once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. Revised documents should be submitted to the REC electronically from IRAS. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which you can make available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for NHS permission for research is available in the Integrated Research Application System, www.hra.nhs.uk or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Insurance]		
Interview schedules or topic guides for participants [Interview schedule]	2	09 August 2017
IRAS Application Form [IRAS_Form_18102017]		18 October 2017
IRAS Application Form XML file [IRAS_Form_18102017]		18 October 2017
IRAS Checklist XML [Checklist_12022018]		12 February 2018
Other [ADASS support]	1	21 July 2017
Other [Response to ethics committee]	1	05 October 2017
Other [Access sheet (focus group)]	2	18 October 2017
Other [Consent form (focus group)]	2	14 August 2017
Other [Unfavourable Opinion Letter]		08 September 2017
Other [Response letter 19-12-17.pdf]	1	19 December 2017
Other [Focus group topic guide]	2	02 February 2018
Other [Consent Form (focus group)]	3	02 February 2018
Other [Focus group - Information for research participants]	3	02 February 2018
Other [3rd response letter final SP.docx]	3	02 February 2018
Other [Focus group - letter template]	3	12 February 2018
Participant consent form [Consent Form]	2	14 August 2017
Participant information sheet (PIS) [PIS]	2	14 August 2017
Research protocol or project proposal [Proposal]		
Response to Request for Further Information		19 December 2017
Summary CV for Chief Investigator (CI) [SP-CV]	1	

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/qualityassurance/

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

17/IEC08/0050	Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely

pp *Barbara Ardelea*

Dr Martin Stevens Chair

Email:nrescommittee.social-care@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Copy to: *Professor Stephen Peckham*

Appendix C: Key decisions and actions from the Programme Board minutes

Care Act Programme Board work streams:

ID	Workstream	SRO/lead	Policy area & lead	Policy commitments	Objectives (summary)
1	Funding reform policy	Tabitha Jay	Cap & Extended Means Test (Sara Mason) Charging Framework Policy (Sara Mason) Funding Reform Legislation (Sara Mason) Financial Services Engagement & behaviour change (John Murphy) Funding Reform Finance & Impact Assessment (Tom Skrinar & James Umpleby) Funding allocations (Jo ?)	Introduction of a cap on care costs that limits the amount a person has to contribute towards the cost of care to meet their eligible needs; Increase the threshold for when financial help becomes available with the cost of care; Introduction of a national, notional standard contribution to living costs.	Delivery and implementation of a reformed system for determining how much people contribute towards their care and support that shares the costs of care between the state and the individual more equitably
2	Appeals	Tabitha Jay	Appeals & Disputes Policy Appeals Legislation	To implement appeals system for 2016:	To consult on appeals policy proposals in early 2015 to inform

			Appeals Finance & Impact Assessment	Be clear and easy to understand;	development of regulations and guidance;
				Be locally accountable;	To develop policy for the appeals system that delivers on ministerial aims for a system that provides some level of independence whilst being proportionate;
				Provide public redress;	
				Resolve issues in a timely, effective and cost-effective way;	
				Have an independent element;	To develop and scope tool kits to help local authorities implement system
				Promote local resolution	
3	Care Markets	Simon Medcalf	Market Shaping & Commissioning (Stephen Airey) Market Oversight Regime (Richard Campbell) Market Impact (Stephen Airey)	To develop a market oversight regime, to be operated by CQC, focusing on ensuring people continue to receive services when certain providers fail; To clarify the responsibilities of LAs	To enhance the operation of adult social care markets: Clarification of the responsibilities of LAs when providers in their area fail Supporting LAs to develop their capacity to shape

| | | | Developing Good Practice in Commissioning, including Commissioning for Better Outcomes (Stephen Airey) Direct Payments in Residential Care (Amy Baldwin) | when providers in their area fail; To provide a general duty for LAs to develop the diversity, quality and sustainability of the local care market; To support LAs to consider the whole population in their commissioning, market shaping and market oversight, not just those they directly fund | diverse, sustainable and high quality markets Develop and improve LA commissioning practices, to ensure a focus on outcomes |

Care Act Programme Board 'enablers'

ID	Workstream	SRO/lead	Policy area & lead	Objectives (summary)
4	Implementation Support	Tabitha Jay	Workforce L&D and Capacity Planning 2016/17 (John Woods / Sara Mason) Funding Reform Implementation Support (John Woods / Avril Mayhew)	Understand local assumptions, risks and opportunities regarding Phase 2 delivery. Share good local practice in terms of planning for the new system and models of service delivery to support councils' and other stakeholders' implementation of Phase 2. Enable local authorities to effectively implement a framework to achieve the policy objectives of funding reform. Encourage local authorities to view their implementation of Phase 2 as part of a wider opportunity to become more effective and efficient as they reshape their local social care offer and operations, rather than in isolation as a response to a new

				cohort of people interacting with the local system.
5	Communications	Steven Pollock	Policy areas and project leads: Fraser Clubbe & Suzanne Lawrence Raising Awareness 2016/17 Reforms Behaviour Change Campaign Strategic Communications	To increase awareness among local system leaders of the rationale behind and vision for the changes; To increase awareness in target media of the difference the changes are making and will make for people; To increase confidence among national stakeholders in the steps being taken by DH to improve care and support;
6	Informatics	Charlotte Buckley	Policy areas and project leads: Matt Birkenshaw (DH) & Mark Golledge (LGA) IT Systems & LA/ Supplier Readiness Citizen Online Data	*IT Systems and LA/ Supplier Readiness* Suppliers and Local Authorities are awareness of Care Act requirements *Citizen Online*

				Nationally to support development of, and address national barriers to, online citizen self-service to support key functions: • Information and advice • Needs self-assessment • Financial self-assessment • PB / IPB calculations • Care Account Access • Care Commissioning *Data* Ensure data collections from local government reflect new requirements of Care Act to facilitate effective monitoring and evaluation.
7	Programme Management Office (PMO)	Martin Caunt & Andrew Hughes	PMO activity leads: External Assurance & Benefits – Clare Brown (DH) Programme Management & Board Secretariat – Rachael Whitaker (DH)	PMO enables the Care and Support Reform Programme Board and associated Boards to effectively and efficiently oversee delivery of the Care Act to the approved Programme Plan

			Implementation Support – Avril Mayhill	PMO supports Local Authorities, service providers and other partners implementation through timely communication of the Programme plan and the key decisions of the Boards
			Implementation Communications – Lynne Morris	
			Provider Implementation – Avril Mayhill / Ian Turner	
			LA Readiness Stocktakes – Tom Shakespeare	DH , LGA and MPA assurance that programme well managed and planned and remains on track for delivery of expected benefits
			Monitoring Programme Budget – Clare Brown	Local authorities understand their own readiness and support needs to implement the Act

Care Act Programme Board – Benefits Realisation

ID	Workstream	SRO/lead	Policy area & lead	Objectives (summary)
8	Benefits Delivery	Simon Medcalf	Policy areas or enablers in benefits phase: Paying For Care – Tabitha Jay Integration & Cooperation – Ed Scully Information, Advice & Advocacy – Paul Richardson Housing – Ed Scully Ordinary Residence – Paul Richardson ASC in Prisons – Anne McDonald Quality and Safety – Paul Richardson Care Planning & Personalisation – Paul Richardson	To understand how the programme has made a difference to the lives of those with care and support needs and their families, both in terms of outcomes and experience of services Learn how the programme has changed local delivery approaches Measure success in terms of monetary savings Understand how the joint programme has added value and supported local implementation Use the knowledge gained to inform future work to maximise the realisation of anticipated benefits

			Assessment & Eligibility – Simon Medcalf Prevention – Simon Medcalf Delayed Discharge – Charlotte Buckley	