Improving choices for care: a strategic research initiative on the implementation of the Care Act 2014

Interim Report

December 2017
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INTRODUCTION and BACKGROUND

This is a draft interim report produced at the halfway mark of the project. During this first phase our focus has been upon:

- The recruitment of research associates: this took a little longer than expected and resulted in some delay in getting underway
- Internal team discussion to plan and arrange the scheduling of the different phases of the work
- Obtaining ethics consent: this too has proved more protracted than expected
- Identification of interviewees for national level interviews and subsequent interview arrangements
- Identification of six local sites for fieldwork; holding meetings in each to secure consent and discuss our requirements: this too has not been straightforward
- Deskwork related to the functioning of the Care Act Implement Support Programme and the ways in which it compares with arrangements for other policy domains
- Deskwork to explore contextual and conceptual issues

This has meant that the first part of the project has been primarily occupied with desk-based activities, securing consent for our fieldwork, making arrangements for fieldwork, completing national level interviews and commencing some local interviewing.

It is still a little early to start drawing out messages and forming judgements about the effectiveness of the Care Act Support Programme. Nevertheless, there is a considerable amount of material in this interim report. It consists of the following sections:

- A brief reminder of the background to the project and our research objectives
- An explanation of the public policy context behind the growing interest in implementation support
- An exploration of conceptual issues around implementation and implementation support
An examination of implementation support arrangements in other policy domains and how they compare to those associated with the Care Act

The Care Act Implementation Support Programme: a descriptive account of arrangements and some early draft messages from the national level interviews

Next steps

Background to the Research Project

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 comprehensive nature of the changes being introduced, the Department of Health was keen to ensure that there was adequate guidance and support to help local authorities make the necessary changes to achieve successful implementation. Drawing on the partnership structures established to develop the Care Act proposals, the Department worked in partnership with the Local Government Association and the Association of Directors of Adult Social Services to create a programme implementation support process that built on these existing partnership structures.

The Department was keen to understand more about the effectiveness of this approach to implementation support – about the lessons that can be learned and about the extent to which it might provide a model for supporting the implementation of other national programmes.

Therefore, using the Care Act approach as a specific example, in this project we seek to 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. In particular, the Department is 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).

Aims of the Research

The aim of this research is to assess the impact of the national and regional partnership implementation support programme on local implementation of the Care
Act. Drawing on this empirical analysis, a wider review of other national programmes and the theoretical and conceptual literature, we aim to identify approaches that are more likely to support effective policy implementation at a local level. Our key research objectives are to:

1. Identify key lessons from previous 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.

Design and methods

Our approach involves undertaking an analysis of the partnership support programme and how it has facilitated local transformational change and service improvement. It is a mixed-methods case study design with the data collection undertaken at macro, meso and micro levels. The research is being conducted in four phases with phases one and two, along with the macro element of phase 3 being the subject of this report.

Phase 1: Contextual and Conceptual Issues

Our starting point has been to understand more about the context within which the need for some form of implementation support has become a more prominent governance issue. We locate this within the debate around 'policy failure' and the various attempts to deal with this problem. We distinguish between implementation preparation, implementation prioritisation and tracking, implementation support (our key focus) and implementation review. In doing so we identify some theoretical models within which to potentially locate our analysis. In addition we report on an analysis of the implementation support arrangements associated with other policy areas. Although this latter exercise has produced a considerable amount of material it is important to note that relatively little information has been reported on how implementation was supported.

Phase 2: The Care Act 2014 and the Implementation Support Programme

In this phase, we examine the broad nature of the Care Act support programme using documentary sources including the programme board minutes and papers and data
from the National Audit Office review of the implementation of phase one implementation.

Phase 3: Analysing the Partnership Support Programme

This phase of the research involves a detailed analysis of the Care Act partnership approach – its impact on local authority planning, decision-making processes and service delivery with data collection and analysis at three levels:

- **Macro**: At national and regional levels, we are examining the roles and functions of the key support mechanisms and structures - the programme board, programme management office and work-streams and regional leads. We are using a mixed-methods approach involving interviews and document analysis to examine process and impacts.
- **Meso**: To examine how local policy and decision-making are influenced by and respond to the national support programme we have begun conducting in-depth research in two county and two unitary councils and two Metropolitan/London Boroughs in England.
- **Micro**: To identify the degree to which various national, regional and local support initiatives have helped facilitate and deliver local service improvement. This will involve interviews with staff and user representatives to understand how service improvements are being enacted.

During the first year of the project we have undertaken ten national level interviews and are currently undertaking interviews in six local authority case study sites. The six case study sites include 1 Unitary Authority, a London Borough, two Metropolitan District Councils and 2 County Councils. Only the macro national interviews are reported in this paper as locality interviews are still at an early stage.

Phase 4: Developing a Framework for Service Improvement Support

In this final phase of the research we aim to identify whether there are generic lessons identified in our analyses of the Care Act support programme, from previous national programmes and the wider policy implementation and implementation science literature that can help inform future policy implementation support. By synthesising the findings from across our work we hope to understand the multi-level coherence between the macro, meso and micro levels for service improvement support which can be used in designing future support programmes.
Phase 1: Contextual and Conceptual Issues

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. 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 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.

The persistence of policy failure

Dunlop 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’ the tendency is to treat failures somewhat tautologically – policy failure is equated with non-implementation, either in

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3 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
5 Harris, J and Rutter, J (2014), Centre Forward: Effective Support for the Prime Minister at the centre of Government, London: Institute for Government
6 Dunlop, C (2017), Policy learning and policy failure: definitions, dimensions and intersections, Policy and Politics, 45(1), pp3-18
full or in part. In reality, as McConnell 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 - 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 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.

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


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).¹¹ 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 OECD¹² 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 of four such policy areas¹³ - 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.

¹¹ National Audit Office (2013), *Over-optimism in government projects*
¹² OECD (2015), Delivering From the Centre: Strengthening the role of the centre of government in driving priority strategies
- **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\(^{14}\) 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.

### 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’\(^{15}\) 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’\(^{16}\) 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\(^{17}\) 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.

### 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.

\(^{14}\) Lipsky, M (1980), *Street-Level Bureaucracy*, New York: Russell Sage Foundation

\(^{15}\) 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


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)\textsuperscript{18} 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.

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\textsuperscript{19} with Ilott et al\textsuperscript{20} 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

\begin{itemize}
  \item \textsuperscript{18} Ansell, C, Sorenson, E, Torfing, J (2017), Improving Policy Implementation through Collaborative Policymaking, *Policy and Politics*, 45(3), pp 467-86.
  \item \textsuperscript{19} Norris, E. and McCrae, J., Policy That Sticks: Preparing to govern for lasting change, Institute for Government, London, 2013
\end{itemize}
will probably tend to be seen as ‘someone else’s problem’. 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.

How politicians and officials plan and act on each of these phases will make or break a policy. However, rather than just let policies drift into full or partial failure, governments are taking an increasing 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.

Developing an implementation programme

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’. 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.

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. 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

21 Weaver, K (2010), But will it work?, Issues in Government Studies, 32, pp 1-17
22 May, P (2015), Implementation failures revisited, Public Policy and Administration, 30(3-4), pp 277-299
23 Hogwood, B and Peters, G (1985), The Pathology of Policy, Oxford University Press
24 Sense About Science (2015), Assessing how the government uses evidence to make policy
thirteen domestic policy departments. Although some examples of good practice were identified there were some general shortcomings around: sharing work done; poor referencing; unclear chains of reasoning; and a failure to consider other policy options.

Gold has noted that few countries have mechanisms in place to ensure more robust policy design. In the UK, the Civil Service Reform Plan 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 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.

An interesting exception in this regard is Australia, where the Department of the Prime Minister and Cabinet has issued guidelines 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 has yet to receive a positive response.

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:

26 Gold, J (2014), *International Delivery: Centres of government and the drive for better policy implementation*, Mowat Centre/Institute for Government
28 HM Government (2014), *Civil Service Reform Plan: Progress Report*
29 Australian Government (2014), *Policy Implementation*, Department of the Prime Minister and Cabinet
- **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.\(^{31}\) \(^{32}\) 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.\(^{33}\) 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\(^{34}\) 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

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\(^{34}\) Aid Effectiveness (2014), *Delivery Units: can they catalyse sustained improvements in education service delivery?*
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 and Cairney, 2015)\footnote{Geyer, R and Cairney, P (2015), \textit{Handbook on Complexity and Public Policy}. London: Edward Elgar Publishing.}

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)\footnote{Allcock, C, Dorman, F, Taunt, R and Dixon, J (2015), \textit{Constructive comfort: accelerating change in the NHS}. London: Health Foundation} 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.

All of this implies 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’\footnote{Pew Charitable Trust/MacArthur Foundation (2017), \textit{Four ways implementation support centers assist in the delivery of evidence-based programmes.}} – entities of various types that work alongside and often at the direction of government to support effective implementation. Franks and Bory\footnote{Franks, R and Bory, T (2015), \textit{Who supports the successful implementation and sustainability of evidence-based practices? Defining and understanding the roles of intermediary and purveyor organisations}, \textit{New Directions for Child and Adolescent Development}, 149, Fall 2015, pp 41-56.} develop a similar concept in their exploration of ‘intermediary organisations’ which, they conclude, ‘appear to play a critical role not only implementing model programs, but also in developing the necessary capacity for systems change’ (p54).
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 the 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 technical support, trouble-shooting, the brokering of areas of dispute and encouraging the utilisation of research and evidence. 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\(^{39}\) and the Change Agent Team in England.\(^{40}\) Both of these implementation support teams have since been abolished.

**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.

Combining all three of these functions – especially compliance and support - within one agency is problematic. There seems to have been relatively little attempt to explore these tensions in contemporary institutions but there is still much to be learned from Henkel’s seminal study of the Audit Commission, Social Services Inspectorate and Health Advisory Service.\(^{41}\) 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.

**Implementation Review**

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. What is much less clear is how to contextualise implementation support or how to assess its effectiveness.

**Contextualising Implementation Support**

It is likely that the implementation support process will more easily flourish in some contexts more than others. A useful framework for understanding the role of context is Matland’s (op cit) classic work on the impact of conflict and ambiguity on implementation. Matland’s premise is that the different characteristics of policies have 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 his distinction between issues about the extent of policy ambiguity on the one hand, and issues about conflict on the other, to develop the matrix shown in Table 1 below.
## Table 1: Matland’s Model of Conflict, Ambiguity and Implementation

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

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.

The task of policy-makers then is to determine which policies require what mix of support to give them the best chance of effective implementation. We will be returning to this issue in the later stages of our research, but an earlier task has been to explore the extent to which ‘implementation support’ has been a feature of policy domains that are broadly comparable to the Care Act. Such an exercise will help in understanding the extent to which, and the ways in which the support programme associated with the Care Act has distinctive features. This is the focus of the following section of the report.

### What Do We Know About Implementation Support in Other Policy Areas?

Through examining patterns, similarities and differences between the Care Act and other relevant national policy implementation support approaches, inferences can be made about the Care Act without the ambiguity of generalisations and therefore allowing for the creation of hypotheses with regards to effective practice.

In order to explore and understand other methods and approaches to national policy implementation support, a mapping review of existing national policy implementation models was conducted. This involved collating, describing and categorising/cataloguing selection of available evidence within a tabular format with a view to using findings to inform a secondary synthesis of evidence looking at comparisons with the Care Act in more detail. This method did not seek to produce a formal quality appraisal of the gathered data, but rather to categorise the data according to an inductively developed framework (O’Cathain et al., 2013).

Data was collected to try to develop an understanding of how support has been given, in order to implement national policies, and what mechanisms may be identified as making a policy implementation model ‘successful’. The data was collated and

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catalogued in order to provide detailed ‘meta-data’ about each policy and its implementation approach. Following the mapping review, the data generated was then used to inform a secondary synthesis of evidence. During this phase, a framework of attributes was developed (built on key criteria emerging from the initial mapping review) in order to gain an understanding of knowledge clusters to draw direct comparisons with the Care Act implementation method.

Mapping Review

The key objectives of the mapping review 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 identified and reviewed as part of the mapping exercise. The policies were selected based on their conformation of the following criteria; national reach (England); related to health and social care; bringing together services at the local level; policy has sufficient information available to catalogue. The search was guided by the expertise of the research group and advisory group and influenced by an initial scoping exercise as part of a team meeting where policies that were connected to social care were discussed.

Information was extracted regarding the key aspects of each the policies along with contextual factors and key mechanisms in order to try to better understand the impact of the policy and to allow for comparisons with the Care Act to be formulated. Data was collected in respect of how the approach was implemented, the role of the government with respect to implementation, support provided for implementation, key contextual factors influencing implementation and whether or not the implementation approach had been evaluated.

In addition, key distinguishing features of the Care Act were established and polices were matched against these to inform which policies would be suitable for further investigation in order to provide a more detailed comparison with the Care Act 2014, (see table 2):

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?

**Table 2: Policies mapped against inclusion criteria for secondary synthesis of evidence**

*Grey highlight indicates policy identified for further investigation*

<table>
<thead>
<tr>
<th>Policy</th>
<th>Scale</th>
<th>Purpose</th>
<th>Reach</th>
<th>Learning</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Place</td>
<td>x</td>
<td>x</td>
<td>✔</td>
<td>✔</td>
<td>x</td>
</tr>
<tr>
<td>City Challenge</td>
<td>x</td>
<td>x</td>
<td>✔</td>
<td>✔</td>
<td>x</td>
</tr>
<tr>
<td>Community Care Support Force (CCSF)</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Cities and Local Government Devolution Act 2016</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>✔</td>
</tr>
<tr>
<td>Community Care Development Programme</td>
<td>x</td>
<td>x</td>
<td>✔</td>
<td>✔</td>
<td>x</td>
</tr>
<tr>
<td>Troubled Families</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>x</td>
</tr>
<tr>
<td>Ensuring the effective discharge of older patients from NHS acute hospitals</td>
<td>x</td>
<td>x</td>
<td>✔</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Academies programme</td>
<td>✔</td>
<td>x</td>
<td>x</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>New Deal for Communities</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>✔</td>
<td>X</td>
</tr>
<tr>
<td>Health Action Zones (HAZ)</td>
<td>✔</td>
<td>x</td>
<td>x</td>
<td>✔</td>
<td>X</td>
</tr>
<tr>
<td>Sure Start</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Health and Social Care Act</td>
<td>✔</td>
<td>x</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Better Care Fund (BCF)</td>
<td>✔</td>
<td>x</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Health and Wellbeing Boards (HWB)</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Vanguards</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
</tbody>
</table>
Information extracted from each of the policies illustrated a vast range of implementation approaches. The policies and their associated approaches had varying degrees of reach. It was noted that some policies provided targeted support looking to address specific concerns/issues (e.g. City Challenge, Community Care Support Force), others were implemented on a pilot basis (e.g. Total Place which included 13 sites), and some had more of a blanket approach across all authorities showing little local variation (e.g. Troubled Families, Academies programme).

In addition, differing levels of central direction and support were evident. Policies such as the CCSF had strong links to central government thus sustaining political support, whilst maintaining effective relationships at the local level with the authorities they were working with. In contrast, the BCF was very much seen as being a national programme with strong political support and less focus was given on the localised elements, with little ‘hands-on’ localised support for authorities reported.

The role of the central government in relation to model implementation can be broadly categorised into two elements; development and management. In almost all policies there was evidence of developmental support for implementation. This included the choosing of pilot/implementation sites (Total Place, New Deal, Sure Start, Community Care), developing frameworks (CCSF, Academies programme, HWB) and establishing central support units or providing expert advisors (Health & Social Care Act 2012, Sure Start, HAZ, City Challenge). All policies had some level of management support from the centre in relation to implementation. This was most often in the form of 'legislative frameworks' produced to guide policy implementation. In addition, the managerial task of funding was often linked to the legislative frameworks put in place.

The clarity of the programmes reviewed along with their comprehension of complexity, was viewed through extracting information regarding the mechanisms and social process utilised in influencing implementation and generating an understanding of the contextual factors that impacted on model implementation. All policies have some degree of cultural change impacting upon the context they were operating within, i.e. fundamental shifts in ways of working or the bringing together of different organisations. Many policies involved the bringing together of different partners, often from different backgrounds (i.e. Independent sector and Local Authority in the Academies programme) which may pose cultural conflicts. Culture shifts are also seen in ways in which policies are prescribing new ways of working, for example the Troubled Families Programme is based on a payment by results approach. In addition, a shift towards an outcomes based focus is evident in both the Community Care and HWB policies.

The mechanisms for creating the changes for the policies reviewed all included some element of partnership working, often with this being central for ‘successful’ implementation. There is a strong sense of the bringing together of relevant partners, often at the local level in order to pool resources and knowledge to facilitate the
requirements of the policy in question. A number of policies also give rise to power being handed down from central to local levels in order that services are able to be designed at the local level to meet local need (i.e. Sure Start, Total Place, City Challenge, CCSF, HAZ, Better Care Fund, HWB).

Comparative Analysis: Implementation approach

In order to better understand how policy relates to the Care Act in terms of implementation approach, using the criteria set out above, each of the fifteen policies included in the initial mapping exercise were assessed to determine which should be included within the secondary synthesis of evidence through a more detailed case study investigation. Community Care Support Force, Sure Start, HWB and Vanguards were all identified as sharing the five characteristics included in the criteria for inclusion in the case study analysis. Troubled Families, although only sharing four of the characteristics has also been included in the analysis following discussions within the project team due to its scale and reach which are very much in line with the Care Act 2014.

The 2014 Care Act was accompanied by an ‘innovative’ implementation support programme focusing on three main areas:

- Clarity of expectations and requirements
- Flexible products
- Collaborative infrastructure

In order to ascertain what impact this approach had on the implementation, the five case studies identified above have been considered in relation to their commonalities, and comparisons have been made between each of the implementation approaches and subsequent perceived success. The implementation support approaches adopted by each case study have been explored below in terms of the extent to which they reflect one or more of three identified ‘models’ based on the work of Gold43 (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

43 Gold, J (2014), *International Delivery: Centres of government and the drive for better policy implementation*, Mowat Centre/Institute for Government
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 3 summarises the implementation support approaches evidenced within each of the case studies and the Care Act and then ranks their properties against the three ‘models’ identified above. The approaches have been grouped into the four key themes identified earlier in section under the types of implementation support provided for the Care Act 2014. It must be noted that the table of implementation approaches is ‘skewed’ somewhat due to substantially more information being available in relation to the implementation of the Care Act compared to the implementation of the other case studies. This, in itself, might be regarded as an important finding – the possibility that implementation support has tended to be seen as somewhat marginal rather than vital to successful policy implementation.

Nevertheless, common themes have emerged throughout the case studies illustrating performance management and problem solving as dominant characteristics of implementation support approaches. Performance management as a dominant characteristic is not surprising given that in order to be included within the analysis policies needed to be of a national nature and have statutory underpinning guidance. Therefore, it is to be expected that there will be (at least in part) articulation of required standards/performance or detailed procedures for performance measurement within the implementation approach adopted. Likewise, problem solving as a dominant characteristic could be argued to be an expected element of a implementation support approach as these approaches are generally developed to assist recipients in implementing the policy/guidance etc. in question.

The majority of approaches included at least in part an element of performance management. These approaches included the production of guidance, funding frameworks and a need for co-ordination between sites. Problem solving was exhibited, at least in part, by all bar three of the implementation approaches. A key feature of all of the policies was the level of locally developed delivery models to meet the identified need presented through the statutory guidance. This 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 seen more within the implementation approaches which focused on support (i.e. through provision of Advisors/Support Force) and where local areas were given greater autonomy to deliver models of service that met local needs.
Table 3: Implementation approach methods within case studies

<table>
<thead>
<tr>
<th>Implementation Approach</th>
<th>Brief description of approach</th>
<th>Approach exhibited in…</th>
<th>Performance management</th>
<th>Problem-solving</th>
<th>Capacity building</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information dissemination, learning and awareness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phased implementation</td>
<td>Phased implementation approach</td>
<td>✔️ ✔️ ✔️ ✔️</td>
<td>In part</td>
<td>Yes</td>
<td>In part</td>
</tr>
<tr>
<td>Written support</td>
<td>Provision of practice guidance</td>
<td>✔️ ✔️ ✔️ ✔️ ✔️ ✔️</td>
<td>Yes</td>
<td>In part</td>
<td>In part</td>
</tr>
<tr>
<td>Product development and information dissemination</td>
<td>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</td>
<td>✔️ ✔️ ✔️ ✔️ ✔️</td>
<td>In part</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Increase public awareness</td>
<td>Commissioned research on regional and local variations</td>
<td>✔️</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Regional support</td>
<td>Appointment of regional teams to promote implementation</td>
<td>✔️</td>
<td>In part</td>
<td>Yes</td>
<td>In part</td>
</tr>
<tr>
<td>Provider implementation support</td>
<td>Provider engagement work to gain understanding of implementation support needs</td>
<td>✔️ ✔️ ✔️</td>
<td>In part</td>
<td>Yes</td>
<td>In part</td>
</tr>
<tr>
<td>Stakeholder support</td>
<td>Providing information and resource support to key organisations and groups involved in implementation process</td>
<td>✔️ ✔️ ✔️ ✔️ ✔️ ✔️</td>
<td>In part</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Stock-take support</td>
<td>Providing regional and LA support for conducting stock-takes of resources</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>--------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>----</td>
<td>----</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td>Training courses and workshop support</td>
<td>Aiding the dissemination of information</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Dedicated support</td>
<td>Individual area Officer/Advisor made available</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Targeted support</td>
<td>‘Support Force’ targeting specific authorities</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td></td>
</tr>
</tbody>
</table>

**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 | ✔ | ✔ | ✔ | Yes | 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 | ✔ | ✔ | ✔ | ✔ | Yes | No | No |
| Collaboration, using and developing strategic partnerships | Linking relevant organisations in order to streamline implementation | ✓ | ✓ | No | Yes | Yes |


Bate (2017) The Troubled Families Programme (England)

49. New Care Models: Vanguards and developing a blueprint for the future of NHS and care services (2015)
The Forward View into Action: New Care Models (support for the Vanguards) (2015)
The Local Evaluation of the New Care Models Vanguards: Our Expectations and Offer of Support for 2017/18 (2017)
A wide range of information dissemination approaches were used by the majority of policies reviewed which assist with equipping local users with the information needed in order to implement the policy in question. The Care Act appears to go further than most however with the approach to information dissemination, bringing in features such as ‘increasing public awareness’, ‘regional support’ and ‘stock-take support’ which are not seen as much in the other policies. Similarly, the Care Act also placed emphasis on the mitigation of risk through the development of a ‘risk register’ which was not observed in the other policies reviewed. However, with the production of risk registers being a standard tool for project management, it may just be that these were not described within the available literature on the policies reviewed.

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 Care Act and Sure Start were viewed to supplement this approach by producing local guidance. ‘National coordination’ was an integral element in the majority of policies whereby direction was given at a national level in leading the policy implementation forward.

In comparison with the other policies, the Care Act appeared to place greater emphasis on co-production and collaboration than the other policies reviewed. However, ‘joint production of operating models’ was viewed to also be present with Sure Start, Troubled families and Vanguards as well as the Care Act.

Implementation success

Successful implementation implies that:

‘…agencies comply with the directives of the statues, agencies are held accountable for reaching specific indicators of success, goals of the statute are achieved, local goals are achieved or there is an improvement in the political climate around the programme’ (Ingram and Schneider 1990).

It is not within the scope of this research to attempt to conduct a thorough evaluation of the impact of the implementation approaches used within each of the case study policies. Therefore, information has been extracted where available from other sources in order to provide an overview of the perceived success of the implementation approaches applied.

It must be noted that success can be measured in a number of different ways. As illustrated in the previous section, each of the case studies has a number of

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44 Ingram, H. and Schneider, A. (1990), 'Improving implementation through framing smarter statutes', *Journal of Public Policy* 10(1): 67-88
implementation support approaches underpinning it. Therefore, in order to assess the success of the implementation of the case study it is important to understand the perceived success of the support methods which contributed to its implementation. Payne\(^{45}\) (2008) argues that only looking for general solutions and not acknowledging the particular context can lead to incoherent implementation efforts and that no ‘one-size–fits-all’ policy exists. Therefore, although an implementation support approach may be evident in more than one policy, in order to unpick its perceived ‘success’ it needs to be considered within the context within which it was implemented.

The problem with unpicking these individual elements of policy implementation is that although many of the case studies have been subject to an evaluation, very few detail the approaches of implementation support provided for the policy. Instead, it is the outcomes produced as a result of the policy’s implementation which are commented upon within evaluations, generally including what impact the policy has had on the target population it aimed to address. The strong focus in the Care Act on the implementation support process itself is therefore unusual and perhaps draws attention to a neglected aspect of the more long-standing debate on policy implementation \textit{per se}.

In all case studies, the policy was implemented, therefore indicting some level of success of the policy as a whole. Two of the case studies, Health and Wellbeing Boards and Troubled Families did not have sufficient evidence available in order to determine the perceived success of how the programme was implemented (note: evaluations have been undertaken however, implementation support approaches are not sufficiently detailed) and therefore conclusions cannot be drawn from these case studies.

The CCSF, Sure Start and Vanguards had different focuses on their implementation approaches, which were viewed to be successful within the evaluations conducted. The CCSF approached implementation through bringing ‘leading edge practitioners’ to authorities in order to work together to tackle the aims of the programme. This approach was stated to be successful as it brought about effective engagement between authorities and central government. Similarly, the Vanguards included individual planning with specific sites, again aiding effective engagement. The implementation approach taken for Sure Start took a different tack, based on consultation feedback, frameworks and guidance were published and disseminated to authorities. Both this process and the published materials were well received suggesting some degree of success.

The approaches taken by CCSF, Vanguards and Sure Start all shared one common theme, namely, effective ‘buy-in’ at the local level. Through working directly with

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\(^{45}\) Payne, C. (2008), So much reform, so little change: the persistence of failure in urban schools, Cambridge: Harvard Education Press
authorities and through consultation events they were able to negotiate the local market to ensure that the right people were involved in implementation. The Care Act showed a similar approach, paying attention to allow for localised dissemination of information and sufficient flexibility within the implementation to allow for local approaches to be adopted.

This section has attempted to assess the extent to which implementation support has been an important element of other policy areas that share some similarity with the Care Act. All of these policy domains are complex and have been subject to varying degrees of monitoring and independent evaluation. Although some commonalities with the Care Act are evident, especially the recognised need for working constructively with local implementing agencies, there is little distinctive evidence to suggest that implementation support was seen as a central mission that was the subject of comprehensive planning and engagement. To this extent the Care Act programme, even if not conceptually unique, may have extended the parameters of how we understand the notion of ‘implementation support’. What remains to be discovered is how it was received at the meso and micro levels.
Phase 2: The Care Act 2014 and the Care Act Implementation Support Programme

So far this report has: highlighted the recurring issue of policy failure; identified four stages of the policy design and implementation support process; and considered the ways in which a range of domestic social policies have been underpinned by implementation arrangements. This section now turns to the Care Act itself and the associated Implementation Support (IS) programme. The raison d’être of the invitation to tender for this work was the assumption that the arrangements introduced to support implementation of the Care Act were sufficiently novel and distinctive to warrant further investigation. The hope was that a better understanding of how this model had worked could be of value in other policy domains.

Our research is testing out this assumption at the macro, meso and micro levels by undertaking fieldwork in six localities and their associated regions. However, this stage of the work has been preceded by a number of national level interviews with some of those directly involved in the creation and operation of the Care Act IS programme. Before reporting on these findings it is necessary to briefly describe the nature and significance of the Care Act and outline the nature of the IS arrangements. That is the purpose of this section.

The Nature and Significance of the Care Act 2014

The Care Act consisted of two phases but in July 2015 it was announced that Phase 2 (introducing a cap on care costs due to take effect in April 2016) was to be deferred until April 2020. This removed a key part of the legislation - and a high-risk aspect – and in terms of Matland’s matrix removed much of the element of ‘political implementation’. It nevertheless left a raft of complex changes to be introduced under Phase 1 from April 2015. The main changes included duties on local authorities to:

- provide services that prevent care needs from becoming more serious, or delay the impact of their needs;
- meet a national minimum level of eligibility for a person’s care and support needs;
- assess carers, regardless of how much care they provide, and meet carers’ needs on a similar basis to those they care for;
- offer deferred payment or loan arrangements to more people, avoiding property sales to pay for care and support;
- provide information and advice (including financial advice) on care and support services to all, regardless of care needs;
- provide an independent advocate where such support is needed;
- work with care providers to get a diverse and high-quality range of local services;
comply with a new legal framework for protection of adults at risk of abuse or neglect; 

give continuity of care to those whose needs are being funded by the local authority who choose to move to another area; 

assess 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; 

arrange and fund services to meet the care and support needs of adults who are detained in prison

Despite its complexity and some measure of political disagreement over the cap on costs, the Act slipped relatively quietly into law. This consensus, both in and beyond Westminster, was sustained by the willingness of ministers to accept changes to the legislation during almost two years of scrutiny. After a public consultation that attracted around a thousand responses, a special joint committee of MPs and peers was established to scrutinise the draft bill, and a substantial number of its 107 recommendations for amendment were adopted. Further changes were agreed as the bill worked its way through Parliament, where – unusually - the Bill commenced in the Lords in recognition of the knowledge and relevant experience of so many members.

This high degree of legislative consensus was an important factor in shaping the next phase that is the focus of this research – 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 on the direction and objectives of the policy. This ‘collaborative policy design’\textsuperscript{46} is the prime feature of the Care Act support model.

The Care Act Implementation Support Programme

The view was taken by the Department of Health and its key implementation partners – the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS) – that a traditional top-down, one size fits all approach to implementation support would be an insufficient model for the complex challenges raised by the Care Act. In an important statement of principle in the Minutes of the Programme Board\textsuperscript{47} in 2013 it was stated that:

\begin{quote}
A traditional approach to providing implementation support is unlikely to be able to meet the needs of all organisations...no one single approach will be universally applicable and a heavily directed approach would neither be well-received nor taken up. Rather, flexible support arrangements that provide
\end{quote}


\textsuperscript{47} Care and Support Reform Programme Board, November 28\textsuperscript{th} 2013
clarity and certainty at the earliest opportunity without constraining local approaches or innovation would be of most value, particularly if this included a strong two-way dialogue on issues and approaches.' (p2)

Here then, the three principles underpinning the support programme – clarity, flexibility and collaboration – are highlighted:

**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 – the Department of Health, the LGA and ADASS.

Three key organisational innovations were created to structure the support programme: Programme Board; a Delivery Board and Programme Management Office; and a regional infrastructure.

**Programme Board (PB)**

The origin of the PB lay in the Implementation Programme Board set up in the wake of the Care and Support White Paper of July 2012. The membership was large (over thirty) with eleven representatives from the Department of Health and the remainder from the LGA, ADASS and other agencies including SOLACE (local authority chief executives), NHS England, Skills for Care and the National Institute for Clinical 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 a raft of work streams.

The PB was seen as having three functions – support, assurance and delivery:

**Support**: The broad purpose here was to provide national leadership and oversee the delivery of practical support to local authority providers and other delivery partners

**Assurance**: The purposes here were to: oversee delivery of the Care Act legal framework; ensure that appropriate local delivery plans were in place; provide

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48 Department of Health (2012), *Caring For Our Future: reforming care and support.*
assurance on the state of readiness and delivery confidence; ensure expected benefits and associated outcomes were being realised.

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

**Delivery Board and Programme Management Office**

The Care and Support Reform Delivery Board had a much more hands-on role. Chaired by a representative of DH it was tasked with: driving timely and effective delivery; ensuring risks and other issues were identified and mitigated; assessing data to monitor impact and drive the delivery of anticipated programme benefits. The Delivery Board met monthly before each Programme Board.

The PMO was established in November 2013 to support the work of the Board and was seen as central to the fulfilment of all three Board functions – support, assurance and delivery. The remit and structure aimed to: group projects together into work streams; provide a single point of contact for progress; enable the Board to agree and prioritise progress; identify a single senior responsible officer to sign off on plans and related issues; and support the identification of cross-cutting issues. Ten work streams were established covering the key areas of the Care Act outlined earlier.

**Regional Infrastructure**

In recognition of the potentially wide gap between central government and a multiplicity of local authorities, the decision was taken to develop a regional collaboration infrastructure to act as a conduit between regions 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 DH 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 implementation support programme for the Care Act 2014 is testimony to the seriousness with which the mission was undertaken at central level. It suggests a keen awareness of the potential danger of policy failure and
a determination to avoid it in ways that could mark it out as different and distinctive. The need for implementation to be in the hands of a multiplicity of local agencies - statutory, voluntary and independent - is a key feature of the 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, 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 Gold49 - managing and regulating; problem-solving; and capacity building.

Before commencing the main empirical part of this research – ‘deep dives’ into six implementing localities – it was important to learn more from those involved at national level in the support arrangements as to how they understood the process to have developed and worked. At the time of the interviews they were speaking with hindsight since the programme had closed some eighteen months previously. Whilst this offered the advantage of being able to reflect on how the arrangements had worked out in practice, it also meant that we were asking respondents to recall events that had been overtaken by the passage of time. Our next section (which is in draft form only) begins to reflect on some of the messages arising from this part of our work.

Messages from the centre: the national level perspective.

This section of the report focuses on preliminary findings from the first round of our document analysis and associated fieldwork - that concerned with national level activities. Specifically we have sought to understand:

- The involvement and contributions of individuals and organisations in the Programme Board
- The methods employed to support implementation and the reasons for their selection
- The planning process - when actions were taken and the length of time for completion

49 Gold, J (2014), *International Delivery: Centres of government and the drive for better policy implementation*, Mowat Centre/Institute for Government
The following three key data sources have been used: documentary analysis of Care Act Programme Board minutes; information on Care Act Programme Board actions; and a preliminary analysis of ten semi-structured interviews. For the interviews, we approached members of the Care Act Programme Board in order to provide detail as to what the IS process entailed. Questions put to members were intended to examine: aims and objectives of IS; the communication of any and all IS plans; considerations about other models of IS; and, any issues arising, such as risks that might occur during the process of policy implementation.

The following questions will be explored: (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?

Why was implementation support needed?

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.50

The paper cites a number of advantages to a distinctive IS 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.”51.

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 execution. The initial documentation produced for IS 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.”52

Of these themes, the presence of a co-production approach in IS has been central. Several meetings of the PB indicate that an insistence on collaboration was at the centre of IS. 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.53

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

51 Ibid, p.2  
52 Ibid. p.1  
53 Programme Board meeting, 28/11/2013
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.54

A second key aspect was risk mitigation. The minutes from one PB meeting gives 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.55

Flexibility in delivery support with support at a sub-central level emerges as another key consideration. It was noted that:

Flexible support arrangements that help provide clarity and certainty at the earliest opportunity, without constraining local approaches or innovation would be of most value. Discussions 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. 56

The organisation and structure of implementation support

Implementation of the Care Act support programme was driven by the PMO (Programme Management Office) and Programme Board consisting of several permanent and non-permanent members across the Department of Health, central government (i.e. Cabinet Office), the Local Government Association (LGA) and Directors of Adult Social Services (ADASS). A number of work streams to tackle implementation dilemmas in more detail were also established. These work streams are set out in Table 4 below.

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54 Respondent A
55 Programme Board meeting, 15/07/2014
56 Hughes, A. (2013), p.2
Table 4: Overview of work-streams for Care Act implementation support

<table>
<thead>
<tr>
<th>Work-stream</th>
<th>Responsibility of stream</th>
<th>Key implementation support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention and housing</td>
<td>• Prevention charging regulations (to be delivered alongside wider Charging for Care regulations); Statutory Guidance on prevention and housing</td>
<td>• Care and Support Specialised Housing Fund - up to £415m used to stimulate the market for specialised housing</td>
</tr>
<tr>
<td>Quality and safety</td>
<td>• Publish, consult and implement regulations on fundamental standards; Implement new system of quality ratings against the new standards</td>
<td>• Evidence-based, outcome-based good practice guidance on adult safeguarding</td>
</tr>
<tr>
<td>Information, advice and advocacy</td>
<td>• Delivery of information and advice services to meet needs of population; Legal duty on local authorities to provide a universal information and advice service</td>
<td>• Improving online LA information; Improve access to independent advice and support for people with eligible needs</td>
</tr>
<tr>
<td>Paying for care</td>
<td>• Support for those planning costs associated with care; Design of deferred payment scheme</td>
<td>• Identification and sharing of best practice; Development of a ‘model’ pathway</td>
</tr>
<tr>
<td>Charging for care</td>
<td>• Distributing costs of care between state and individual in equitable manner</td>
<td>• Development of a toolkit for local authorities to support readiness; Input into training materials for local authorities</td>
</tr>
<tr>
<td>Planning and personalisation</td>
<td>• Statutory guidance for care planning (including care planning process, reviews, and personal budgets/resource allocation)</td>
<td>• 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</td>
</tr>
<tr>
<td>Assessment and eligibility</td>
<td>• Assessment regulations; Statutory guidance on assessment</td>
<td>• 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</td>
</tr>
<tr>
<td>Care markets</td>
<td>• Regulations for the market oversight regime (definition of business failure, entry criteria, obtaining information from group companies including)</td>
<td>• Principles for dealing with serious provider failure; Self-help networks of DASS’s to provide mutual support</td>
</tr>
</tbody>
</table>

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

In addition, a number of papers scoping implementation support were produced by the PMO and members of the PB. The timescale for which the actions were decided and taken is between November 2013 and March 2016. As part of the documentation, a series of diagrams were produced to visually present how IS should function for the Care Act. There are three key areas that have been put forward as central to the IS process - collaboration, clarity and flexibility – figure 1 portrays the intended intersection between these variables.

**Figure 1: Understanding implementation support for Care Act**

![Diagram showing the intersection of collaboration, clarity, and flexibility in implementation support for the Care Act.](image)

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58 Hughes, A. (2013), p.1
From Hughes' paper, the following describes how each section of the above diagram should be understood:

*This model focuses on flexibility, clarity and collaboration: Clarity of expectations and requirements, of the framework and financial issues, and of the outcomes to be achieved. Effectively communicated to meet the needs of different audiences. Access to a range of flexible products to draw on in a way that meets local needs; reflecting the local starting point; the scale of change and other local issues and to have available a range of products (developed either locally, regionally or nationally) to meet these needs. Within a supported collaborative infrastructure that supports collaboration at local, regional and national levels through an on-going two-way supportive dialogue that builds a collective knowledge base.*

A subsequent document, also authored by Hughes (2014), set out the following categories as priorities for implementation support: “(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.”

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 5 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 (DH), NHS England, Skills for Care, ADASS, Social Care Institute for Excellence, and, the Local Government Association (LGA). Drawing upon these interviews we have identified a range of support practices to better understand and categorise the data shown in table 6.

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59 Hughes, A. (2013), p.2
### Table 5: Implementation support typology categorised from PB minutes

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

### Table 6: Implementation support typology from national interview data

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

42
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 IS process had been largely well-received and successful along several key dimensions.

**Clarity of information and guidance**

One of the primary goals of the IS 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 of this type of implementation is to provide a standardised set of information for local authorities to aid training and learning for staff and professionals. Broadly our 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.*

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.

**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. 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*

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61 Respondent B
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.\textsuperscript{62}

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 such 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’\textsuperscript{63}

\textit{Products and programme management tools}

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

\textit{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.}\textsuperscript{64}

The ambitious intention was to deliver the Act under a set of arrangements that it was felt had previously not been employed for major policy shifts. Overall, the picture from the national interviews is one of positive reflections and responses, but a verdict on the effectiveness of the model will depend upon how it was received, understood and valued at the level of local implementing agencies. This will be the focus of the next stage of our project.

\textsuperscript{62} Respondent C
\textsuperscript{63} Respondent D
\textsuperscript{64} Respondent E
Looking ahead: analysing the effectiveness of the partnership support programme

We are not yet in a position to assess the effectiveness of the Care Act IS programme but there is a need to reflect on how the effectiveness of all such programmes might be assessed. At one level it will be necessary to assess results in terms of the stated objectives of the programme. A paper produced for the PB in 2015 identified three key areas, each of which will be examined in our local studies:

**Effectiveness of the Implementation Tools:** A wide range of implementation support tools was commissioned including toolkits, best practice guides, models and templates. Some of these were developed by key partners such as Skills for Care and SCIE, in which case separate assessments of effectiveness were said to be in place.

**Effectiveness of the Communications Strategy:** This strand aimed to raise awareness of support products, the assurance process and timelines for implementation. Plans were said to be in place to evaluate success by using survey and statistical techniques.

**Effectiveness of the Public Awareness Campaign:** This was said to have two phases. Firstly to increase awareness among users, carers and those approaching the point of need of what the Care Act changes would mean for them. Secondly, more ambitiously, to ‘… inspire behaviour change at societal level so that it becomes more normal for people to prepare for potential care and support needs as part of wider financial planning’.

Given the failure to implement Phase 2 of the legislation the fate of this second strand is unclear. However, when the PB reached its point of closure in 2016 it was agreed that ongoing implementation risks would continue to be reported to an existing DH forum, the Social Care Oversight Group. As well as all of these internal activities it is important to mention the role of independent scrutiny, most notably by the National Audit Office and indeed our own ongoing evaluation which aims to evaluate the extent to which these support arrangements have been successful and identify wider messages for implementation support programmes.

At a broader level a more 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).

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Applying these three levels to the process domain of policy making gives us the following provisional framework for assessing the contribution of an implementation support programme.

Table 7: A Framework for the Assessment of Implementation Support Programmes

<table>
<thead>
<tr>
<th>CRITERION</th>
<th>RELATIVE SUCCESS</th>
<th>CONFLICTED ATTAINMENT</th>
<th>RELATIVE FAILURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>HELPING TO SECURE POLICY LEGITIMACY</td>
<td>Few challenges to the legitimacy of the policy from implementing bodies</td>
<td>Contested legitimacy with potential for long-term damage</td>
<td>Policy process deemed to be illegitimate and successful implementation unlikely</td>
</tr>
<tr>
<td>DEVELOPING STAKEHOLDER SUPPORT</td>
<td>All key stakeholders support the policy and participate in support programmes</td>
<td>Patchy and uneven engagement amongst stakeholders; some key groups missing</td>
<td>Widespread resistance to engagement</td>
</tr>
<tr>
<td>CLARITY OF PROGRAMME CONTRIBUTION</td>
<td>Aims of the implementation support process are agreed and understood</td>
<td>Some of the aims and activities of the support programme are unclear and/or contested</td>
<td>Little understanding or awareness of the support programme</td>
</tr>
<tr>
<td>COMPREHENSION of COMPLEXITY</td>
<td>A reputation for understanding the complexity of 'real-world' implementation</td>
<td>Only a partial understanding and awareness of implementation dilemmas</td>
<td>Perceived and as a remote agency with little understanding of the problems facing implementing bodies</td>
</tr>
<tr>
<td>SUSTAINING POLITICAL SUPPORT</td>
<td>Support programme has clear and sustained backing at the highest political levels</td>
<td>Uncertainty as to whether political support is being sustained over the implementation period</td>
<td>Support programme is undermined by waning political support and interest</td>
</tr>
<tr>
<td>CONTRIBUTING TO ATTAINMENT OF POLICY OBJECTIVES</td>
<td>Evidence that the support programme has contributed to the achievement of policy objectives</td>
<td>Some evidence of policy success but uncertainty around the contribution of the support process</td>
<td>Both the policy itself and the implementation support process are unable to demonstrate achievements</td>
</tr>
</tbody>
</table>
Next Steps

Our next steps are as follows:

1. To further interrogate the data contained in our national level interviews

2. To complete our locality fieldwork and interrogate the data

3. To assess the extent to which the IS programme seems to have achieved the aims it set for itself

4. To locate the Care Act IS programme within McConnell’s adapted framework for assessing the effectiveness of implementation support programmes more generally

5. To locate the concept of implementation support within Matland’s conflict-ambiguity matrix to better understand the context within which different types of support are more likely to flourish