Implementing the Care Act 2014 – a synthesis of project reports on the Care Act commissioned by the NIHR Policy Research Programme

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Introduction

As part of the NIHR Policy Research Programme (PRP), five projects were commissioned to consider the implementation of the Care Act 2014. This report synthesises the findings of the projects. In particular, it considers why the apparent success of the implementation readiness programme for the Act (as reported in the project by Peckham et al. (2019)) led to only partial success in the elements of the Care Act considered by the other PRP projects (market-shaping; personalisation; prevention; carers).

An in-depth exploration of the Care Act 2014 itself can be found in a parallel report by Manthorpe (2020) which summarises the main content of the legislation and provides a summary of the findings of the projects.

This report focuses in particular on the findings of the projects relating to implementation. Each project looked at one or two elements of the Care Act, as shown in Table 1 below.

Table 1: The PRP reports about the Care Act

Project	Focus
Peckham, S., Hudson, B., Hunter, D., Redgate, S. and White, G. *Improving choices for care: A strategic research initiative on the implementation of the Care Act 2014*	An evaluation of the implementation support programme intended to ensure that associated agencies were 'ready' for the introduction of the Care Act.
Needham, C., Allen, K., Burn, E., Hall, K., Mangan, C., Al-Janabi, H., Tahir, W., Carr, S., Glasby, J., Henwood, M., McKay, S. and Brant, I. *Shifting shapes: how can local care markets support personalised outcomes?*	Market shaping and personalisation. Information and advice. Care and support planning/review. Personal budgets. Direct payments.
Tew, J., Duggal, S., Carr, S., Ercolani, M., Glasby, J., Kinghorn, P., Miller, R., Newbigging, K., Tanner, D. and Afentou, N. *Building social resources to prevent, reduce or delay needs for care and support in adult social care in England*	Preventing, reducing or delaying need for services. Capacity building (social connections). Enhancing wellbeing.
Fernández, J. L. Marczak, J. Snell, T. Brimblecombe, N. Moriarty, J. Damant, J. Knapp, M. and Manthorpe, J. *Supporting carers following the implementation of the Care Act 2014: Eligibility, support and prevention*	Trends in carers' access of support. Processes to support carers within local authorities. Information and advice to carers.

About the four reports

The four reports are summarised below. A table setting out their sampling and data sources is provided as an appendix. All of the studies were multi-level, combining national data with local case site work. Peckham et al. also interviewed regional implementation leads. Most of the studies selected local authority case sites to maximise variance by relevant characteristics such as geographic location, demographic profile and care service usage. Tew et al. drew on a best case sample of local authorities, working in those sites which were known to be doing innovative work on prevention.

Peckham et al. – Improving choices for care: a strategic research initiative on the implementation of the Care Act 2014

The implementation support programme aimed to assist local authorities and partners to prepare for the changes created by the Care Act and was found by Peckham et al. to have been effective in supporting 'implementation readiness'. In particular, the programme developed stakeholder 'buy-in' and policy legitimacy. The programme also facilitated two-way communication between local authorities and the policy centre, assisted by the introduction of a regional tier of implementation support. A series of events and materials were developed which aimed to support organisations to progress towards implementation readiness, although there were some concerns raised that operational staff may not have received this material. Tensions were identified within the 'stocktake' element of the programme as to whether it aimed to support local authorities or monitor their performance. The effects of austerity and funding cuts were found to have limited the ability of local authorities to fulfil the principles of the Care Act.

Needham et al. - Shifting shape: how can local care markets support personalised outcomes?

The Care Act gave local authorities a duty to create effective care markets that stimulate provider innovation and diversity in order to offer choice and control to people using services. Progress towards effective market shaping and personalisation was found to be limited in local case sites, hampered by complexity (multiple and overlapping markets operating in each locality) and by risk aversion. The instability of the social care market – affected by ongoing funding uncertainty, high turnover of local authority staff and recruitment challenges faced by providers – had further obstructed local authorities in developing a coherent approach to market shaping. Whereas the Care Act encouraged a loosening of local authority control over the market (e.g. by working in partnership with other stakeholders to co-design services and allowing personalised commissioning), financial pressures were a countervailing force, leading to a tightening of local authority control. Self-funders continued to be treated largely as bystanders by local authority market shaping strategies.

Tew et al. - Building social resources to prevent, reduce or delay needs for care and support in adult social care in England

The project combined a survey of local authorities with case study work in 'vanguard' local authorities which were known to be engaging in preventative work. It found that a substantial proportion of local authorities had been investing in preventative and capacity building activity, with a diversity of models being deployed. Case sites were using approaches such as strengths-based models of social work and social care, community capacity building and peer support, targeted use of personal budgets and ways of mobilising the effectiveness of people's family and other networks of personal support. Given the resource-constrained environment, local authorities were finding it difficult to sustain investment in prevention. A national policy emphasis on addressing delayed transfers of care from NHS services encouraged a focus on providing traditional social care placements rather than exploring preventative alternatives. Reductions in staff headcount had limited the ability of local authorities to embed the cultural changes required for a preventative approach, such as distributed leadership. Overall, they found associations in the case study sites between the introduction of strengths-based approaches and reductions in the use of more expensive forms of long term care, such as residential and nursing care, and between community capacity building and overall reductions in social care spending and spending on unplanned healthcare.

Fernández, et al. - Supporting carers following the implementation of the Care Act 2014: Eligibility, support and prevention

The Care Act established the right to a carer's needs assessment. Such assessments are based on the carer's need for support rather than the level of care provided, with the intention that this would increase the accessibility of support for carers. The aim of the project was to understand the processes and resources required to assess and meet the needs of carers in England following the introduction of the Care Act. It also sought to examine whether there had been significant increases in the level of support available to carers. The project identified that the importance of carers' wellbeing was recognised at both national and local levels. However, this recognition was often contradicted by the implications of a challenging financial context which encouraged local authorities to prioritise managing service demand. Analysis demonstrated that there has been a steady decline in the number of carer assessments conducted in England since 2009/10. There has also been a reduction in carer-related expenditure since the introduction of the Act. Analysis of data from the Survey of Adult Carers in England indicated that the provision of on-going support for carers was concentrated on those providing the most intense levels of care.

Was the Act successfully implemented?

Peckham et al. note that the Care Act was somewhat unusual in the focus that was given to implementation in advance of the Act coming into force. The formal programme of implementation support involved close partnership between the Department of Health and Social Care (DHSC), the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS). There was a Programme Board, a Delivery Board and Programme Management Office, and a regional infrastructure, with nine work programmes. Peckham et al.'s report looks at how far the programme achieved its aim of ensuring implementation readiness, rather than the extent to which implementation of the Act itself was successful. It provides broadly positive analysis on the programme of implementation support (and the authors discuss implementation support programmes as an intervention in more detail in Hudson et al., 2019).

The other three reports are less positive, highlighting the difficulties and challenges that were faced by local authorities when attempting to meet aspects of the Care Act. By looking across all of these reports, it is possible to draw out learning about why 'implementation readiness' led to only partial success in implementation.

Implementation success and failure are best understood as a continuum rather than as binary categories. Peckham et al. (2019) summarise the literature on implementation and identify three points on the continuum: relative success, conflicted attainment and relative failure. They use this categorisation in reporting their findings. By applying the same lens to the other reports, a summary of implementation progress can be derived, shown in Table 2 overleaf.

Table 2: A continuum of success and failure in Care Act implementation

	Relative success	Conflicted attainment	Relative failure
Peckham et al. Implementation Support Programme	• Securing policy legitimacy • National partnerships between DHSC, LGA and ADASS • Two-way information flow between national and local government • Regional implementation support	• Information flow within local authorities • Timeliness of information, guidance and training • Stocktake of local authority progress • Impact of austerity	• Information for users and carers • Uncertainty about Part 2 of the act (relating to the cap on care spending) • Shortage of relevant skills and capacity within local authorities
Needham et al. Market shaping and personalisation	• Continued support for the principles of the Act • All local authorities were trying to actively engage with the multiple markets in their sites	• Ambiguity of key Care Act terms made it difficult to trace attainment (e.g. market shaping and personalisation) • Some local authorities had prioritised personalisation (e.g. direct payments) in the past but were now reducing choice and control to stabilise the market	• Local authorities were cycling between different types of market shaping rather than taking a strategic approach • Lack of information and support for self-funders • Lack of information and support for carers
Tew et al. Prevention	• Widespread support for principles of prevention • Some evidence that prevention initiatives are effective in reducing demand for more expensive forms of long term care, such as residential and nursing care	• Austerity context intensified the need for prevention but made it harder to invest • Coproduction with communities and families was vital but can undermine fidelity of the intervention • Small-scale piloting worked well but encountered resistance when trying to extend to other teams	• Reliance on a few key individuals – not embedded • Short term pressures hampered long term investment needed for prevention • Lack of support for young carers and vulnerable young adults
Fernández et al. Carers	• Considerable progress in legitimising carers as co-clients • Legal recognition of the importance of carers' health and wellbeing • Increased access to information and advice	• Emphasis on managing, rather than meeting, service demand. • Closer working with the voluntary sector but uncertainty about what support they provide • Information and advice of variable quality	• Reduction in number of carers' assessments • Carers still treated as a 'resource' by local authorities rather than a co-client

Peckham et al. identified several themes as explaining the successes and limitations of the implementation programme, which they organise into the '5Cs' – context, clarity; complexity; collaboration and closeness (p. 111). Below we have used and adapted these categories to encompass the findings of all of the projects, to draw out the factors that led to some elements being successful and others more challenging. We changed 'closeness' to 'capacity', to better reflect the findings of all of the reports. The categories are defined as follows:

> **Context** – the national conditions and policy environment that can influence policy implementation and the outcomes achieved by a policy.
>
> **Clarity** – the extent to which the goals of policy are clear and consistently applied, and interpreted by relevant stakeholders.
>
> **Complexity –** the system conditions in which a policy is implemented. Policy implementation can fail to acknowledge complexity and attempt to design out variability, or can be designed to work with this complexity and recognise learning and adaption as essential features of complex systems.
>
> **Collaboration** – the extent to which multiple agencies are able to work together horizontally, with trust and aligned incentives.
>
> **Capacity** – the extent to which local government bodies are able to undertake the tasks set.

Context

Peckham et al. draw attention to the national and local contexts within which policy is implemented, and that 'it is likely that the implementation support process will more easily flourish in some contexts than others' (p. 112). To some extent they found a helpful context for the implementation programme, concluding: 'a recurring caveat throughout this report has been the receptive political and professional context within which the Care Act support programme functioned' (p. 112). However they also draw attention to aspects of the national context which have been less amenable, in particular the difficult financial context facing local authorities. They note:

> 'We encountered strong feelings that the austerity programme was rendering unattainable the key operating principles of the Care Act such as independence, wellbeing and prevention; rather localities felt they were being effectively confined to responding to crisis situations. This highlights the difficulties that arise when a policy that is collaboratively designed, popular with the receiving audience and supported by an implementation programme, is not properly funded to achieve its objectives. An implementation support programme, no matter how good, may be best regarded as a necessary but not a sufficient factor in securing policy objectives'. (p. 9).

The challenges created by austerity (in particular the real terms fall in social care spending from 2009 to 2016 (IFS, 2017)) are also heavily emphasised in the other three reports. Tew et al.*'s* report on prevention identified that this environment obstructed the investment of resources required to embed sustainable preventative social care. Although there was strong support for the principles of prevention, local authorities often had to prioritise meeting existing demand rather than investing in prevention. Needham et al.'s report on market-shaping found that: 'The combination of cuts in local authority funding and workforce shortages in the sector has created a very difficult context for Care Act implementation' (p. 11). In Fernández et al.'s report, financial pressures are again a key factor in explaining the findings. The report identifies that 'The capacity of local authorities to meet policy ambitions with regard to carers therefore has been mediated by budgetary constraints as well as constant demographic pressures' (pp. 17-18). While there has been an increase in the proportion of carers accessing information and advice, this has not necessarily resulted in increased access to support.

Austerity is a 'catch-all' term, and not all stakeholders in the social care sector may agree on its extent and duration, so it is useful to draw out the particular ways in which it was found to have impacted on Care Act implementation:

- **Lack of access to services**

  Limited access to services was evident in Fernández et al.*'s* report where they found a reduction in services available to carers (with particular reference to replacement care services), despite the explicit promises of the Care Act to improve support for carers. Findings also suggest that some local authorities have focused on administering assessments for newly identified carers. This focus has diverted resources away from the provision of support and undertaking reviews for carers who are already receiving support.

  Needham et al. also highlighted falling capacity in the residential sector, which providers saw as being linked to low local authority fees and unsustainable business models. Lack of capacity was particularly evident in relation to nursing homes, where some sites indicated that they were considering entering the market in partnership with health commissioners because of shortages of beds.

- **Risk aversion and tighter local authority control**

  Needham et al. and Tew et al. noted that constrained resources were seen by some interviewees as a driver for innovation. However a more common response in all of the reports was that austerity was leading to risk-aversion and a compliance approach. Whereas

the Care Act was designed to encourage less local authority prescription, Needham et al. found that case local authorities were seeking to ensure sufficiency of supply through becoming more prescriptive, moving away from the more ‘open market’ approaches which had been developed to maximise choice and control following *Putting People First* (HM Government, 2007).

- **Short-termism**

  Short-term resource pressures to meet current demand were found to conflict with the more long-term and relationship-building approaches required for prevention and market shaping. Local authority interviewees in Tew et al.’s study indicated that any impact of preventative approaches would likely to be seen within a timescale of 1-5 years. At a time of high expectations for year on year savings, this delay can mean that it is difficult to safeguard the continued investment required to embed a preventative approach.

- **Low trust between partners**

  Needham et al. found that the financial difficulties faced by providers affected the closeness of their relationship with the local authority, with providers taking a defensive stance to protect their business interests rather than engaging with attempts to shape the market. Some local authority commissioners were wary of for-profit providers, expressing concerns that they were extracting excess profits at a time of resource constraint. Lack of trust between commissioners and providers made it very hard to build up the long-term partnerships that are an essential part of market shaping.

Clarity

A second factor which Peckham et al. use to discuss implementation is clarity. One of the features of the Care Act was that some of its principles and duties were ambiguous. Greater clarity in legislation (and the tools used to implement it) is not necessarily correlated with successful implementation: indeed, Matland (1995) discusses how ambiguous language can aid implementation by keeping together a diverse coalition of stakeholders. However there are a number of ways in which lack of clarity was a barrier to Care Act implementation:

- **Vagueness of key terms**

  Some of the key terms in the Care Act – wellbeing, prevention, market-shaping – were not clearly defined. Peckham et al. found that some of these were less well supported than other, more specific elements of the Act: ‘For example, prevention and wellbeing are the central underpinning principles of the Care Act but were not always perceived to be

centrally located within the support provided. No reasons were identified for these gaps' (p. 105). Needham et al. found that market-shaping, although a duty in law, was interpreted in different ways by local authorities, and there was uncertainty about what 'good' market shaping looked like. Fernández et al.'s documentary analysis of Parliamentary debates on the Care Bill identified that there was often no clear distinction between services for carers and services for people with care needs. As a result, there was often inconsistencies as to what services people were charged for – with charges being applied for replacement care, whereas information and advice was often supplied without charge (p. 9).

- **Funding cap and wider national funding settlement**

  There was a lack of national clarity on policy for self-funders following the removal of Phase 2 of the legislation (relating to the cap on funding for self-funders) and the repeatedly delayed Green Paper. This is linked to, but somewhat separate from the point discussed earlier in this report about the impact of austerity. The green paper, intended to 'fill the policy lacuna' (House of Commons Library, 2019, p. 12) generated by the postponement of phase two of the Care Act, never appeared. Needham et al. found that this uncertainty contributed to a lack of coherence within local authorities' approach to market shaping, and in particular contributed to a failure to respond to the Care Act duties relating to self-funders. Furthermore, providers were unwilling to commit to long-term building-based investments at a time of uncertainty about the future of social care funding. Some interviewees expressed a sense of fatalism, as negative national and local press about cuts and the 'care crisis' reduced people's sense of what was possible.

Complexity

Social care sits within a complex adaptive system (CAS) (Health Foundation, 2010), which means that linear models of standardised implementation will not be effective. Writing about health systems, Braithwaite et al. note:

> The patterns of interaction between agents and their environment are locally specific, and although they share features with other CASs, they also exhibit remarkable variation from one site to the next. The notion, then, that a new practice can be adopted equally well and in the same manner across a whole health system, is untenable… (Braithwaite et al., 2018, pp. 7-8).

All of the Care Act reports found variation in local practices relating to implementation of the Care Act, as each locality sought to adapt it to the distinctive challenges of its local setting. Levers of control

are weak in complex adaptive systems, and this was evident in Needham et al.'s report, with local authorities struggling to shape their markets, despite the legal duty placed on them by the Act. Those areas that were engaging most effectively with their local systems were those in which rules and control had been minimised in favour of provider- and community-led innovation. Practices that respond to local variance and allow stakeholders to experiment and learn – such as co-design processes – were being tried in some localities, but were hampered by the low trust and uncertainty discussed above.

Tew et al.'s report reached similar conclusions about the difficulty of attempts to impose control or consistency in local settings. Distributed leadership and genuine co-production with citizens and communities were key aspects of flourishing prevention initiatives. However, this did create a paradox – 'local adaptations and solutions can be crucial for ownership and effectiveness, but it is important to make sure that they do not compromise the core logic of the innovation' (p. 8). They advocate clarity at all levels of the organisation about the key features of the intended model to avoid local modifications that damage the integrity of the intervention.

There is an ambiguity here, which goes beyond these Care Act projects, about the extent to which departure from a standardised intervention is a threat to integrity or an inevitable and desirable consequence of working in complex systems (with their feedback mechanisms and inter-dependencies). Braithwaite et al.'s work on combining implementation science and complexity science highlights the need to deploy methodologies in which 'the focus of implementation shifts from the fidelity of the intervention to its effective adaptation' (2018, p.8). The implication is that implementation and evaluation both need to proceed differently if complexity is taken seriously. Examples of such approaches are emerging in the health sphere – e.g. Normalisation Process Theory (May et al., 2016) – but are underdeveloped in social care.

Collaboration

Collaboration was identified by Peckham et al. to be 'perhaps the defining feature of the Care Act' (p. 119). The implementation programme necessitated the main stakeholders working together, particularly DHSC, LGA and ADASS, and Peckham et al. found that this had worked well. A key part of the success of the implementation support programme was the involvement of 'a multiplicity of local agencies' (p.116) and in particular the role of the regional co-ordinator that acted as a conduit and supported communication between the national and local level (a 'very lightly funded regional tier ended up having a significance that far exceeded expectations', p. 116). A benefit of this approach is that it facilitated shared learning between local authorities and so developed a level of closeness

among implementation bodies. Within local sites however Peckham et al. found that horizontal collaboration had not been so effective:

> there was relatively little coordination between the prime local implementing agency – local authority adult social care – and other partners with a role in the promotion of health and wellbeing. The prison service, housing agencies, public health and others often seemed to be left on the outside of the support arrangements (p. 120).

The other reports similarly found tensions in working with partners – including care providers and the third sector. Key issues were:

- **Differential incentives**

  Tew et al.'s report found that a lack of alignment of incentives could affect the embedding of preventative approaches. In particular, the drive from health partners (including DHSC) to reduce delayed 'transfers of care' from hospital settings meant that minds were often focused on establishing access to packages of nursing and social care. Tew et al. conclude: 'There is a need to realign incentives so that the pressure to avoid delayed discharge of people from hospital does not translate into the hasty and inappropriate provision of expensive packages of nursing or social care that may be hard to disentangle once implemented' (p. 7).

- **Collaboration not at the right level**

  Peckham et al. found that it was often only the senior management in the local authority who were involved in collaboration with partners. Instances were reported where there had been a breakdown of communication with information not passed on from senior management to operational staff (pp. 67-8). This resulted in operational staff filling this perceived gap by developing their own implementation interpretations which had the potential to lead to front-line confusion.

- **Lack of accountability**

  Fernández et al. identified that collaboration between local authorities and the voluntary sector increased following the Care Act, with voluntary sector organisations often providing assessments and preventative services for carers. While this collaboration can support carers to access low-level services, some participants within local case sites did suggest that preventative services aimed at building the resilience of carers 'masked sometimes strategies aimed at diverting people from using core social care services' (p.24). Data on assessments done or services provided by voluntary sector may not be captured by local reporting mechanisms.

Capacity

All of the reports highlighted issues relating to the capacity of local authorities to implement the Care Act effectively. In particularly this related to skills, workload and continuity:

Staff skills

Peckham et al. noted the importance of getting the right skills into the implementation support roles, particularly at the regional level. However they noted that the skills set to do this well within regional and indeed local government was demanding, and unlikely to be easy to find: 'We heard recurring reference to some of the required personal qualities such as trust, knowledge, experience and professional credibility… we also know that such skills are not in plentiful supply.' (p. 99). They go on:

> Whilst much attention is given to issues such as governance and budgets in policy implementation, much less is given to the role and behaviour of those who could undertake a dedicated responsibility to create and sustain a range of complex connections in pursuit of implementation support activities (p. 117).

The importance of staff having the skills to build effective relationships is a key element of Needham et al.'s report – relating to internal and external relationships. Within a local authority, attempts to shape the market do not just rest on those with direct responsibility for social care commissioning but can also require the support of other departments, such as procurement and legal teams, as well as services such as housing and planning. Needham et al. found that 'several commissioners discussed how they had experimented with partnership approaches – including co-designing approaches with providers and other stakeholders – but had to abandon this approach due to internal resistance from legal and procurement teams and an inclination to emphasise contract price' (p. 30).

Shifting away from this requires a commitment to a broader cultural change within local authorities, linked to greater risk taking and learning. Peckham et al. warn against 'an obsession with competences'. Instead they promote the idea of capability: 'the extent to which individuals and groups can adapt to change, generate new knowledge and continue to improve their performance in situations where there is little certainty or agreement' (p. 118). Similarly Needham et al. call a move away from a 'heroic lone commissioner' towards a recognition of the need for a more relational set of skills within local authorities.

Leadership has a role to play here. Tew et al.'s report found that a reduction in local authority headcount has meant that there is limited capacity to strategically embed prevention: 'With a thinning out of management as part of overall cost reduction in many local authorities, there can be limited

strategic capacity to envision and implement the degree of system and cultural change that is integral ….to prevention' (p.6). The importance of distributed leadership, which takes a system-wide approach, is well known within the sector, although accountability mechanisms often continue to favour the 'hero leader' model (Mangan and Lawrence-Pietroni, 2019).

Staff continuity

Changing personnel within local authority commissioning departments due to staff cuts was a further barrier to implementation. In discussing the sustainability of preventative initiatives, Tew et al. recommend broad organisational buy-in to ensure that one person is not charged with leading the initiative. This then ensures that preventative programmes can be championed, even if a key contact moves to a new role. The high churn of local authority staff was highlighted by interviewees in Needham et al.'s project as affecting the development of positive working relationships between providers and local authorities: 'From the provider perspective, a key barrier to trust was the high turnover of local authority commissioners, care managers and social workers, which inhibits communication, continuity and a coherent organisational long-term strategy' (p. 32). It was also suggested that a high-level of churn may negatively affect institutional memory within the local authority. This could be to the detriment of developing a coherent and planned approach to social care provision and, in particular, market shaping, as there was little recall of the learning that had previously been gained within the commissioning team. Needham et al. recommend investment in recruitment, training and retention of commissioners, recognising that local authorities need to be able to take long-term, relational approaches to building local care markets.

Conclusion

This document has reported on the implementation of the Care Act 2014, synthesising the projects funded under the NIHR Policy Research Programme. In particular it has sought to better understand the factors which have led to a lack of progress on some aspects of implementation, despite the apparent success of the implementation readiness programme (Peckham et al., 2019).

The document sets out the elements of the Act where it is possible to see success, others where there has been conflicted attainment and some where failure is evident. It then looked in more depth at these findings using the five explanatory categories of context, clarity, complexity, collaboration and capacity.

It is clear that there is a distinction to be made between securing legitimacy (acceptance) for a policy and the practical implementation of the policy. Implementation support programmes can be challenged by issues relating to national context, clarity of the legislation, complexity of local care

systems, weak collaboration and insufficient capacity. Some of these issues were anticipated by the support programme but that the destabilising effects of funding cuts have been a counterweight to implementation readiness.

Peckham et al. (2019, pp. 9-10) include a number of recommendations to aid implementation readiness for future legislation such as: agreement on an adequate funding stream for achieving policy objectives; and separation out of monitoring/regulation roles from support mechanisms. It is also vital to see the features of complex adaptive systems ('emerging ideas, iterative approaches, feedback mechanisms, inter-dependencies, building momentum over time, dynamic communication with multiple stakeholders, systems perturbation' (Braithwaite et al., 2018, p. 12)) as fundamental to the care sector rather than an awkward implementation barrier to be overcome.

In a recent book on *Great Policy Successes*, Compton and 't Hart (2020) distinguish between the political legitimacy of a policy and its programmatic performance. The Care Act successfully established and retained political legitimacy, but its programmatic performance has been somewhat disappointing. Compton and 't Hart also draw attention to what they call 'endurance assessment', focusing on how performance and legitimacy develop over time, and noting how 'Great Policy Successes' (for example relating to tobacco control) have sometimes taken many years to achieve. The principles of the Care Act – especially its overarching commitment to wellbeing - continue to enjoy high levels of legitimacy and could still underpin the longer term settlement that the sector needs.

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Appendix – Data sources and sampling approaches

Project	National data sources	Regional data sources	Local data sources	Broad sampling approach
Peckham et al.	Interviews with Programme Board members and related stakeholders. Review of Programme Board minutes and implementation support documents.	Interviews with regional leads based in three regions within which case studies were located.	Interviews with strategy and management staff, and operational staff and focus groups with people using social care services and carers.	Purposive sampling. Six local authorities selected to provide a mixed sample based on type of local authority, geographical location, percentage of people over 65 and population size.
Fernández et al.	Quantitative data analysis of local authority activity and expenditure data (via NHS Digital). Analysis of data from the Survey of Adult Carers in England (SACE). Survey of working age carers. Follow-on telephone interviews with working age carers / former carers. Analysis of local websites (mystery shopper exercise).		Process evaluation of approaches to support carers. Interviews in 4 local authorities with local authority staff and stakeholders.	Purposive sampling. Four local authorities selected to provide a mixed sample based on type of local authority.
Needham et al.	Online national survey distributed to all local authorities in England who hold responsibility for adult social care. Telephone interviews with national stakeholders.		Interviews and focus groups with: - Local authority staff members - Local stakeholders - Social care providers - Personal assistants - People accessing social care services - Carers	Purposive sampling of eight local authority case sites. Sites were selected according to measures of social care related quality of life reported by people using state-funded services, estimated

Project	National data sources	Regional data sources	Local data sources	Broad sampling approach
			- Potential future users of social care Initial and follow-up questionnaires completed by service users and carers asking about quality of life and use of health and social care services.	proportion of self-funders, type of council, geographical spread and political control.
Tew et al.	Online survey distributed to all local authorities in England who hold responsibility for adult social care.		Interviews and focus groups with staff and external stakeholders (two waves). Interviews with a sample of beneficiaries and family members. Initial and follow-up questionnaires on quality of life and use of health and social care services.	Purposive sampling. Seven local authorities identified to take an innovative approach to prevention. Selected to include a diverse geographic mix as well as a range of local authority structures. Case study sites included both earlier and more recent adopters of innovation.