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The impact of the Care Act 2014: a summary of research evidence commissioned by the NIHR Policy Research Programme

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This is a brief summary of the findings of four studies that investigated the impact of the Care Act 2014. They were commissioned by the National Institute for Health Research (NIHR) Policy Research Programme. It starts with setting out briefly the legal changes. The studies explored what had changed in adult social care because of the Act. The Care Act came into force in 2015 in England, although not all of it was fully implemented. This summary reports what the evaluations found out about the Act's implementation, the problems encountered during implementation and remaining challenges. The studies' full reports are available and listed at the end of this document. For ease of reading, in this summary the evaluations are called the Implementation (Peckham et al 2019), Carers (Fernandez et al 2020), Market Shaping & Personalisation (Needham et al 2019), and Prevention (Tew et al 2019) studies. This summary was produced at the request of the Department of Health and Social Care to help understand the research evidence on what the Care Act has improved, where the aims of the Care Act have not been achieved, and what would be needed to achieve them.

The context of Care Act changes

Many changes to adult social care were made by the Care Act. It reformed or consolidated several laws underpinning local authority (LA) duties and permissive powers, and changed legislation affecting adults with care needs and their (family and friends) carers. Some of these reforms amended or rescinded long-standing legislation such as parts of the National Assistance Act 1948. But a major part of the Care Act was not implemented (mainly Sections 15-16 covering a cap on care costs). The impact of this is mentioned particularly in the Market Shaping & Personalisation study that included a focus on self-funders (people paying for their own care and support). Had these 'non-implemented' sections been implemented then it is likely that other parts of the Act would have been affected.

The four evaluations set the scene by covering the background to their specific areas of investigation. They all addressed the extent and impact of the changed legal context, such as the Carers' study which investigated what happened as a result of carers' increased entitlement to assessment. This study analysed the numbers of carers' assessments made by local authorities and found that, contrary to expectations that greater numbers of carers would be assessed, numbers had fallen compared to previous years. LA expenditure on carers had also fallen since the Act. It explained these trends by reference to the reduced funding available to LAs, restricting what they could offer to carers.

Other changes in the law were evaluated. For example, the Prevention study commented on the many different definitions or mentions of prevention in the Act

and in its Guidance documents, reflecting the new generalised LA duties to prevent needs for care and support arising or escalating. Under this permissive regime some LAs were choosing to link their duties to 'prevent' to their duty to promote wellbeing under the Act; but others were not developing the duty to prevent within a legal or rights-based framework. In the Prevention study the term 'second wave' is used to refer to prevention and capacity building approaches that were becoming mainstream following earlier 'first wave' changes in adult social care, such as personalisation, signposting and reablement which started prior to the Care Act. The Prevention evaluation makes reference to the potential for prevention and community capacity to divert the need for expensive social care and for people to have better lives but concluded that these need to be both bedded in and also to be effective before any such savings may be found. Nonetheless, it considered such savings would be potentially large, to the order of diverting 25-50% of demand (in perhaps just the short-term) for more intensive care services. This aspiration is expressed very cautiously.

Most of the evaluations also reflected the new legal context of a duty for LAs to provide information and advice (Carers; Market Shaping & Personalisation) and to promote diversity and quality among care services (Market Shaping, Prevention). The duty to promote integration of care and support with the NHS is not covered specifically, although it is touched on in the Carers' study and in the Prevent study, in the latter this is mainly in relation to mental health services.

Improvements following the Act

The Implementation study focused on how central government support to LAs assisted in making the changes required by the Act or helped move an organisation (generally meaning a local authority - LA) to a receptive state for implementation (what it termed 'implementation readiness'). Its focus was on older people's services and the researchers interviewed people working at national, regional and local levels (in six case study sites). Older people's services account for most LA social care funding making this a valuable focus. This evaluation found nationally funded policy support programmes were able to help with implementation readiness as they generally seemed to have a good understanding of 'messy' contexts (by messy they mean complicated which is probably very applicable to adult social care). It judged the three main organisational innovation 'vehicles' (a Programme Board; a Delivery Board and a Programme Management Office) as working very effectively and saw them as something new when compared to how other policy changes had been put in place (beyond social care). Regionally based support was judged as more effective than might have been presumed. This evaluation suggested moving from simplistic notions of policy success or failure to a focus on policy support, not just with implementation but early on, with policy design and with agreed measurements. These include acknowledging that some elements of the Care Act could seem 'ambiguous' or open to interpretation. A specific synthesis of all the studies' findings about the Act's implementation is available (Burn and Needham 2020). This develops some of the early reflections on the Care Act by the National Audit Office (2015) which had noted that not only was LA income declining sharply but that need was rising at the time of the extra commitments being made by the Act.

As noted above, sections of the Act were not implemented – at first, they were due to come into force in April 2016, however they were postponed to April 2020, and later further postponed. As the Market Shaping & Personalisation study observed, this change particularly impacted on arrangements for LA duties to self-funders (people paying for their own care and support who might have been affected by a cap or limit on the money that they were paying for care or whose needs were not severe enough to be eligible for LA support). The need for such changes continues to be debated at the present time in political, pressure group and media arenas. The subject of adult social care was therefore by no means ‘settled’ by the Care Act and confusion and uncertainty remain – as the evaluations noted these were affecting care market stability, workforce investment, and charging for care services. This stood in contrast to the political consensus during the passage of the Care and Support Bill through Parliament; as detailed in the Carers’ study. The Implementation study commented that if the part of the Act that was not implemented (the cap on care costs) was ever to be re-introduced or another development ensue, then attention to implementation readiness would be wise.

Preparing for the Act

Getting ready for the expected changes of the Act was covered by most studies that then reported on unfolding developments. For example, the Carers’ study found that LAs had prepared for an expected rise in the numbers of carers calling on them for support by arranging for local voluntary organisations to have the authority to undertake carers’ assessments. Many LAs had also moved much of their information provision online, but the study found this LA website material varied in quality and extent even though it was classed as a ‘service’. While more information was being put online for carers the researchers concluded that this information needs to be more consistent, accurate and meaningful.

‘Doing more’ on prevention was one aim of the Act, as an activity for professionals but also for local commissioning or funding of services, and for local communities to develop capacity to share the support of its local citizens. Drawing on responses to a survey completed by one-third of LAs and in-depth case studies of seven LAs (that were considered to be in the ‘vanguard’ of such efforts), the Prevention evaluation noted that prevention was not simply a new focus in adult social care but that it was becoming threaded through other approaches or ways of working, many of which were locally decided. It observed that the ‘pace’ of such changes seemed to have picked up following the Care Act. In the seven case study sites, LAs were experimenting with different models or approaches especially in social work services. Baseline and follow-up (approximately 12 months) data collection included stakeholder interviews and data concerning 33 people receiving social care support.

The Market Shaping & Personalisation study asked if LA market-shaping (a term used in the Care Act Guidance) activities were providing good quality information and care services, in a cost-effective way, and if learning was emerging to improve performance, quality and choice nationally. As others have done, it describes market shaping as meaning a LA is collaborating closely with (various) partners to encourage, support and facilitate the whole local provider market for care, support and related services; which many people have also interpreted as extending its responsibilities to people paying for their own care (self-funders) and broadening activities in information and advice giving. This evaluation conducted a survey and

undertook a set of in-depth case studies. The differences that emerged clustered around whether the LA was setting binding rules around procurement (purchasing of services), for example, or managing the market with a small number of providers who met the LA rules. Alternatively, the LA might be developing a strong or weak relationship with local providers (operating as a competitive local market or a small in-group in 'partnership'). Developed into a matrix or typology, the study concluded that market-shaping is still evolving.

This moving kaleidoscope was evident in the Market Shaping & Personalisation study's eight LA case studies (the evaluations avoided studying the same LAs in their case study work). It found that some LAs were moving between different types of market shaping but sometimes without a clear awareness of the implications for providers and for people using care services of these changes, including self-funders whose choices are affected by changes to LA commissioned services even if they are paying directly – and sometimes they are paying more. While something called a partnership would probably sound more attractive and most of the case study sites were trying to develop this approach, this seemed to rely on a stable local market and high-trust relationships with providers and other partners which were not evident in most of the sites. Building up a small in-group of providers also risked destabilising open market arrangements so some providers gave up. A hybrid model between the partnership model and the open market model may be the best option in the views of the evaluators (e.g. home/domiciliary care could be more open; residential more partnership-based; OR a prime/sub-provider model might offer the benefits of both within one sub-market). This study played particular attention to the logic models inherent in the Care Act philosophy, noting that the theory of market shaping was built on a vibrant and sustainable care market (context) that should lead to quality support (improved outcomes or processes) which will enhance wellbeing (and reduce need for other support, e.g. from the NHS, or delay need for paid care services) (the outcomes).

The evaluation focussing on Personalisation asked if people accessing state-funded care services were receiving individualised or personalised support, accessing personal budgets, and achieving good care outcomes, and distilling any lessons to improve control, choice and care outcomes nationally. It considered that the Care Act was relying on the model of an 'active consumer' but noted that there were many untested assumptions about self-funders and how 'active' they could be, with limited information about them in national datasets and local uncertainties. They estimated that 6.4% of people aged 65 years and over are paying for home care from their own resources – a group that is often over-looked when talking about social care finances.

The Market Shaping & Personalisation study also directed its attention to the implications of the Care Act on mental health care and support, producing a literature review focusing on this (rather limited) 'market' of services and the more complicated commissioning arrangements for mental health services that are very much orientated to NHS hospital-aligned services in any locality. In this evaluation the potential for integration (between LAs and NHS) of market shaping activities is noted but seemingly yet to be a mainstream objective. The study also observed that existing mental health markets did not seem to be responding adequately to equality and diversity imperatives. As with the Prevention evaluation, it noted the potential for

building community capacity to shape the market, particularly for people with long-term mental health or multiple needs.

Where the aims were not achieved

Most of the evaluations say it is not possible to make a definitive judgement on whether the Care Act was a success. All highlight the substantial impact of the financial context of public spending austerity at the time of the Act's introduction and early years of implementation.

The impact of financial austerity was particularly clear in the Carers' study where cost-shunting – the move of costs falling on one group rather than another – was evident in the trend for short-breaks for carers (respite and similar) to their 'purpose' and become instead a break for the care user and therefore subject to eligibility and means testing thresholds (in other words a care user would be asked to pay for this service which had often previously been free to their carer – as a carer's break). Interviews with local authority and voluntary sector staff revealed significant tensions in balancing the policy goal of maximising carers' independence through increasing the provision of information and advice (now described as a service), with the risk of undermining carers' wellbeing by reducing their practical and emotional support. There was evidence of infrequent assessments and reviews, and of shortfalls in the availability of replacement care which negatively impacted on carers' wellbeing and labour market (employment) outcomes.

Analysing national data, the Carers' study found those carers who did get services were likely to be providing many hours of care (drawing on data from the Survey of Adult Carers in England). The policy goal that carers' wellbeing and participation in employment would be enhanced was not borne out in the survey of working carers. This confirmed the widely held view that carers often give up employment if they cannot get support and their needs are higher when more support is being required of them.

The volume of carer assessments, the number of carers receiving support and levels of local authority gross expenditure on carers continued to decrease after the Care Act, as did carer satisfaction with the support received. However, the evaluation found that some of these trends relate to developments that were already emerging before the Care Act. For instance, numbers of carer assessments in England have been declining steadily since 2009/10 (from approximately 450,000 in 2009/10 to just over 350,000 per year in 2017/18). This trend was similar in terms of numbers receiving services and information. Overall, carer-related expenditure was found to have decreased in the years following the Care Act. So, while overall social care expenditure increased by 3% in cash terms from 2015/16 to 2016/17, carer expenditure fell by 6% in that year.

It was evident to the Prevention evaluation that targeting financial resources such as Direct Payments 'upstream' to prevent things getting worse or needs increasing was difficult when there were other pressures from declining resources within LAs, especially stemming from the need to respond to delayed hospital discharges. This study recommended that a five-year financial settlement (rather than an annual one)

would be one way of helping LAs realise the benefits of preventative work; current annual planning systems do not lend themselves to a prevention approach. While LAs thought that most prevention initiatives would be likely to achieve impact over a one to five years period, it was hard to evidence this or indeed to allocate funding for upstream prevention at a time of competing immediate priorities. Reference was made to the uncertainty of LA future financial settlements suggesting that while there were 'strong aspirations to enable (potentially) vulnerable citizens to lead better lives, this was proving harder to evidence in a systematic way, and remains a challenge for the future'.

What would be needed to deliver the changes of the Care Act?

It would be simplistic to say that full implementation of the Care Act or a different public finance context would have been totally successful (however defined) in delivering the multiple changes of the Act. This context is addressed in all the evaluations. The wider basis of LA funding is considered relevant and the studies expose how the implementation of the Act was considered effective in some ways but did not or could not bring the resources that might have been able to meet some ambitions and expectations. Competing pressures from other policy goals, such as reducing delays in hospital discharge and managing the LA budget while providers were finding it hard to sustain their services, were also evident.

The evaluations all make recommendations for further changes or research. These cover changes in partner behaviour or systems, such as the call by the Prevention evaluation team for further work on realigning incentives and systems around the present policy imperative of avoiding delays in hospital discharge which became a pressure point and so marginalised some Care Act aspirations. This study found it was hard to track expenditure and outcomes on prevention and suggested development of more transparent financial systems and agreements over outcome measures that could capture 'prevention' and capacity building approaches in social care.

Few comments were made about the specific legal changes of the Act. There appeared to be continued agreement that its aspirations were hard to criticise, even though terms such as market shaping and prevention were proving to have the advantages of flexibility but also the disadvantages of indeterminacy. Other research has been more critical of the legal basis of eligibility for publicly funded social care (Slasberg 2017) which was not the key focus of the four evaluations.

Changing cultures in terms of professional behaviour was addressed mainly in the Prevention evaluation which articulated most clearly the culture changes it thought necessary to deliver a 'fundamental reimagining of a co-productive rather than a service delivery relationship between the citizens and services'. Delivering culture change by legal reform may be a challenge for legislators particularly when resources are limited, as predicted by the National Audit Office (2015). Those seeking to promote an empowering context may wish to explore if this is achievable though revised Guidance, accompanied by stories combined with robust evidence from experiments or pilots. Changing cultures is probably not just a task for LAs alone. However, other developments around the time of the Care Act, such as the moves to Make Safeguarding Personal, seem to have influenced and built on the

Care Act guidance to prompt cultural change among professionals (Local Government Association 2015). Further NIHR research (particularly funded by NIHR School for Social Care Research) is investigating some of the ‘promising’ approaches identified in the Prevention study that were being adopted by the vanguard sites or case study areas.

The evaluations are being published at a time when new social care policy is promised and after the Coronavirus pandemic has thrown a spotlight on the sector. As noted, the Care Act was never fully implemented, and its full contents may be worth re-reading or considering in the current context and by current policy makers.

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