Department of Health & Social Care

Evaluation of the Accelerating Reform Fund: main report

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Executive summary

The Accelerating Reform Fund (‘the fund’), announced in October 2023, is a social care innovation grant funding programme intended to support local places to embed and scale new approaches to providing care and improve services for unpaid carers. Ipsos UK was commissioned by the Department of Health and Social Care (DHSC), in March 2024, to conduct an evaluation of the fund.

Note: 'systems' are defined in this report as groups of local authorities, which were organised into consortia based on integrated care system (ICS) footprints that submitted joint funding bids.

The evaluation

The evaluation of the fund, and the Social Care Institute for Excellence's (SCIE) associated support offer, was both a process and impact evaluation. Process elements of the evaluation focus on the national evaluation of the fund, and impact elements focus on impact measurement at a local system level.

The evaluation took a mixed-methods approach including:

- scoping research and evaluation co-design
- surveys and interviews with various stakeholder groups
- reviews of supplementary evidence and management information

The core evaluation questions were:

- has the fund supported local areas to create the conditions for the embedding and scaling of innovations in adult social care?
- has the fund and/or SCIE's support offer helped local areas to overcome barriers and to embed and scale innovation in adult social care?
- what are the impacts of embedding and scaling innovative approaches to delivering care and supporting unpaid carers?

The fund

The Accelerating Reform Fund (ARF) allocated £42.6 million over 2 years (financial year 2023 to 2024 and 2024 to 2025) to support local authorities in England to reform and

improve their adult social care services through innovation projects. The ARF aimed to support local systems to:

- effectively overcome barriers to adopting and scaling innovations
- support contributions to the evidence base for what interventions lead to better outcomes
- build on the evidence base for effective implementation of interventions in local places

DHSC also set 12 national priorities for delivery to guide the design of innovation projects.

The fund distributed funding through groups of local authorities in an ICS footprint (referred to as 'consortia') with a nominated lead authority. In total, 42 consortia and 148 local authorities (all in England) were allocated funding, with funding allocated based on the collective relative needs formula.

A support offer was commissioned by DHSC to provide delivery support to local systems and maximise engagement with the fund. This was provided by SCIE.

Implementation and delivery

End-of-grant reports were submitted by 39 of the 42 consortia that received ARF funding. When aggregated, these returns included 141 ARF projects. This is a larger number than the original 122 projects agreed at the start of the fund (across 42 consortia).

Analysis of the programme was based on projects' delivery phase (how much progress they have made) and category (what their main activities are). Over 50% are now being meaningfully delivered, with another 11% showing emerging evidence of impact. Projects related to setting up or implementing digital platforms (41 projects) and providing carers breaks and respite (35 projects) are most common. Projects related to hospital discharge (11 projects) and community-based care models (9 projects) are least common.

There was variation in projects’ progress, and this appears to relate to the type of activities being delivered. Community-based care models and Shared Lives projects have taken the longest time to reach full delivery, while those setting up digital platforms and supporting unpaid carers have been fastest. Projects that have set up or implemented digital platforms and technologies, and projects establishing community-based care models are most likely to be able to demonstrate impacts at this stage. Significant enablers to project delivery include:

- strong governance

- strong collaboration
- drawing upon wider expertise and peer learning
- sufficient staffing/resources
- co-production

Barriers and challenges include:

- funding instability (including a significant delay in committing funds related to the timing of the 2024 General Election) and sufficiency of resources
- procurement
- data governance
- risk aversion
- a lack of collaboration
- low service engagement or uptake

Supporting delivery

The ARF's funding model was seen by most systems as fostering collaboration between local authorities, leading to joint projects and shared learning. The 12 national priorities helped provide strategic direction and a focus on unpaid carers. Sometimes, system-wide collaboration was challenging, and the impact of the funding model was therefore influenced by pre-existing relationships.

SCIE's support offer included:

- workshops
- communities of practice (CoPs)
- one-to-one targeted support
- broad-ranging communications

The topics covered included:

- co-production

- compliance with the Care Act 2014
- hospital discharge
- digital self-service

The support offer received particularly strong engagement during the EoI phase. The targeted support and CoPs were generally well received, as they facilitated peer learning and provided valuable expertise. One-to-one support led to tangible progress in several systems.

However, the limited availability of reporting about what projects were taking place, where and their delivery progress meant targeting support in the right places was challenging. The timing of the support offer in relation to slower-than-anticipated project delivery meant some systems were not ready for support when it was offered. Some workshop attendees felt they were not sufficiently tailored to system needs, although the varying level of need and maturity would have made this difficult.

SCIE has summarised emerging learning that they have collected through delivering the support offer in their Embracing change: scaling innovation in social care in practice report.

Outcomes and impact

Around 1 in 10 (11%) projects are now evidencing short-term outcomes, based on analysis of end-of-grant reports, with many more reporting that they have systems in place to measure changes in the future.

The most commonly observed outcomes for individual projects so far include:

- increased carer identification and support
- improved access to information and services
- enhanced digital support
- better assessment and discharge processes
- the development of community-based care models

Projects related to technology or digital platforms and identification and assessments for carers, which have overcome procurement and other barriers and entered the delivery phase, appear to have had the biggest effects.

However, projects focused on more complex delivery that required greater collaboration across local systems (including with the NHS and voluntary, community and social enterprises (VCSE)), such as hospital discharge or setting up new community-based care models, may prove to have greater impact in time. Unintended consequences exhibited in some ARF projects include the creation of a 'two-tier' support offer dependent on:

- digital literacy
- the generation of additional demand
- the identification of additional unmet need

Evidence of projects managing to scale or embed their innovations is mixed at this stage and depends on project progression and local contexts. Successful scaling and embedding often depends on factors such as the development of sustainable business models based on:

- strong evidence of what works
- integration with existing services
- securing alternative funding within individual local authorities

Conclusions

Some of the primary conclusions from the evaluation include:

- the programme has shown some impact on overcoming barriers to innovation and built the evidence base around implementing and producing better outcomes
- the evidence base around outcomes is only just emerging, and remains incomplete, as many projects have in practice taken longer to implement than was anticipated, including as a result of delays in funding distribution
- innovative approaches are hard to implement in adult social care. They take time to set up, and even longer to understand the effects
- the fund was well designed for its purpose (an ICS footprint-based funding model that is non-ringfenced and in line with national priorities) and has fostered an environment of both collaboration and innovative practice
- the support offer enabled systems that fully engaged with it to deliver innovation but was limited by slower than anticipated project delivery. It improved its broader relevance to systems and impact upon their progress over time, as it became more

focused on peer learning and one-to-one support. Future support offers of this nature should continue to focus on these elements, which most systems feel are more valuable

- projects focusing on technology or digital platforms and identification and assessments for carers have demonstrated the most significant outcomes to date, due to the extent to which they can be implemented and adopted quickly (once any procurement challenges have been overcome).

- projects involving digital platforms are most geared towards scaling, at this stage, due to the inherent potential of digital tools to reach wider audiences and integrate into mainstream services.

- projects focused on carer identification, assessments and hospital discharge prioritise embedding into existing systems, with scaling dependent on demonstrated success

- the fund has enabled systems to focus more on longer-term innovation and addressing systematic barriers to innovation, potentially facilitating further innovation beyond what was in the ARF projects themselves

Recommendations

It is recommended that DHSC:

- considers how to further support the scaling and embedding of successful ARF projects and sustain innovation in adult social care more broadly. Support could allow successful projects to scale and further develop their impact

- enhances the availability and sharing of best practice within social care innovation, and provide ongoing support to systems through tailored guidance, peer learning, and knowledge exchange

- adopts this funding model for programmes of a similar nature. The combination of flexibility with clear guidance and priorities has aided systems in devising projects

- requires outcomes measuring and sustainability plans as a condition for receiving funding under any future programmes, and support systems in:

    - developing business cases

    - exploring diverse funding models

    - integrating innovations into mainstream services

- considers adopting a narrower, more targeted approach to funding local areas through national programmes of this nature, and focus future social care innovation funding on scaling emerging good practices, such as a national approach to digital support for unpaid carers

- improves the guidance, information and communication available around social care innovation and DHSC's strategy for spreading best practice

- introduces more standards and guidelines around the adoption of digital tools, including providing clear guidance and support on data protection and information governance, particularly for artificial intelligence (AI)-driven innovations

It is recommended that systems:

- streamline procurement and data governance processes, including streamlining procurement for digital tools and addressing data sharing issues to enable quicker technology implementation. This will facilitate faster access to and more efficient use of technology in care settings

- address the potential for a 'digital divide'. Ensure equitable access to digital tools by addressing digital literacy gaps and infrastructure limitations. Strategies should focus on providing resources and support to bridge the digital divide

- strengthen co-production processes by supporting local authorities (through peer learning or national guidance) to develop effective co-production methods, focusing on engagement with people with care and support needs and their carers. Resources should address common challenges in engaging these core stakeholders

- improve evaluation capacity, with a focus on attribution and longer-term impacts. Integrate evaluation principles and frameworks into change management processes before projects begin

See the 'Conclusions and implications' section for more detailed recommendations.

Introduction

The ARF, announced in October 2023, is a social care innovation grant funding programme intended to support local places to embed and scale new approaches to providing care and improve services for unpaid carers. Ipsos UK was commissioned by DHSC in March 2024 to conduct an evaluation of the fund.

About this evaluation report

This final evaluation report presents summative feedback and learning generated by the activities that formed part of all the evaluation fieldwork. This report is accompanied by 2 other related final outputs, which can be found on the Evaluation of the Accelerating Reform Fund page:

- the local impact assessment synthesis report
- case studies of 12 ARF projects

Purpose

The specific objectives of this final report are to:

- provide more conclusive research findings against the evaluation questions, with a fuller assessment of the emerging outcomes and impacts linked to the fund
- inform the evaluation approach for future social care innovation funds
- inform DHSC's approach to managing future social care innovation funds
- provide a summative assessment of the efficacy and impact of the SCIE support offer, which formally ended in March 2025

Structure

The structure of this report is as follows:

- 'About the fund' outlines the fund's design, rationale and delivery
- 'Implementation and delivery' details the findings related to the implementation and delivery of the fund
- 'Supporting delivery' details findings related to the mechanisms within the fund that are designed to support delivery

- 'Outcomes and impact' details findings related to the outcomes and emerging impacts arising from the fund, including sustainability and scope for future scaling
- 'Conclusions and implications' summarises the main conclusions from these summative findings, and draws some implications and recommendations for this Fund and future funding to support adult social care innovation

Overview of the evaluation

The evaluation of the fund, and the associated support offer, was both a process and impact evaluation. Process elements of the evaluation focus on the national evaluation of the fund, and impact elements focus on impact measurement at a local system level. The evaluation took a mixed-methods approach including:

- scoping research
- evaluation co-design
- surveys
- interviews with various stakeholder groups
- reviews of supplementary evidence and management information

The evaluation delivery process was split into 5 stages:

1. scoping and evaluation design phase (March to June 2024)
2. wave one data collection and analysis (July to September 2024)
3. wave 2 data collection and analysis (October 2024 to January 2025)
4. wave 3 data collection and analysis (February 2025 to April 2025)
5. final analysis and reporting (May 2025 to June 2025)

Evaluation methodology

The evaluation methodology included a scoping and design phase involving:

- document reviews
- scoping interviews
- co-design workshops with DHSC and SCIE

This phase informed the development of a theory of change, which served as the foundation for the evaluation.

Data collection involved online surveys of consortia representatives (leads, project leads and delivery partners) across 3 fieldwork 'waves'. The surveys explored topics such as:

- project development
- funding
- the SCIE support offer
- embedding or scaling innovation

Semi-structured interviews were conducted with consortium leads across all waves, focusing on their experiences with the fund, project rationale, and progress. Project lead interviews, also conducted across multiple waves, provided insights into individual project:

- delivery
- barriers
- engagement with the fund and support offer

Additional interviews were conducted with SCIE representatives, innovation partners, and unpaid carers and care users, primarily in later waves, to gather diverse perspectives on:

- the support offer
- innovation implementation
- service user experiences

Across the 3 waves, survey responses totalled 40, 90, and 56 respectively, representing 28, 35, and 31 of the 42 consortia. In wave 3, survey data from 120 individual projects was provided. Semi-structured interviews were conducted with 28 consortium leads over the 3 waves, with some leads participating in multiple waves. Project lead interviews, also conducted across multiple waves, involved 24 interviews (including 7 group interviews) in wave one, 11 interviews in wave 2, and 10 interviews in wave 3, gathering insights from a range of projects across all 12 DHSC priority areas.

Data analysis involved quantitative analysis of survey data and thematic analysis of interview transcripts, using a coding structure linked to pre-defined evaluation questions.

The full methodology for the project is detailed in 'Appendix 1: evaluation methodology' below.

Evaluation questions

The following evaluation questions have been co-developed with DHSC.

Process evaluation:

- has the fund supported local areas to create the conditions for the embedding and scaling of innovations in adult social care?

- has the fund and/or the SCIE support offer helped local areas to overcome barriers and to embed and scale innovation in adult social care?

Impact evaluation:

- what are the impacts of embedding and scaling innovative approaches to delivering care and supporting unpaid carers?

Limitations

The limitations to the evaluation and methodology that should be considered when interpreting the findings are as follows:

- incompleteness of grant reporting and local impact assessment data: of the 42 consortia in receipt of ARF funding, 39 returned end-of-grant reports in time for inclusion in the evaluation findings. Furthermore, 29 of the 42 consortia returned local impact assessments to the evaluation team

- sample size and skew: the sampling criteria for interviewees and projects included as case studies accounted for factors such as project category group, system geography and range of potential outcomes. However, sampling of projects was limited by engagement levels - some projects had to be substituted for others that were more responsive. Furthermore, the consortia and projects included in interviews represent around half of the total systems and projects in receipt of ARF funding. Therefore, the extent to which these interviewees and projects can be viewed as representative of activity within the fund is somewhat limited, despite the sampling considerations being broadly fulfilled

- timing of fieldwork in relation to project delivery: while many projects have now progressed to early delivery (see the section on 'Implementation and delivery' below), a significant minority are still being set up and only a small proportion are able to evidence outcomes from specific innovations. Evaluation findings related to outcomes

(outlined in 'Outcomes and impact' below) are limited by this, often based on emerging evidence or anticipated future outcomes

About the fund

This section describes the ARF's context and design, rationale and delivery.

Design and objectives

The fund was announced in October 2023. The fund allocated £42.6 million over 2 years (financial years 2023 to 2024 and 2024 to 2025) to support local authorities in England to reform and improve their adult social care services.

The main aims of the fund were to drive innovative ways of delivering services and prompt a change for improved services for unpaid carers. The fund was designed to promote partnership working across local areas, as well as the sharing of learning and best practice nationally.

The strategic objectives for the fund, as defined by DHSC, were to:

- support local places to effectively overcome barriers to adopting and scaling innovations, including support for unpaid carers, in social care
- support contributions to the evidence base for what interventions lead to better outcomes for unpaid carers and those who draw on care and support
- build on the evidence base for effective implementation of interventions in local places

Local authorities, working collaboratively with other local authorities and delivery partners in their ICS geographies (defined in this report as 'consortia'), including the NHS, care providers and VCSE groups, were enabled by the fund to take forward projects relevant to their local contexts. Decision-making by consortia on how to spend the funding was guided by a published list of 12 priorities, which included illustrative innovative interventions deemed suitable for scaling.

Scaling in the context of this evaluation is defined as one of 2 processes (or a combination of both):

- replicating an intervention more widely in a local area
- building infrastructure to support full-scale implementation and rollout

The fund was designed to support at least 2 projects in each ICS area, with at least one having a particular focus on unpaid carers. Funding allocations were calculated based on the adult social care relative needs formula (RNF) at a local authority level and summed for the ICS consortium, based on the total number of local authorities opting in and which

consortium they join. After an EoI process, 42 consortia in England (and by extension 148 upper-tier local authorities) received funding.

Payments were a non-ringfenced grant contribution paid to local authorities towards implementing projects in line with the DHSC's 12 national priorities for innovation and scaling in adult social care. There were no conditions on the grant, though there were expectations of:

- a minimum level of progress reporting to the DHSC
- for sharing learning and evidence with the national evaluation provider (Ipsos) and other systems

Oversight was provided by a mid and end-of-grant reporting return administered by DHSC.

DHSC's national priorities

The 12 national priorities identified by DHSC were:

- priority 1: community-based care models such as shared living arrangements
- priority 2: supporting people to have greater control over their care options, such as by using digital tools to self-direct support or communicate needs and preferences
- priority 3: investment in local area networks or communities to support prevention and promote wellbeing, enabling people to age well in their communities
- priority 4 (focuses on unpaid carers): ways to support unpaid carers to have breaks which are tailored to their needs
- priority 5: digital tools to support workforce recruitment and retention, for example through referral schemes
- priority 6: develop and expand the impact of local volunteer-supported pathways for people drawing on care and support
- priority 7 (focuses on unpaid carers): ways to conduct effective carer's assessments with a focus on measuring outcomes and collaboration
- priority 8 (focuses on unpaid carers): services that reach out to, and involve, unpaid carers through the discharge process
- priority 9: digital workforce development and market shaping tools with capability to map, strengthen and grow local workforce capacity relative to system demand

- priority 10: social prescribing to connect people with information, advice, activities and services in the community
- priority 11 (focuses on unpaid carers): ways to better identify unpaid carers in local areas
- Priority 12 (focuses on unpaid carers): ways to encourage people to recognise themselves as carers and promote access to carer services

The aim of the ARF is to support the adoption or scaling of projects that deliver these priorities.

The support offer for the fund, provided by SCIE, was intended to maximise participation in, and successful delivery of, the ARF. The activities of the support offer included helping local areas:

- develop partnerships
- refine proposals
- deliver projects

It aimed to help identify issues and challenges, galvanising co-production and ensuring people who need care and unpaid carers were at the heart of the programme. As it is a learning programme, SCIE was also tasked with sharing learnings, including barriers and enablers to innovation in practice.

The main phase of SCIE support for projects ended in March 2025, although the CoPs formed as part of its offer continue, as does a much more limited offer providing ongoing support to around 14 projects (funded by DHSC). Additionally, SCIE has produced a match-funded support offer, for which 4 projects so far have applied, above and beyond any free support available.

Context and rationale

The experience of those providing and receiving adult social care often falls short of expectations. As detailed in the Health Foundation's report A radical new vision for social care, people want and prefer care to:

- be as close to home as possible
- have a more proactive, preventative focus
- address their holistic and individual needs

- be more relational - meaning that care emphasises positive and consistent interactions and relationships, enabling the involvement of family and communities of support

With an ageing population and an increase in the number of people projected to be living with major illness, this will place increasing demand on an already stretched care system.

The aim of the fund is therefore to address barriers to adopting innovative practices and build capacity and capability in adult social care, to address this growing challenge. Both DHSC and consortia representatives outlined a clear rationale and need for:

- promoting and embedding innovation to respond to rising demand for support and the changing needs of the population

- making person-centred care and support a reality for those who draw on it

In discussions with stakeholders at DHSC and SCIE, the evaluation team developed an understanding of the term ‘innovation’ within this context. For the purpose of this report, it is defined as developing services using new or novel approaches, such as introducing digital technologies or shared living arrangements.

While the care system has been innovating for decades, there is a tendency for impactful innovations to remain on the margins, rather than becoming an integral part of how care and support is delivered. The failure to adopt or scale innovations in social care is a long-standing, complex challenge, limiting access to and potential improvements in care and outcomes for people. The specific challenges systems reported related to this fund are outlined in the 'Barriers to implementation and delivery' section below.

The focus on unpaid carers was an explicit part of the fund's design. Unpaid carers will be a significant asset in responding to this increasing demand, and the value of unpaid carers' contributions to the adult social care system is very significant. However, caring responsibilities can negatively impact on the health and wellbeing of unpaid carers if they do not have adequate support. Failure to deliver this support can lead to:

- detrimental impacts on a carer’s physical and mental health and quality of life

- exacerbate existing inequalities between carers who share protected characteristics and those who do not

Theory of change

The national, programme-level theory of change (ToC) for the fund was developed through a series of scoping interviews, document review and co-design workshops. It details the activities, outputs, outcomes and impacts anticipated from the fund, alongside the

mechanisms by which it is anticipated that these outcomes will be achieved. See Figure 8 in 'Appendix 2: theory of change and mechanisms for change

Delivery

Both tranches of funding have been delivered and the universal support offer provided by SCIE has now finished, with a more limited programme of support continuing. SCIE has summarised emerging learning that has collected through delivering the support offer in its Embracing change: scaling innovation in social care in practice report.

The fund formally ended in March 2025 at the end of the 2024-2025 financial year. However, since the second tranche of funding was received in November 2024 and the fund is non-ringfenced, most projects are continuing their activities into the 2025-2026 financial year. Activities in most consortia are still ongoing at the time of writing this report. All consortia have now completed final grant reporting returns for DHSC.

As a result of ARF funding, 42 consortia were formed and initial proposals for 122 projects across those consortia were approved. Subsequently some projects were put on hold and sub-projects were developed meaning the final number of projects evaluated is 141, on the basis of end-of-grant report submissions. The 'Project Implementation and delivery' part of the 'Implementation and delivery' section details the specific focus of these projects in relation to the 12 priority areas and delivery themes.

The table below outlines the inputs (in terms of funding, geographical scope and projects) associated with the fund's delivery:

Table 1: outline of funding provided through the ARF to consortia and local authorities

Funding provided	Consortia funded	Local authorities funded	Projects funded
£42.6 million total - £20 million in financial year 2023 to 2024 and £22.6 million in financial year 2024 to 2025	42 (with funding allocated based on collective RNF)	148	141 identified from 39 of 42 consortia

Implementation and delivery

This section covers findings related to the implementation and delivery of ARF projects, including the enablers and barriers associated with different types of projects and stages of delivery.

Project implementation and delivery

This section describes how ARF projects have been set up and delivered to date, exploring variations by project category group.

As part of the evaluation, consortia were asked to complete 2 rounds of grant reporting: a mid and end-of grant report and a local impact assessment. A review and thematic analysis of responses was conducted.

In consultation with DHSC, each project's progress was analysed and coded based on findings from previous waves. This section also draws on data from:

- DHSC end-of-grant reports
- a survey of consortia and project leads
- qualitative interviews with both groups

Project maturity levels

Projects have each been categorised into one of the following 4 levels of maturity:

1. Scoping and design: establishing project aims and objectives. This is the initial planning phase.
2. Implementation and set-up: setting up projects and acquiring necessary resources (such as hiring staff or developing tools).
3. Project delivery: delivering the service or tools but not yet observing any changes as a result. This is the active implementation phase.
4. Impacts emerging: changes (outputs, outcomes or impacts) have been measured as a result of the project delivery, which may still be ongoing. This phase shows demonstrable results.

Project category groups

Projects were also categorised into 6 project category groups. These categories are not intended to be mutually exclusive. In many cases, projects fit into multiple categories. Where a project could fit in more than one category, a decision was made about which was most appropriate.

Here we outline the categories, and the kinds of projects included within them:

1. Setting up or implementing technology or digital platforms: projects enhancing support for carers, improving access to information and streamlining process through technology. Examples include:
    - app development
    - online portals
    - digital directories
    - assistive technology solutions
2. Identification and assessment of carers: projects focused on improving carer identification and ensuring timely and appropriate assessments to access support services. Examples include:
    - targeted campaigns
    - improved data collection through apps
    - remote support
3. Providing carer breaks, respite or other forms of support for carers: projects offering carers breaks from caring responsibilities such as respite care, short breaks, and access to wellbeing activities. This category also includes broader support such as:
    - counselling
    - peer support
    - information and advice
4. Hospital discharge: projects improving hospital discharge processes for carers and those they care for, aiming to prevent readmissions. Examples include:
    - dedicated carer support roles in hospital

- improving communication between health and social care teams
- access to community discharge support

5. Shared Lives: projects focused on introducing, expanding and enhancing Shared Lives schemes, which offer personalised support and accommodation for adults with care needs. Examples include:
    - carer recruitment campaigns
    - training programmes
    - improving matching and efficiency across schemes.
6. Community-based care models: projects strengthening community support networks, improving access to local resources, and promoting preventative care. For this more varied category, examples include:
    - developing local area networks
    - micro-provider schemes
    - social prescribing initiatives
    - community hubs

Project progress by delivery stage

End-of-grant reports were submitted by 39 of the 42 consortia who received ARF funding. When aggregated, these returns included 141 ARF projects. This is a larger number than the original 122 projects agreed at the start of the fund (across 42 consortia) and reflects how consortia have developed sub-projects that they have monitored and evaluated separately.

The breakdown of how project progress was as follows:

- 22 projects (16%) were in the scoping and design phase, indicating that a minority were still at the early stages of defining project aims and objectives
- 33 projects (23%) were in the implementation and set-up phase, suggesting that a substantial number were still working on procuring resources, developing tools or finalising partnerships
- around half (71 projects, 46%) of projects reported being in the active delivery phase. This indicates that a significant proportion of projects had moved beyond initial set-up

and were actively delivering services or tools to carers and people with care and support needs. However, it is important to note that projects at this stage have not yet observed or measured any clear outcomes or impacts

- a small proportion (15 projects, 11%) had reached the impacts emerging stage, where measurable changes resulting from project delivery had been observed

However, the evaluation team's assessment of project delivery based on local impact assessments (detailed in the 'Accelerating Reform Fund: local impact assessment synthesis report' published alongside this evaluation) is that projects are behind where they have self-assessed in the end-of-grant reports as described above, in terms of delivery, though based on local impact assessments more projects were in the demonstrating impact phase than in the survey results. In local impact assessments:

- 5% of projects were being scoped and designed
- 39% were being set up and implemented
- 30% were being delivered
- 25% were demonstrating some impact

This suggests that consortia may be over-reporting their project delivery to date but under-reporting outcomes in some cases when submitting end-of-grant reports to DHSC. It might also be that less advanced projects (particularly those in the scoping and design phase) were less likely to submit local impact assessments or take part in the survey.

Project delivery by project category group

Analysis of the distribution of project category group reveals a diverse range of activities funded through the ARF. The most common project category group was ‘Setting up or implementing technology or digital platforms’ (category 1, 41 projects), reflecting the emphasis on digital innovation in supporting carers.

‘Providing carer breaks, respite, or other forms of support for carers’ was the next most frequent category (category 2, 35 projects), followed by ‘Shared Lives’ (category 3, 25 projects) and ‘Identification and assessments for carers’ (category 4, 20 projects).

Fewer projects focused on ‘Hospital discharge’ (category 5, 11 projects) or ‘Community-based care models’ (category 6, 9 projects).

The below table shows the distribution of project categories across the 4 delivery stages as of May 2025. The project categories and examples of each type are described in 'Project category groups’ above.

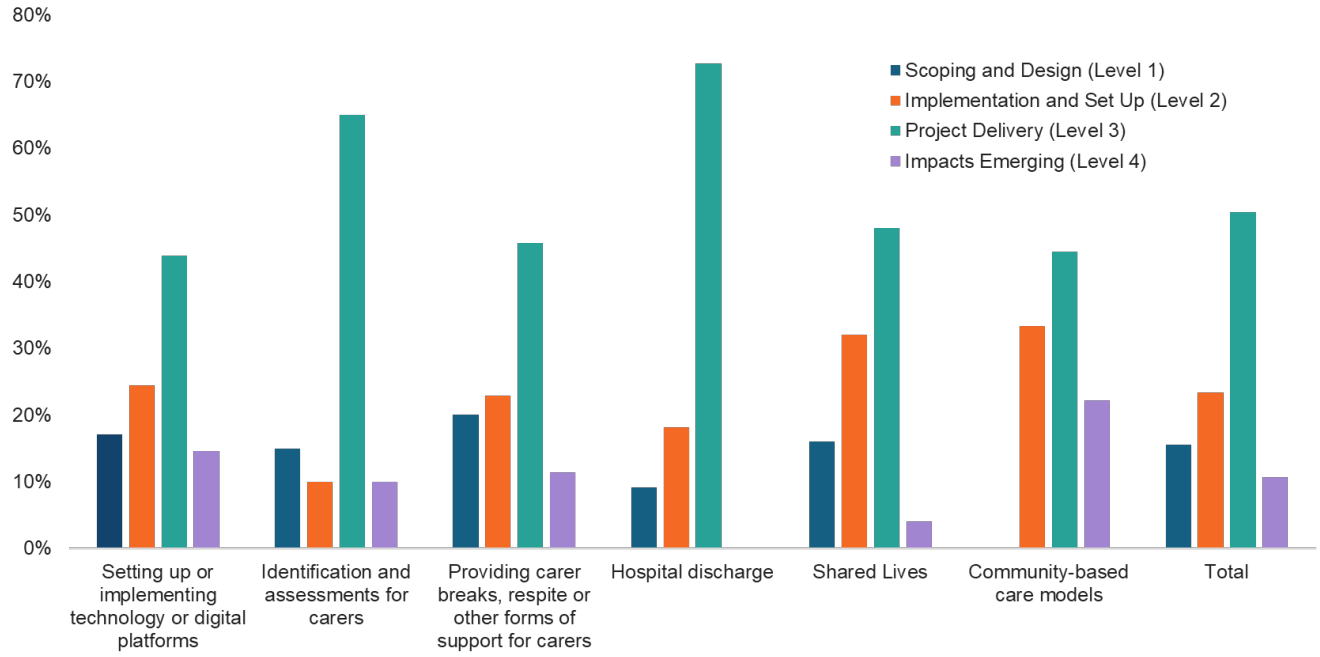
Table 2: proportion of projects of each category group by delivery stage

Project category	Scoping and design (level 1)	Implementation and set-up (level 2)	Project delivery (level 3)	Impacts emerging (level 4)	Total projects
1. Setting up or implementing technology or digital platforms	7 (17%)	10 (24%)	18 (44%)	6 (15%)	41
2. Providing carer breaks, respite or other forms of support for carers	7 (20%)	8 (23%)	16 (46%)	4 (11%)	35
3. Shared Lives	4 (16%)	8 (32%)	12 (48%)	1 (4%)	25
4. Identification and assessments for carers	3 (15%)	2 (10%)	13 (65%)	2 (10%)	20
5. Hospital discharge	1 (9%)	2 (18%)	8 (73%)	0 (0%)	11
6. Community-based care models	0 (0%)	3 (33%)	4 (44%)	2 (22%)	9
Total	22 (16%)	33 (23%)	71 (50%)	15 (11%)	141

Row percentages have been added to aid with interpretation, but the small sample sizes should be noted.

Figure 1: project category group by delivery stage

Sample: in total, 39 consortia submitted an end-of-grant report and 141 projects took place.



Projects of all types are found at each delivery progress level, with the exception of the community-based care models of which none of the 9 are still at scoping and set-up:

- providing carers breaks, respite or other forms of support is the project category group most likely to be at scoping or and design (20%)
- community based care models (33%) and Shared Lives (32%) are most likely to be at implementation phase, not yet in delivery. Several of the community-based care model projects included dispensing grants to community organisations and so this may reflect the intended outcome of the grant - to dispense grants
- hospital discharge (73%) and Identification and assessments for carer (65%) are the types most likely to be in delivery but not yet showing any impacts
- setting up or implementing technology or digital platforms (15%) and community-based care models (22%) are most likely to be demonstrating impacts

In interviews, project leads generally expressed satisfaction with their progress. However, they also acknowledged challenges such as resource constraints, partnership working, and data protection (see 'Barriers to implementation and delivery' below). The most significant learnings included the importance of:

- adaptability
- strong partnerships
- realistic timelines to allow for complexity

Enablers to implementation and delivery

Systems highlighted various factors that enabled the implementation and delivery of their projects. The following themes emerged:

- co-production and governance arrangements typically enabled project implementation
- resources typically enabled project delivery
- collaboration, expertise and peer learning typically enabled both implementation and delivery

See below for further details about each.

Co-production

Projects were expected to include co-production activities in the design and set-up of their activities.

Table 3: are you currently co-producing solutions with people with lived experience more or less than you were before the ARF was set up?

Response	Proportion of total response (%)
Much more or a bit more	74%
About the same	23%
Much less or a bit less	0%
Do not know or prefer not to say	4%
Total	53

The majority of systems have been doing some form of co-production. Three-quarters of all survey respondents report co-producing solutions with people with lived experience more than they were before the ARF was set up. Systems implemented various mechanisms for co-production, including:

- co-production groups
- working groups

- dedicated co-production work streams

These provided a structured framework for involving carers and people with care and support needs in the project development and implementation. The role of co-production for each system differed in line with the focus of each project as well as its maturity. Often, co-production was an enabler early on in the project development process, helping to inform the project design and set-up. In some cases, the co-production itself was a significant project output. For example, in one case, the digital tool being developed had not yet launched so system representatives described the involvement of carers in the process of developing the tool as a significant output for them.

Co-production was seen to impact projects positively by ensuring carers felt heard and involved in shaping the project and outputs. Examples included co-producing digital interventions, gathering carer feedback to inform the digital tool development.

Interviewees emphasised that timing needs to be considered when co-producing interventions. They cautioned that a system needs to ensure adequate time to do co-production as limited timescales can impact how much engagement can be done and some felt they did not have enough time to do this meaningfully within the timescales for the fund. Where successful, interviewees reported that they had engaged people in co-production from an early stage.

Collaboration

Interviews with consortium representatives, innovation providers and project leads all highlighted the importance of collaboration for effective project implementation and delivery. This was viewed as one of the most important enablers, especially during the early stages of a project when pre-existing partnerships and relationships were seen to facilitate projects being set up quickly and easily. The organisations and individuals that need to effectively collaborate with one another differs across consortia. This could include:

- NHS organisations
- healthcare professionals and representatives
- VCSEs
- academics
- local authorities
- community health and social care

Where there were pre-existing networks of partners or stakeholders, this enabled projects to be set up more quickly.

A consortium lead said:

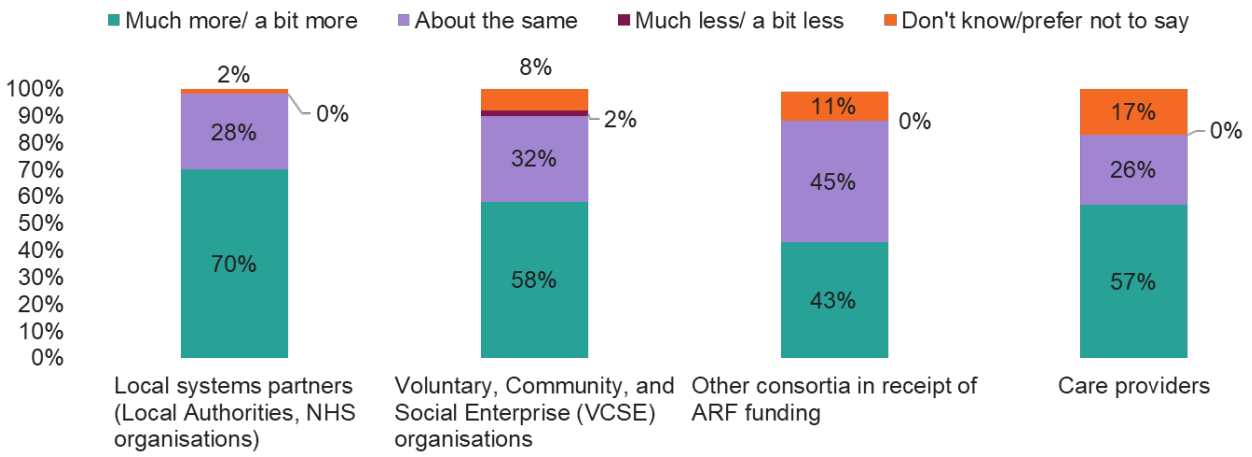
> "We had quite an established network of carer leads already… when this money came in on an ICB [integrated care board] footprint… we already knew the people who needed to be involved."

The fund appears to have facilitated collaboration with other local systems partners in the majority of cases. Survey respondents were asked whether they were collaborating more or less with various organisations (local systems partners, VCSE organisations, care providers and other consortia in receipt of ARF) compared with before the fund was set up. Nearly three-quarters reported collaborating more with local system partners, while a smaller majority said they were collaborating more with VCSE organisations and care providers. The fund may have had a smaller impact on collaboration between consortia.

The only circumstance in which less collaboration than before the fund was reported was in relation to collaboration with VCSE organisations (2% of respondents saying they were collaborating less with VCSEs than before the fund).

Figure 2: are you currently collaborating with the following organisations more or less than you were before the ARF was set up?

Sample: 39 respondents answered this question.



Interviewees saw effective collaboration as:

- a willingness among all parties to be involved in the project and do the work. A project lead said:

  > “All of the partners are very much engaged and willing, and very collaborative in the way that they're working."

- representing and hearing from a diversity of views and stakeholders to ensure the best solution. A project lead said:

  > "Even though we do have [local authority] looking at delivering something slightly different…there's no animosity or any difficulty in negotiating that… we've tried to explore a more collective solution that would work for everybody, and we've had really good, positive discussions to explain and understand what the localised needs are for each of those local authorities."

- having regular communication and meetings between organisations, which was seen to help partners align on goals and establish a shared vision. A project lead said:

  > "When you actually get everybody around the table… everybody's in agreement we're doing the right thing… we have regular meetings in terms of where we're going… about the project board. We're very clear in terms of what we are aiming to deliver."

Effective communication was seen to have the following effects, all of which enabled projects to be set up and delivered well:

- ensuring a solutions-focused approach, where solutions are tailored to the area, sector and stakeholders

- avoidance of conflict between parties

- amplification of the work through a diversity of advocates, to increase the visibility of the work being done

Governance arrangements

Strong governance arrangements are seen as essential to effective project implementation. Specifically, interviewees emphasised the need to have these set up early in the project. They established joint working arrangements within an ICS footprint, citing regular meetings, joint commissioning groups, shared projects, and established governance structures as the core facilitators of this. Additionally, buy-in from senior stakeholders was seen to enable projects to be set up effectively. A consortium lead said:

> "We have existing governance set-up. [a] partnership, … a transformation programme, so it's work that we're all working on together…we were able to easily insert another project within that existing governance for the Accelerating Reform Fund… therefore… a steering group was established which then reports within our existing governance structure."

Some systems already had subject-specific boards such as a co-production board which also facilitated project implementation. A project lead said:

> "We're a big authority, … we've got a carers' co-production board that sits underneath our strategic co-production board that oversees our co-production."

Resources

The main resources that enabled the projects to be set up and delivered were the funding itself and staff capacity. The funding model is covered in the 'Funding model' part of the 'Supporting delivery' section below.

In many cases, the funding was used to set up specific roles to aid successful project delivery - for example, hiring staff to deliver services or project managers. These were seen as critical to the project delivery. However, the ability to keep these roles going on an ongoing basis was unclear following the end of the funding period.

One system also explained how having a dedicated consortia lead was a critical resource for them, which enabled them to co-ordinate various projects and liaise with different stakeholders, including project leads, Ipsos evaluators, sponsors and other local authorities. They saw their role as essential for ensuring all reporting (financial and government) took place. A consortium lead said:

> "Having my post [consortium lead] has been an absolute essential … somebody to, sort of, co-ordinate… to be a single point of contact for the projects… financial reporting, you know, government reporting, co-ordinating activities… I don't think we would have been able to drive it as much if we hadn't had the post."

Additionally, some interviewees valued the minimal reporting requirements as part of the fund, describing the reporting process as 'non-bureaucratic' and 'proportionate'. This allowed systems to focus their resource and capacity on project delivery rather than too much administrative work. This was contrasted with other funds seen to have more in-depth reporting requirements. A project lead said:

> “For me, it’s been one of, probably, the best funds that I’ve worked with… paperwork is quite light, it’s proportionate, it’s not overly burdensome.”

Expertise and peer learning

Interviewees valued the opportunities to learn from other consortia and what they were doing, often through networking sessions, CoPs and workshops organised by SCIE. Hearing about what other consortia were doing and their progress reassured individuals about their own systems' pace of work and approach. This helped them to feel more confident in what they were doing and reduced feelings of isolation. Peer learning helped systems streamline the process of solving challenges as they could see how others had addressed similar issues and implement similar approaches.

One project lead described it as a 'shortcut' to addressing challenges:

> “It was just useful to hear other people… I found that reassuring that we weren’t doing anything that was completely bizarre or useless.”

Barriers to implementation and delivery

In the third wave of fieldwork, where many ARF projects had progressed to being delivered (see 'Project implementation and delivery' above), 7 in 10 (70%) survey respondents reported experiencing challenges in delivering their ARF projects, while a quarter (25%) of respondents stated that they faced no such issues. This is consistent with the findings from the second wave of fieldwork, where over 6 in 10 (62%) of respondents reported facing challenges delivering their projects and only around a quarter (26%) of respondents reported facing no such issues.

The main barriers identified by systems throughout the evaluation period are covered below.

Funding uncertainty and instability

Throughout the delivery of the programme, systems consistently identified funding uncertainty and instability as the most pressing barrier to social care innovation. Feedback from systems highlighted that the most significant historical obstacle to social care innovation was the lack of sustainable, long-term funding. The fund was a welcome source of support to address this barrier to innovation.

However, systems underscored the substantial impact of funding timing and processes on project planning and delivery, leading to various challenges. The uncertainty caused by the delay in the second funding tranche significantly hindered planning efforts and postponed crucial decisions. A consortium lead said:

> “So, for a lot of people, certainly team leaders and service delivery managers have been expected to deliver the ARF, the priorities and the day to day within their existing resource.”

The delay in the second tranche's confirmation and release, attributed to the 2024 General Election and subsequent government transitions, disrupted project timelines and forced systems to develop contingency plans, diverting resources and creating hesitation in committing to long-term initiatives. SCIE reported that this also influenced attitudes towards their support offering and affected take-up of the support. This also impacted:

- project planning
- resource allocation
- recruitment
- implementation
- future sustainability

A project lead said.

> “We also held back a little bit, because obviously there was that big pause, wasn't there, between tranche one and tranche 2. Where tranche 2 seemed quite uncertain, so we paused some of that while were getting some clarity on whether tranche 2 was actually coming or not. Because we didn't want to, again, commit funding that was uncertain.”

Systems gave specific examples of how funding instability acted as a barrier to delivery and sustainability. For example, one system directly linked the funding delay to a pause in activities, impacting the implementation of Shared Lives expansion and online carer self-assessments. Another system also faced challenges related to funding continuity, with concerns about sustaining the arts-based carer support programme beyond the ARF timeframe. While the flexibility to carry forward funds offered some mitigation, it did not fully alleviate the disruptive impact of the delayed second tranche of funding. A further system noted a lack of initial clarity regarding eligible expenditures, further complicating planning efforts. This suggests a need for clearer communication and more predictable funding streams in future initiatives. A project lead said:

> “It's the funding to continue that's the really tricky bit.”

Projects involving new initiatives, which often required significant upfront investment in infrastructure or staffing, were particularly vulnerable to funding delays. The uncertainty made it difficult to commit resources and make long-term plans, hindering their ability to get off the ground. One consortium lead explained that the uncertainty surrounding the second tranche of funding led to a pause in some project activities, as they were hesitant to commit to spending without confirmation that the funding would be available:

> “The delay in, sort of, a pause in the second tranche being announced, I know it wasn't anybody's fault, that's just pure circumstances but it did hold us up a little bit, I suppose, we just dithered. The projects were okay but it kind of slowed momentum, I suppose, and it definitely slowed the Shared Lives.”

While also affected by the delay, projects scaling existing services rather than procuring new ones may have had more flexibility to adapt. They could potentially pause expansion plans or re-allocate existing resources while awaiting confirmation of the second tranche.

Innovation providers highlighted funding uncertainty, particularly the lack of assurance regarding ongoing funding and support for innovation, as a major barrier. This lack of long-term commitment reduced confidence in initiating projects and created a risk that existing innovative work might be jeopardised if funding was diverted to new initiatives.

It was also noted that the limited scale of ARF funding was a significant constraint, requiring substantial goodwill and additional resources to achieve meaningful impact. It is unclear whether this involved reducing profit margins or other forms of contribution, and whether this was a common experience across other providers. This resonates with broader concerns about funding sustainability raised by systems throughout the evaluation. Further investigation is needed to understand the extent to which providers contributed additional resources to ARF projects and the implications for their long-term viability.

An innovation provider said:

> “If there is little reassurance that there will be ongoing forms of funding or support to implementing innovation, then I think both for ourselves and for the organisations that we work with and that have been part of the ARF, then your confidence levels to actually get something started are far lower.”

Procurement processes and data governance

Procurement processes have presented a persistent barrier for systems throughout the delivery of ARF-funded initiatives, impacting project timelines and resource allocation across various project category groups and phases of project delivery. In the initial stages of project delivery, due to capacity limitations or the need for further scoping, some projects encountered delays in the procurement process.

The fund required consortia to follow ICS footprints. Some consortia established separate projects in each local authority, while others have projects that cover 2 or more local authorities. Projects involving multiple partners or geographically dispersed areas faced particular procurement complexities, due to the need to co-ordinate across multiple

organisations with differing procedures and priorities. One system, for example, noted the difficulty of navigating differing service models and procedures between county and city, which influenced procurement decisions and processes. The project lead said:

> “One of the main challenges is working with the culture of organisations in [X], that perhaps they haven't always worked particularly cohesively.”

One digital innovation provider highlighted the complexity of working ICS footprints and navigating ICS-wide procurement processes as a major challenge. The lack of clarity regarding procurement responsibilities and procedures at the ICS level led to delays and confusion. This fragmentation undermined efforts to deliver innovation at scale and created difficulties for providers trying to co-ordinate across multiple stakeholders within an ICS. An innovation provider said:

> “It took time for some projects to get off the ground because they weren't sure how to organise an ICS-wide procurement, who would do it, how it would be organised.”

As projects made progress, systems highlighted the lengthy and complex nature of procurement, particularly surrounding the legal and governance requirements associated with transferring or distributing funds and commissioning services. The nature and scope of the projects also significantly influenced the complexity and duration of procurement processes. The process of establishing data-sharing agreements across multiple local authorities and/or the NHS, and external services has been slower and more challenging than anticipated, significantly affecting project timelines.

For one system, for example, the process of establishing legal agreements for fund transfers between local authorities was cited as a "massive delay" encountered by the consortium representative. Another system also noted that the procurement and legal processes associated with consortia-based funding were more complex and time-consuming than anticipated, adding another layer of difficulty to project implementation.

This suggests that, while the consortia model encourages collaboration, it can also introduce administrative burdens related to procurement that require careful consideration and streamlining.

A consortium lead said:

> “Distributing the funds to partners has been a massive delay. So, actually getting the legal agreement between council as the lead or local authority and the other local authorities for us to distribute the grant funding to each of the partners has been, has taken a very long time to get that legal agreement in place so that we can transfer the money.”

While this was not a single or isolated case, it was not a widespread theme across the fieldwork programme.

Data governance started to emerge as a significant, and often unanticipated, barrier for systems as they moved to procurement. This is particularly true for projects involving digital tools. The differing levels of digital experience and expertise among systems made it especially challenging to set up digitisation projects involving multiple partners. These challenges became apparent as systems advanced through project design and service procurement and were not anticipated by systems during scoping and set-up.

More recently, systems have highlighted the complexities of navigating data protection and information governance requirements, especially in the context of AI-driven innovations. This reinforces concerns raised in previous waves of fieldwork about the need for robust data governance frameworks and data sharing agreements.

One system, for example, described these issues as more challenging than anticipated, requiring extensive engagement with data protection leads and IT security teams. Likewise, another system described the complexities of localising a digital support platform and adapting its AI functionality to ensure appropriate and safe outputs, highlighting the need to consider safeguarding protocols and ethical implications. The project lead said:

> “The AI aspect, because that was the learning in itself on the fact of how to talk and do prompts for AI and that that was a bit of a challenge. And the fact of, you know, you're trying to tell him, tell AI to do this, but you shouldn't do this. So, it was just that sort of learning part and that's why we had to really sort of localise it. And then that's been sort of a challenge around actually, you've got to be very, very clear on your prompts. So, you're not generating something untoward or anything of sorts.”

Capacity constraints (staff time and expertise)

Capacity constraints, encompassing both staff time and the availability of specialist expertise, have been a persistent barrier throughout the fund. This has impacted:

- project scope
- ambition
- timelines
- staff wellbeing

Early evaluation fieldwork captured capacity constraints as a significant barrier to scaling innovation in adult social care. Some projects faced setbacks because of staff sickness or

challenges in recruiting for specific roles. Staff shortages, high turnover, recruitment challenges, and heavy workloads limit the time and capacity available for innovation. These issues are further exacerbated by demanding working conditions and low pay in the adult social care sector, making it difficult to attract and retain skilled staff.

As projects progressed, systems also identified resourcing constraints as a significant barrier to the delivery of ARF-funded innovation projects. Specifically, systems cited the following as continuing barriers to project implementation and delivery:

- limited staff capacity
- lack of dedicated project managers
- recruitment difficulties

A consortium lead said:

> "Recruitment has just been a real struggle for the Shared Lives… they've really struggled, both to retain their operational leads… people have just left."

More recently, systems have consistently reported that the demands of ARF projects stretched existing staff resources, often requiring individuals to manage project delivery alongside their day-to-day responsibilities. For some systems, all ARF-related work was absorbed into existing roles, creating significant stress and limiting project capacity.

In many consortia included in interviews throughout the evaluation, the tension between supporting innovation and managing existing workload pressures within resource-constrained environments was apparent. A consortium lead said:

> "It [the fund] is in some ways, a bit of a distraction from the core offer… it's been a huge resource ask for them to deliver these additional grants as well, without a huge amount of additional investment in the resources to do that."

The short-term nature of ARF funding also presented a barrier to recruitment and staff retention as the associated posts were often temporary. One system encountered difficulties recruiting for temporary positions within the Shared Lives strand, as candidates often prioritised more secure, long-term employment. Another system emphasised the inadequacy of 12-month funding cycles for new projects, noting that this short timeframe hinders effective set-up, delivery and evaluation, and can contribute to staff attrition due to contract uncertainties. A project lead said:

> "What we found was we were offering temporary posts to people, and then they were finding long-term work, so they didn't want the temporary posts."

Risk aversion

Risk aversion was initially identified as a potential barrier to innovation in the ToC development and mentioned early in the ARF programme by systems. Although not as relevant as project delivery has progressed, risk aversion has been referenced as an obstacle during design and implementation by many systems, particularly when combined with other barriers. Systems underlined the impact of a risk-averse culture on innovation in adult social care more generally and regarding the fund.

However, the latter stages of project delivery demonstrate that risk aversion may have been less of an impediment than initially anticipated. This suggests that the ARF's emphasis on innovation, its flexibility and the explicit 'permission to fail' fostered a more supportive environment for experimentation and risk-taking, potentially mitigating some of the inherent risk aversion within the social care sector. A consortium lead said:

> “I think what was really good was the permission to fail, not ring-fencing it. That allowed the innovation. That allowed authorities to very much focus on coming up with their own ideas, and the operational teams particularly did that.”

However, one system’s example of needing to reassure stakeholders about the human-led nature of AI-driven decision-making indicates that risk aversion may still be a factor in certain contexts and departments within local authorities, particularly when procuring novel technologies or approaches that challenge established practices. While the fund appears to have successfully encouraged a degree of risk-taking among consortia and project leads, it is important to acknowledge that risk aversion may persist in specific areas and requires ongoing attention and targeted support. A consortium lead said:

> “Making sure that decisions are always actually taken by a person, not the tool. I think that's been really key in us, in getting that over the line."

Innovation providers also highlighted the effect the fund has had on encouraging local authorities to take risks and try new innovative approaches. One provider stated that the fund provided a rare opportunity for local authorities to "take a punt" on innovation, allowing them to experiment with new approaches and build an evidence base without the usual funding-related hesitations. This suggests that the ARF's dedicated funding and explicit focus on innovation created a more permissive environment for local authorities to explore and implement new solutions that they might not have otherwise considered due to financial constraints or risk aversion. An innovation provider said:

> "I think the ARF has enabled people to take a punt on stuff and build that evidence base."

Lack of collaborative and partnership working or differing needs within large geographical footprints

Although also seen as an enabler, challenges related to collaborative and partnership working emerged as a recurring barrier for systems. This was particularly the case when projects:

- involved multiple organisations
- spanned large geographical areas
- required co-ordination across different sectors

The consortium model, while promoting collaboration, presented challenges, particularly when working within ICS footprints. It resulted in forced or unsustainable partnerships due to differing priorities or ways of working between local authorities. Many systems were already working with partners in advance of the ARF, but the strength of these relationships varied. Some had established communication channels but limited project experience together, while others had more embedded partnerships with joint contracts and governance structures. A consortium lead said:

> "Working in partnership has created its own challenges, which it always does, because you've got people who want to work at different paces."

As project delivery progressed, there was clearer evidence of increased collaborative working within consortia. However, partnership working, particularly across multiple local authorities, continued to present challenges due to:

- differing priorities
- working practices
- financial pressures
- governance and procurement structures

While the ICS footprint funding model encouraged collaboration, it also created difficulties in budget allocation across projects. Systems cited the importance of pre-existing partnerships as a foundation for innovation, highlighting strong existing relationships and established joint working arrangements between local authorities as primary facilitators.

The fund also facilitated new partnership-building activities across multiple sectors involved in delivering adult social care, including engagement with primary care networks (PCNs), GP surgeries, and ICBs, and the establishment of new shared governance structures for ARF projects. Despite these successes, systems also acknowledged the

inherent challenges of managing multi-partner projects, such as difficulties engaging health colleagues due to competing priorities and resource constraints within the NHS. A consortium lead said:

> “If we'd have been told, 'This is how much you've got to spend on each of the projects' and each of the projects had had a defined budget to start, it would have been a lot easier. It would have been a lot easier to manage. But asking 6 individuals to go out and come back with a wish list of what they would like to do and how they're going to deliver it, to then determine how much money can be split, was very difficult. So, that was very stressful. Managing the 6 leads has been very stressful for me because, obviously, it being 2 different local authorities, we do things completely differently.”

One innovation provider highlighted the lack of existing partnership structures within ICSs as a major barrier to implementing Shared Lives schemes. The variation in maturity of Shared Lives schemes across different local authorities within consortia further complicated collaborative efforts, making it difficult to implement a uniform approach across an ICS footprint. Providers also emphasised the importance of established relationships between local authorities, ICSs and local carer organisations as crucial for successful implementation, noting that, where these relationships were weak or non-existent, projects struggled. The short timescales of the ARF often exacerbated this challenge, leaving limited time for relationship-building. An innovation provider said:

> “Trying to come together and do something collaborative is quite tricky, obviously.
>
> “If you give someone 2 months to pull something together like this, then it often takes 2, 3 months - longer than that, even - to establish the relationship. So, what we've found is that where they've been able to realise the opportunity is where those relationships have already been established previously.”

Low service uptake or engagement

While not a universal barrier, low service uptake emerged as a concern in some areas, particularly for projects:

- involving digital tools
- with platforms targeting specific demographic groups
- involving new service models

This issue was identified as projects moved into the delivery phase and began actively engaging with target audiences. It therefore may be an ongoing issue as more projects move to that stage of delivery.

One system explicitly mentioned low service uptake in relation to the challenges of engaging hospital staff. For several systems, recruiting Shared Lives carers in core target areas or demographics was more challenging than expected. Another system noted lower-than-anticipated participation in the dual-support programme for carers and people with dementia, reinforcing the potential for low uptake, particularly for projects involving new or unfamiliar service models. The project lead said:

> “We've delivered what we set out to do, we've got the reporting and the feedback, it's worked very well for people who've used it. I think, you know, slightly overambitious in the number of people but better outcomes and impact for the people that did receive it.”

These experiences highlight the importance of ensuring that services are accessible, user-friendly and meet the needs of the target audience. Co-production was seen as a potential mitigating factor to support this - however, even with effective co-production, there could still be challenges with service uptake. Co-production can enhance the relevance and appropriateness of services, but it does not guarantee engagement. Other factors, such as accessibility, affordability and awareness, can still influence whether people actually use the services designed through co-production.

Further investigation is needed to understand the complex interplay between co-production and service uptake, and to identify strategies for maximising engagement, even in co-produced projects.

Supporting delivery

This section provides findings related to the elements of the fund that were designed to support innovation delivery: the funding model, guidance and support offer.

Funding model

The funding model for the fund is based on distributing money through groups of local authorities defined as consortia, grouped within ICS footprints, with a lead local authority receiving funding - see, for example, the Accelerating Reform Fund 2024 to 2025: grant determination

This model was generally seen as a positive feature of the fund by most stakeholders, fostering collaboration between local authorities that led to joint projects and shared learning. Consortium representatives in particular focused on the broader strategic benefits of the ICS model, such as fostering system-wide thinking and enabling the scaling of initiatives.

However, the model also presented challenges. Requiring partnerships within ICS footprints sometimes resulted in forced or unsustainable collaborations, particularly when local authorities had differing priorities or working styles. Limited funding spread across multiple projects within a consortium also potentially hindered individual projects from achieving significant scale and impact, particularly in ICSs covering large numbers of local authorities. Concerns arose regarding the exclusion of geographically distant authorities that might have been suitable partners, limiting the diversity of needs and priorities.

A project lead said:

> “The idea of trying to get one fund across 13 local authorities and only having one bid and then you have areas where you've only got one or 2 local authorities in ICB and giving them the same amount of opportunity to bid, that's a bit weird, isn't it?”

A consortium lead said:

> “Distributing the funds to partners has been a massive delay… getting the legal agreement… has taken a very long time.”

The impact of the funding model was clearly influenced by pre-existing relationships, strengthening strong relationships but exacerbating tensions in weaker ones. Overall, simply allocating funding within an ICS footprint did not guarantee effective collaboration or innovation. As discussed in 'Collaboration' in 'Enablers to implementation and delivery' and 'Lack of collaborative and partnership working or differing needs within large geographical

footprints' in 'Barriers to implementation and delivery' (both above), success depended on pre-existing relationships, strong leadership and sufficient capacity to work together effectively. 'Collaboration' describes some of the procurement challenges that arose from working across organisations.

In addition to the funding being delivered at an ICS footprint, systems also valued other aspects of the funding model, as follows.

The requirement to use the funding for innovative projects

Within the context of stretched and limited adult social care budgets, many interviewees described a general reticence to spend money on innovation or to prioritise this over ‘business as usual’ requirements. Therefore, the dedicated fund for innovation enabled them to experiment and try out new approaches.

Flexibility with how the funding was used

This included flexibility for systems to carry over money across financial years as well as there being minimal constraints around how and when the money was used. This enabled them to implement something that best fits the needs of their system.

The option to use the funding to scale existing initiatives

In cases where projects were being scaled, the ability to build on existing infrastructure enabled projects to be implemented more quickly and efficiently than if starting from scratch. Around half of systems were doing some form of scaling: 1 in 5 survey respondents (16%) said they were primarily using the funding to scale existing initiatives, and a third (32%) were doing an equal mix of scaling and setting up new initiatives. Half (52%) were using it primarily to set up new initiatives.

As projects progressed, the delay in the second tranche of funding negatively impacted many projects, causing delays and disruptions and highlighting the model's vulnerability to external factors. However, the flexibility to carry forward funds mitigated some financial challenges. This reinforced the need for careful management to ensure effective and equitable resource distribution:

As evaluation fieldwork progressed, systems also continued to report co-ordination and implementation challenges. Aligning priorities and working practices across multiple local authorities, especially in larger or more diverse ICS areas, remained difficult. Project leads highlighted the practical challenges of co-ordinating activities and navigating differing service models and working practices across local authorities.

Ultimately, the ICS footprint funding model had a positive impact, facilitating collaboration and resource sharing while also creating co-ordination, implementation and funding

distribution challenges. For some systems, success hinged on pre-existing relationships, dedicated project management, clear communication and the ability to navigate local variations. A consortium lead said:

> "I think I mentioned this last time as well, but we had quite an established network of carer leads already, and that was linked to the ICB. In fact, yes, I suppose, and even before then, actually, but we already had a number of established links. I think, importantly, that included the ICB is probably a better way of putting it. So, when this money came in on an ICB footprint and for carers on an ICB footprint, we already knew the people who needed to be involved in that."

Fund guidance

Throughout the project lifecycle of the ARF, the 12 national priorities established by DHSC in the Accelerating Reform Fund for adult social care: guidance for local authorities significantly shaped project selection, design and implementation. From the initial stages, systems reported using the priorities as a framework to identify projects that aligned with national goals while also addressing local needs. This framework:

- guided decision-making
- encouraged strategic project selection
- ensured a focus on the most important areas within adult social care

The emphasis on identifying and supporting unpaid carers - a prominent theme within the priorities - was consistently welcomed and resulted in a diverse range of carer-focused interventions. These included:

- digital support platforms
- expanded grant schemes
- combined service models offering both carer training and support for those they care for
- projects focused on improving hospital discharge processes and carer assessments

The priorities also influenced the types of innovations pursued, notably promoting the exploration and adoption of technology and digital solutions, such as:

- AI-powered tools

- digital platforms for carer support and information
- the integration of digital records into existing services

The flexibility built into the priorities was consistently highlighted as a strength. This adaptability enabled systems to tailor interventions to local needs and explore innovative solutions, fostering a balance between national direction and local ownership.

The fund was designed in such a way as to give maximum space and discretion to systems to use it as they wished and not constrain innovation or create unnecessary reporting. Systems broadly liked this - however, it is notable that some would have preferred a tighter, more controlled approach with more guidance. Particularly during the initial stages of project development, some systems commented on the lack of clear guidance and support from DHSC. While clear guidance on funding timelines and reporting requirements was mentioned, some systems would have liked more formal guidance around areas of funding management and delivery.

Several consortia representatives criticised the lack of defined budgets per project and the expectation that project leads would develop plans and costings without sufficient guidance. This made it difficult for systems to effectively allocate resources and manage expectations. A project lead said:

> “I suppose some of the things that I would suggest could be improved for the future, going back to my point about, sort of, more clarity and guidance about what the money could and should be used for.”

Several systems expressed a desire for greater clarity regarding DHSC’s long-term vision for the fund and its expectations regarding sustainability. One system, for example, sought more information about DHSC’s expectations regarding long-term funding and the potential for scaling successful initiatives. Systems expressed a lack of clarity about what DHSC wanted to achieve from the fund and their longer-term vision for transformation in adult social care.

A project lead said:

> “It would be really useful to know what the follow-on is going to be, what the expectation from DHSC is. Is this something that they're looking for innovation for their practice, for national practice, or is it just to enable local places to be able to come up with new ideas, and new ways of doing things for themselves?”

A consortium lead said:

> “If DHSC want transformation, what transformation do they want? They've got a different viewpoint to us, haven't they?”

However, it is recognised that the political context during the ARF’s delivery period introduced significant complexity. The programme spanned a period of substantial political change, including a general election and a change of government. This likely constrained DHSC’s ability to articulate a long-term strategic vision with certainty or consistency.

SCIE support offer

Support delivery

Over the course of the fund, SCIE has delivered support to consortia through a variety of channels, including:

- webinars
- events, such as:
  - National Children and Adult Services Conference
  - NHS England Carers’ Conference
- thematic and topic-specific workshops
- bespoke targeted and general support
- CoPs
- a dedicated Accelerating Reform Fund programme webpage and email communications

SCIE set up and worked with both a stakeholder advisory group and co-production 'Experts by Experience' group to advise on both the support offer and fund, and helped to raise the profile of the fund more broadly though communications, media and social media channels when possible.

SCIE was appointed to provide hands-on support to local areas, supporting innovation through local partnerships and project development, and sharing significant learnings and best practice for the benefit of the wider sector and future of adult social care. SCIE's support role has been as a learning and engagement partner. Specifically, SCIE's overarching objectives were to:

- identify enablers and barriers to innovation in social care

- maximise enablers and overcome barriers to innovation
- ensure local authorities gain shared learnings, peer support and expert insights

The initial offer from SCIE provided support and communications during the EoI and application process, which took place between October 2023 and January 2024. All 153 local authorities engaged with SCIE over this period with 149 actively participating in webinars and events.

Between April and October 2024, 16 workshops were held (focused on specific challenges identified from the EoIs) and were reported by SCIE to be well attended. While these sessions provided a valuable platform for information sharing, feedback suggested that depth of engagement and impact were limited by the fact that many projects were at an early stage. This highlighted a need for more tailored support that could address the specific challenges faced by projects at different stages of development.

SCIE developed the support offer, in consultation with DHSC, by building on the insights gained from initial support activities and ongoing data collection including:

- webinars
- surveys
- DHSC ARF mid-year reports
- ad hoc support requests
- provider interviews
- iterative feedback from Ipsos

This included developing communities of practice and focusing targeted support on a small number of projects to gather in-depth learning.

Communities of practice (CoPs)

In the second phase of support, SCIE introduced CoPs centred around 4 themes relevant to the ARF projects. These CoPs involved workshops, conducted through Microsoft Teams and online Teams channels to facilitate peer learning, collaboration and information sharing. The themes included:

- co-production
- Care Act compliance

- hospital discharge
- digital self-service

Overall representatives from 27 of the 42 consortia attended at least one CoP workshop. Participants specifically valued learning from the experiences of other regions and consortia, hearing about shared challenges, and being exposed to innovative ideas that inspired reflection on their own practices.

However, feedback also indicated areas for improvement and SCIE used this learning from the workshops to shape the targeted support offer.

SCIE's targeted support offer (October 2024 to March 2025)

SCIE launched a targeted support offer from October 2024 to March 2025, approved by DHSC. This offer was designed to provide bespoke, hands-on assistance to 20 ARF projects in addition to the other broader forms of support offer.

The selection of projects for targeted support was based on the following criteria to ensure a diverse representation of themes, locations, project stages and approaches:

- self-identified challenges - projects that had reported challenges during the mid-grant reports
- recent engagement - projects that had recently reached out to SCIE for specific support
- SCIE's assessment - projects identified by SCIE as needing or benefiting from support based on their progress, scope and potential impact. This included potential to address DHSC's main priorities, alignment with the government's 10 Year Health Plan for England: fit for the future, and project commitment to co-production and stakeholder engagement

By March 2025, SCIE had:

- sent out 21 initial support offers
- conducted 19 discovery meetings
- moved 15 projects into the planning stage
- had 13 projects in the execution phase

Four projects had successfully completed the support process by this stage.

For the targeted support offer, SCIE approached each identified project or consortium with a brief proposal outlining potential support areas and offered an initial diagnostics meeting to co-create ongoing support needs. Projects were then offered up to an average of one day (7 hours) of support per month, outlined below.

The main themes for anticipated support requirements that were identified by SCIE and informed its initial targeted offer included:

- co-production and stakeholder engagement: facilitating meaningful co-production and effective stakeholder engagement through workshops, drop-in sessions and hands-on support

- project planning and governance: providing tools, templates, and guidance on project management, governance structures, and compliance with legal and grant conditions

- digital solutions and innovation: connecting projects with digital providers and offering advice on digital strategy and execution

- sustainability and impact evaluation: helping projects develop clear theories of change and impact frameworks and providing resources on impact evaluation and sustainability planning

- collaboration and partnership-building: facilitating joint-working and peer support across local authorities and ICS consortia

While SCIE reached out to projects with an initial support offer based on its analysis, some projects instead proposed areas where they felt they needed more support. These included meeting co-ordination and follow-ups, project management support, and additional support for carer engagement and co-production.

In addition to the webinars, CoP workshops and one-to-one support, SCIE provided dedicated support for co-production, including:

- involving its Experts by Experience co-production group

- reviewing co-production plans

- offering advice and guidance

- running dedicated workshops and one-to-one support sessions

SCIE also facilitated peer learning and collaboration through various activities, including:

- workshops designed to connect projects with shared challenges (separate from the CoPs)
- promoting interaction and contact sharing
- using its website to highlight projects and encourage networking

Furthermore, SCIE collaborated with Social Finance, a non-profit supporting the design, funding and scaling of social issues in the UK, to deliver workshops focusing on the sustainability and scaling of ARF projects.

SCIE also played a role in connecting projects with relevant providers. A survey of projects revealed that many had engaged providers such as Looking Local, Carers Trust, Shared Lives Plus, Bullet AI, Mobilise and Agilisys Transform.

Although the formal funding period has ended, SCIE will be providing a small amount of ongoing targeted support to around 12 ARF projects during 2025 and 2026. Furthermore, 4 projects have approached SCIE independently to commission ongoing support.

Engagement with the support offer

The majority of systems had engaged with the SCIE support offer in some form, which spans active engagement with events and webinars as well as passively receiving email communications from them. Engagement with the support offer often varied by stage of the project life cycle and type of support.

Those who did not engage with the support offer cited a range of reasons for this. These are discussed in more detail in 'Reasons for non-engagement' below.

Timing of engagement

The majority of consortium representatives and project leads engaged with the support offer at discrete points during the project life cycle, choosing to engage with support they saw to be most relevant to their individual needs. Typically, most consortia engaged with the support offer at either or both of the following points:

- at the early stages of project scoping and implementation: consortia drew on support from SCIE during the process of writing their EoIs and when scoping their projects. They also engaged with early sessions related to specific subjects such as project evaluation and ToC development. SCIE representatives explained that these early workshops were well attended and participants were keen to learn what other systems were doing

- towards the end of the funding period, when CoPs were set up: a number of consortia engaged with the CoP workshops (although limits on participant numbers at the initial sessions meant only a few representatives attended from each consortium). For some, this was the first time they had engaged meaningfully with the support offer. Echoing this, SCIE representatives felt that the engagement through the CoPs was more meaningful for some consortia compared with earlier engagement as projects had progressed more by this point so there was more to share. However, they also noted that engagement with the CoPs fluctuated. Initial workshops were well attended but subsequent engagement with the online Teams channels was lower. A SCIE representative said:

  > "Coming closer to the end of the programme, we got a lot more engagement from projects reaching out...our communities of practice have up and down engagement. It started off really, really well...but then we put up Teams channels for each of the 4 different themes, communities of practice we had, and that was less well engaged."

Consortia who accessed one-to-one or bespoke support from SCIE tended to report having an ongoing relationship with SCIE rather than accessing one-off support at specific points. These consortia described sharing and receiving ideas, thoughts and feedback with SCIE on an ongoing basis, throughout the project life cycle.

SCIE representatives explained that fewer consortia received this one-to-one support but that it was comparatively more impactful than other types of support being delivered. They also described how the demand for one-to-one support increased significantly as projects moved into the delivery phase.

However, this surge of enquiries happened as SCIE's support offer was drawing to a close (in February to March 2025) - therefore, their ability to deliver this support was limited by the capacity they had available in this short timeframe.

Types of support accessed

The majority of survey respondents had engaged with the SCIE support in some way and, most commonly, this involved:

- receiving email communications from SCIE (66% of survey respondents in the latest wave of fieldwork had received emails from SCIE)

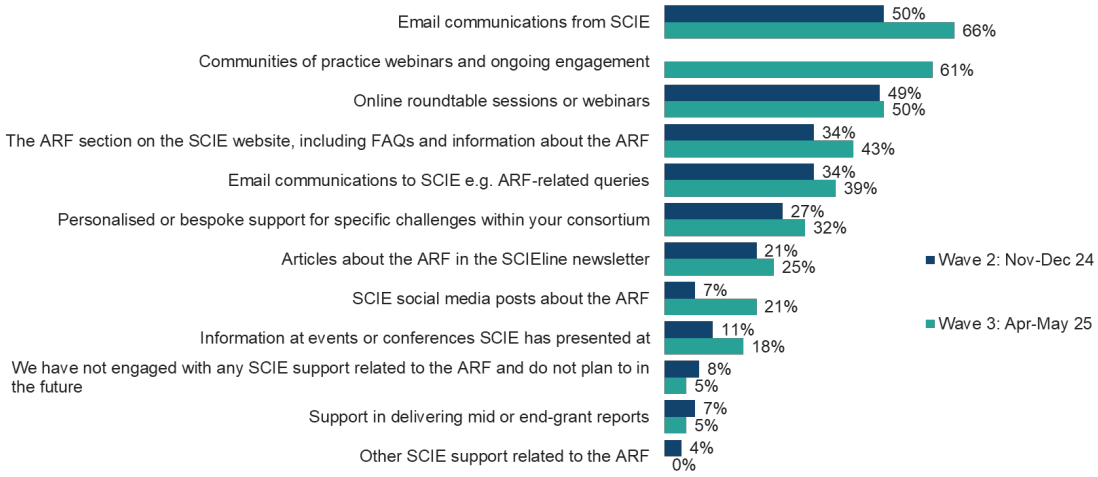
- attending CoP webinars or ongoing engagement (61% in latest wave)

Fewer engaged more actively with the support offers (for example emailing SCIE or receiving bespoke support).

At the latest wave of fieldwork (towards the end of the funding period), reported engagement with most types of support had increased compared with the previous wave of surveying. This may demonstrate increased levels of engagement as projects entered the delivery phase.

Figure 3: SCIE has offered support to help consortia develop project proposals and expressions of interest. Which, if any, of the following have you engaged with from SCIE?

Sample: all respondents who answered this question (wave 2 had 90 respondents to the survey, wave 3 had 56 respondents).



Sample sizes for the survey are low so sub-group analysis should be interpreted with caution. However, survey respondents from consortia that are primarily using the fund to set up new initiatives are more likely to have accessed personalised or bespoke support from SCIE (11 of the 29 respondents who are setting up new initiatives said they accessed it), as well as those who are doing an equal mix of new initiatives and scaling existing ones (6 of 9 respondents), compared with those who are solely scaling existing initiatives (1 of 18 respondents).

In early interviews, consortia representatives called for additional support from SCIE, with some identifying the need for more tailored, one-to-one support to address specific challenges. Learning from this and other feedback, SCIE developed its support offer to include more targeted support.

During the later wave of interviews, after this new type of support had been offered, a number of interviewees described tailored support they had received. Examples included:

- setting up connections with other local authorities to facilitate peer learning, sometimes grouping together those working on similar projects, and allowing consortia to share experiences in SCIE workshops

- SCIE working with their consortium to develop and produce materials and outputs, including producing a how-to guide or a case study and offering feedback on training materials

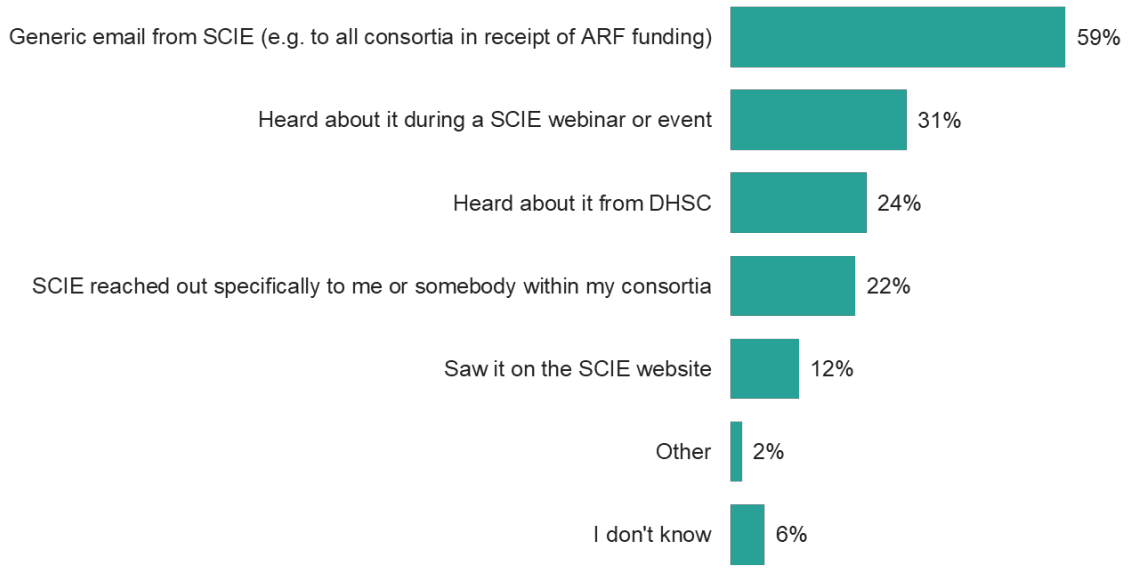
- engaging with delivery partners directly including doing site visits, conducting an in-depth review, and producing a case study and a film

Survey respondents heard about the support offer though different and sometimes multiple channels, mainly through SCIE. The majority (three-fifths) heard about it through generic emails from SCIE and just under a third heard through SCIE webinars or events.

Other ways in which respondents heard about the offer through SCIE included through individual contact from SCIE or on the SCIE website. About a quarter heard about the support offer through DHSC.

Figure 4: how did you find out about the SCIE support you accessed?

Sample: 49 survey respondents who reported engaging with the SCIE support offer.



Reasons for non-engagement

Interviews with consortium representatives and project leads highlighted the reasons why some of them had not engaged with the support offer at all or had not done so meaningfully. For context, the survey showed that only a small minority (5%) had not engaged at all. While some may have engaged more passively with the support offer (for example, only receiving emails from SCIE), a third had engaged actively with the support as they reported received bespoke or personalised support (32%)

Reasons for not engaging at all, or not engaging meaningfully, cover both reasons related to the:

- consortia and projects
- support being offered by SCIE

The main reasons in relation to the consortia and projects were:

- a lack of capacity within the consortia: some felt they did not have enough time to engage with the support offer or felt that the value provided by the support offer was low so therefore not worth taking the time to engage with
- staff turnover within consortia: one consortium noted that staff changes meant that offers of support from SCIE were not followed up on
- support not being needed: in cases where the projects were viewed as straightforward, consortia representatives felt they did not need any additional support from SCIE. In other cases, representatives explained they did not need support because they already had the right infrastructure to deliver their projects, measure impact and co-produce solutions. A project lead said:

  > "Our projects, for us, felt fairly self-contained and so we didn't feel the need to, kind of, dive into lots of that additional resource."

- project maturity: SCIE interviewees explained that timing impacted levels of engagement. Early in the programme, many consortia did not engage meaningfully because they were in the design phase and did not know what support they needed. This was further impacted by the general election and delays with tranche 2 funding payments which stalled progress in many cases. However, as projects matured, their need for tailored support became clearer, leading to a surge in demand for one-to-one support before the SCIE support offer ended in March 2025 when many projects had not yet reached the delivery stage

SCIE representatives described how, in one instance, a lack of engagement and interest from consortia had led them to cancel a co-production session for Shared Lives projects facilitated by people with lived experience.

In some cases, concerns about the communication from SCIE led consortia representatives to lack confidence in the support offer as a whole. These individual systems gave some specific examples:

- meetings being cancelled and not rescheduled. In some cases, this was due to the general election and the pre-election period, which interfered with delivery plans and meant in-person meetings were changed to later online sessions

- a lack of follow-up with resources that were promised to consortia. One consortium said they were promised a project planning template, which was not delivered. They waited for this and then later found there was no template. However, in this instance, the consortium did not follow up about this, which could reflect their own levels of capacity

- the main SCIE point of contact leaving the organisation and this not being effectively communicated to consortia (the interviewee did not specify which point of contact this was), followed by a lack of proper introduction to the new replacement

- events and support sessions being advertised too late for consortia to be able to attend in a small number of cases (examples included the CoPs webinar)

Additionally, some felt that the support was not relevant enough to their needs. Examples of this included the early project planning sessions (particularly where consortia already had experienced project managers working on the project) and sustainability sessions. In some cases, this led support participants to be more selective about engaging with later sessions.

Experience of the support offer

Impact of the support offer on project design and delivery

Based on interviews with consortia representatives, at the scoping and design phase, the SCIE support was seen to help consortia:

- design their projects: communications from SCIE around the requirements helped consortia shape the design of their projects in line with Fund guidance

- translate ideas into concrete project plans: for some, SCIE supported them to turn their ideas outlined in the EoI into project plans, facilitating project set-up. However, the extent to which SCIE support could have an impact here depended on the maturity of

the project plans, a number of consortia already had clear plans in place or were building on previously developed plans so did not draw on SCIE support

- draw on expertise to inform project development: when SCIE put consortia in contact with experts such as specialists in developing co-production techniques, this enabled consortia to draw on their expertise and use it to develop their projects

At the project implementation and delivery phase, the SCIE support was seen to help consortia:

- share knowledge with other consortia and identify solutions to challenges: SCIE facilitated knowledge sharing between consortia which enabled them to 'shortcut' decision making by learning how others had addressed challenges

- feel reassured about their plans and progress: interviewees reported feeling reassured about their pace of work and approaches as a result of hearing other consortia's plans and progress, it helped them to feel confident and reduced feelings of isolation. A project lead said:

  > “That sharing of progress is really where it's been the most valuable to us in terms of seeing how fast or slow the others are moving.”

- raise the profile of their work: In some cases, SCIE assisted with sharing the work being done by consortia more broadly, helping to raise their profile and communicating to other organisations interested in doing similar work

- scale projects: linked to the point above, in one case, SCIE offered bespoke support by helping promote the work being done by a consortium to other organisations with the aim of selling these products. A project lead said:

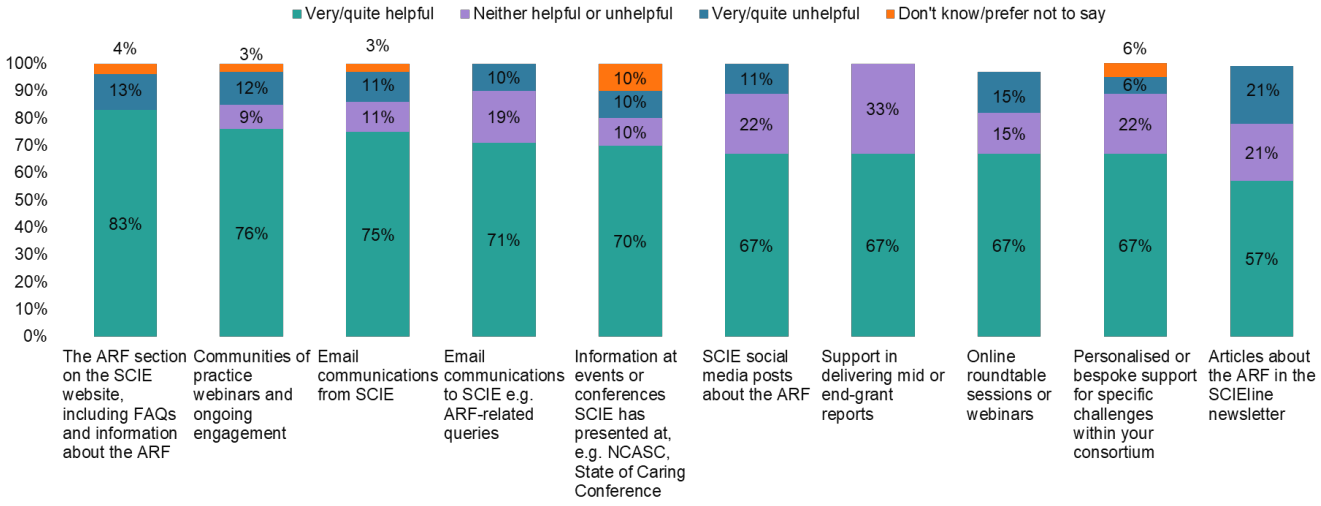
  > "With this promotional video, which has been created… there's a lot of material which has been now created to support this promotional piece, SCIE are going to support us to scale this out and more or less sell it to other consortiums within the ARF fund because … we've created the foundation training and other councils [are able] to benefit from this, so there's going to be a charge around that because obviously that's an ongoing cost part of it and the scaling up."

Elements of the support offer that were most helpful to consortia

Survey responses from the latest wave of fieldwork indicate that most people who engaged with each type of support found it helpful. Support elements most often seen as helpful were the ARF section on the website, CoPs and email communications from and to SCIE.

Figure 5: how helpful or unhelpful did you find each of the following from SCIE?

Sample: survey respondents who engaged with each type of support.



When project leads were asked in qualitative interviews which aspects of the support offer were most helpful, this included:

- the initial webinars and early sessions outlining how the whole process would work. They explained that this provided clarity and set expectations
- the CoPs, which enabled consortia to share and learn from others
- one-to-one support. Consortia who engaged with this said it was especially helpful. This often related to sharing work more widely. Examples included:
    - SCIE promoting the consortium's work, developing how-to guides and case studies. This was seen to increase visibility of the work being done. A project lead said:

    "They've helped us with creating a case study which is on their website… they're also supporting us to create a how-to guide with the project... spreading the word they've been really, really helpful with."

    - SCIE working directly with a carers' organisation (a partner in their project) to highlight their work and share it, again raising visibility of their work
    - SCIE helping a consortium navigate their project timelines and manage delays

Extent to which SCIE support fulfilled aims and suggestions for improvement

The majority of those who engaged with each type of support from SCIE found it helpful. When asked about the impact of the support more broadly, only a minority of respondents agree that the support from SCIE in practice had each type of impact on their consortium, which may partly reflect that support was sought for specific purposes by each consortium (through attending a relevant CoP or tailored support).

The SCIE offer was most supportive in helping consortia to engage with peer-to-peer support and share learning with other consortia:

- around 2 in 5 (44%) of those who had engaged with the SCIE support offer in some form saying they did this a great deal or a fair amount
- over a quarter (28%) said the SCIE offer helped them facilitate collaborative partnerships within their consortium
- one in 5 said it helped them facilitate collaborative relationships with local systems partners (20%), involve local populations in developing their projects (20%) and overcome barriers to successful project implementation (20%)

There does not appear to be large differences between those who engaged with personalised support (18) and those who didn't - however, generally, those who did engage found the support offer more impactful across most areas.

For context, while the SCIE offer was available to all consortia, several interviewees told us they did not need support from SCIE.

Therefore, the group of people not answering 'a great deal' or 'a fair amount' includes those who received support, but who did not consider that they needed it in order to engage in the activities such as collaboration and peer learning.

It should also be noted that SCIE support was tailored to support systems with the particular areas they needed support with at that time, and so it could not be expected that the support offered would help every consortium with every type of activity. A project lead said:

> "It's something that I particularly haven't needed but, you know, I appreciate that's probably not the same for everyone."

Table 4: to what extent, if at all, has SCIE supported your consortium to do the following?

Outcome of SCIE support	Those who had engaged with the SCIE support offer in any way (% experiencing each outcome)	Those who engaged with SCIE's personalised or bespoke support (% experiencing each outcome)
Engage with peer-to-peer support and share learning with other consortia	44%	56%
Facilitate collaborative partnerships within your consortium	28%	33%
Facilitate collaborative relationships with local system partners	20%	22%
Involve local populations in developing your projects (co-production)	20%	28%
Overcome barriers to successful project implementation	20%	33%
Identify challenges to embedding or scaling innovation for your specific project(s)	18%	22%
Identify solutions to overcome barriers to embedding and scaling innovation for your specific project(s)	18%	22%
Develop project plans to meet the needs in your system	14%	22%
Engage with unpaid carers and address their specific needs	12%	6%
Sample size	50	18

Interviewees highlighted suggestions for improving the support offer so that a broadly well received offer becomes one that more often impacts on projects' delivery. These suggestions can be grouped into 3 broad categories:

- improved communication
- more tailored support
- more opportunities for partnership building

While some of these have already been offered by SCIE, this reflects the types of support that were seen to be most effective by consortia or that they were aware of.

Improved communication
Of the suggestions listed, improved communication came through most often. This was typically raised by people who had not received bespoke or personalised support. People who had received targeted support tended to be positive about SCIE's communications. Respondents suggested there was a need for:

- clearer communication about what SCIE offers and the support available earlier in the process: suggestions included outlining a 'menu' of support options available or updating the website more regularly with the full breadth of support available (although SCIE noted that their website was updated regularly, albeit with a pause at the request of DHSC during the general election period). Some consortia representatives explained that they were not aware of elements such as action learning sets until too late

- consistent communication: some consortia noted that there were periods where there was lots of communication and others where they did not receive any communication, which made it difficult to maintain ongoing engagement. While the interviewees did not specify when these periods were, as mentioned above, there were limits around communication during the general election period for 6 months which may have led to this. Some interviewees reported receiving quick and clear communications from SCIE, so views are mixed

- more interactive sessions: this includes considering whether some presentations could be shared through email to free up time for peer-to-peer discussions

More tailored support
A need for more tailored support came through in interviews frequently at the wave 2 fieldwork (before the rollout of CoPs). As above, it was typically raised by people who had not received any bespoke or tailored support. In wave 3, this was called for less, but some continued to want more tailored support. In some cases, when the timing was seen to misalign with project support needs, this was a barrier to engaging with the SCIE support.

The following suggestions were made:

- co-produce the support offer with local authorities: consortia felt this could ensure the support offer fits the support needs of consortia

- personalise communication: some felt that the generic emails deterred them from engaging and they would prefer communications that were tailored to their individual context

- offer one-to-one, tailored support: early interviews highlighted a need for more tailored, one-to-one support and as a result the support offer was adapted to offer

bespoke business support and CoPs set-up. These were generally viewed favourably with three-quarters of survey respondents finding them helpful. A similar offer in future could benefit from being tailored

- consider timing of support: there are challenges associated with supporting a large cohort of consortia at different stages of delivery. Considering the best timing for the support would ensure it has maximum impact as some consortia felt this misaligned with their support needs, for example guidance on project delivery being shared after a project had already been implemented

- provide more support related to project sustainability for those who are trying to secure longer term funding as this needs to be built into the design of the project and the way in which evidence is gathered for developing future business cases

- be more proactive in offering support and provide strategic advice: this would ensure they could offer maximum support. Those who had engaged with one-to-one support especially valued the role SCIE played as a 'critical friend', so this is something to prioritise in future

More opportunities for partnership building

Many interviewees felt that SCIE was already supporting partnership building (typically those who had attended workshops or CoP sessions), and it was something they really valued. They called for more opportunities to do this such as:

- even more structured opportunities for peer learning: building on the opportunities established by the CoP sessions - for example, grouping together consortia working on similar projects to learn from both successes and challenges

- more face-to-face opportunities to meet with other consortia: one interviewee was disappointed when the sessions which were scheduled to be in-person were amended to virtual sessions (due to external factors related to the general election and, after that, as a result of a decision to boost attendance) as the face-to-face sessions were valued. It is worth noting that other systems felt that delivering sessions online made them more accessible and easier to attend

- creating opportunities for consortia to link up with each other directly: for example, by providing a centralised directory or list of all ARF-funded projects, more proactively setting up networking opportunities, or 'buddying up' similar projects to maximise learning and avoid duplication of effort. SCIE noted that it had wanted to do this, but its ability to do so was limited by data protection restrictions

- considering the size of CoPs: one interviewee felt that having larger groups attend the CoPs would facilitate more productive conversations and expose people to a

diversity of perspectives. SCIE noted that groups were formed around the focus of projects, so the group sizes reflected the number of projects being delivered in each area

Factors limiting the impact of the support offer

Interviews with SCIE representatives highlighted the factors that constrained the impact of the support offer. These were:

Resource and time constraints

These meant that SCIE could not proactively contact all consortia individually throughout the process, even though this could have benefitted project delivery. SCIE reported that there were too many projects to support within a limited timeframe (particularly with the support offer being interrupted for the 2024 General Election).

The uncertainty around the second tranche of funding delaying project set-up had a knock-on effect as it concentrated requests for help once projects were in the delivery phases, towards the end of the support offer. An SCIE representative said:

> "In an ideal scenario, what we would have wanted is to embed ourselves more into the projects, so that we get to know what they are doing at any given point, and also be able to predict challenges that they may have based on the learnings that we have had from other projects and be able to almost offer the support before they face the challenge, rather than wait for them to get to a point where they struggle with it."

Better reporting and access to data

While SCIE had access to the central reports collected by DHSC (mid and end-of-grant reports), it felt that having access to more project-level detail much more regularly would have helped it keep track of what individual consortia needed at a given time and design more responsive support.

Information-sharing and administrative limitations

Limits around information sharing between systems made it difficult to share learning across systems, and the administrative processes required to share information between DHSC, SCIE and Ipsos impacted SCIE's ability to shape the support offer. A SCIE representative said

> "I think this can be achieved through a reporting system that allows us to know as much about the projects as possible. Because I think from one of our surveys where we asked projects why they haven't accessed support, some of them indicated that, 'We plan on accessing support when we reach

> a certain stage.' But if we don't have a way of knowing when they have reached that stage, we might lose them, like, they just get lost to follow up."

Lack of a clear description of the offer
Lack of clarity around SCIE's offer and whether or not it was a service for which consortia would need to pay.

Overly broad project eligibility
The large number of projects being funded meant that only a minority were selected for targeted support when more projects may have benefited from it.

SCIE representatives suggested that, if the EoI process was adjusted to reduce the number of successful projects in receipt of funding, this would enable it to provide more hands-on support as it would have capacity to do this. A SCIE representative said:

> "Working with a smaller number of projects would definitely allow us to give more focus and attention to each and every project and be as embedded in their work as possible. And I think it would also allow us to create… smaller groups that can collaborate, that are working on common areas, be it hospital discharge, or Shared Lives."

Outcomes and impact

This section details findings related to the outcomes and impact generated by the fund to date, with reference to:

- what the ToC identified as the intended outcomes
- the potential for the future sustaining and scaling of innovations

Measuring outcomes and impact

The evaluation has assessed projects' perceived ability to measure outcomes and the processes they have in place to do this.

Survey respondents were asked about each project in the consortium during the third wave of fieldwork. This means that, for the project-level analysis, there are 116 projects reported on by 50 respondents.

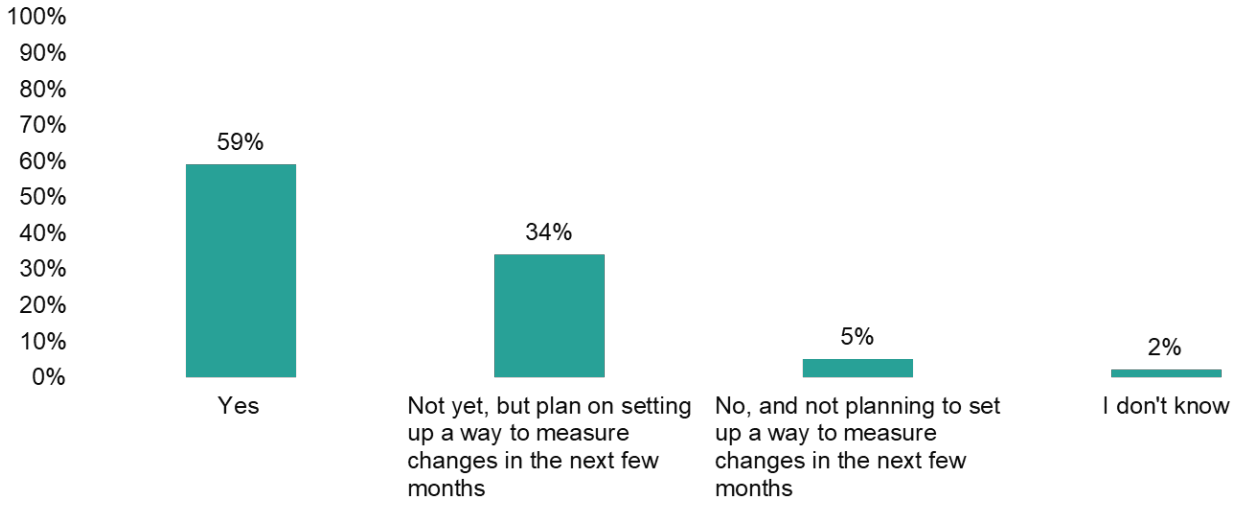
Measurement approaches and data collection

Three-fifths of projects (59%, 68 out of 116 projects) were reported to have established systems for measuring changes (such as outputs, outcomes and impacts). However, one-third (34%, 40 projects) are still developing their approaches, and a small number (7%) were reported as not having or planning to implement outcome measurement systems.

This mixture of measurement maturity reflects the varied nature of projects, with 52% primarily setting up new initiatives, 16% primarily scaling existing ones, and 32% pursuing a mix of both. A majority of survey respondents (69%) reported not facing challenges in evaluating their projects, indicating confidence in their existing processes.

Figure 6: do you have a way of measuring any changes as a result of your ARF project?

Sample: all survey participants from the wave 3 survey, representing 116 projects.



The survey findings align with findings from the 'Accelerating Reform Fund: local impact assessment analysis report' where projects in the earlier stages of development (scoping and design) often lack structured measurement processes. Early-stage projects (those in scoping and implementation and set-up phases) frequently report anticipated outcomes but have limited evidence of impact to date.

Methods and indicators

Projects with established measurement systems, according to the survey, use a mix of quantitative and qualitative methods.

Monitoring data (87%), such as the number of carers registered or service uptake, provides a readily available measure of project activity.

Qualitative methods, including interviews or case studies (61%) and surveys or feedback forms (54%), are also frequently used to capture the lived experiences of carers. For example, one project used innovative qualitative methods like letter writing after each session to capture carers' reflections, demonstrating a commitment to gathering rich, personal insights. One carer wrote (reported by a project lead):

> "The difference it has made is astonishing."

Data collected by partners (45%) and data integrated into digital tools (42%) also contributes to outcome measurement, offering different perspectives and levels of detail.

The analysis of local impact assessments confirms these findings, with technology-focused projects leaning towards quantitative metrics and relational or community-based projects favouring qualitative feedback. This aligns with the insight from the local impact assessments that technology and digital platform projects tend to show earlier and more measurable outcomes, while Shared Lives and community-based models often rely on qualitative evidence and may take longer to demonstrate impact.

Challenges associated with capturing and reporting outcomes

Despite these efforts, a quarter of survey respondents reported facing challenges in evaluating their projects. Qualitative interviews revealed several barriers including:

- short timeframes meaning it is too early to observe outcomes
- attribution difficulties
- limited resources
- lack of evaluation expertise

A consortium lead highlighted the resource constraints:

> "Everyone that has delivered on all of the projects… has done it as part of their day job."

This quote emphasises the challenge of dedicating sufficient time and resources to evaluation when project delivery is layered on top of existing responsibilities.

Participants highlighted the difficulty of attributing outcomes to specific interventions within complex systems and the need for more robust evaluation methods that account for external factors. This challenge is further reflected in the local impact assessments, where a notable number of projects, especially in the early stages, report anticipated outcomes without clear supporting evidence. As projects move towards generating medium and long-term outcomes, which are more dispersed across health and care systems, the issue of attribution may become more salient.

Early positive changes are emerging, particularly in projects at higher maturity levels. Analysis of local impact assessments shows that projects in the later stages of maturity (3 - project delivery and 4 - impacts emerging) have processes in place to gather quantifiable and qualitative evidence of outcomes. This is supported by qualitative interview data, where project leads described being able to observe tangible outcomes in projects where delivery was well established.

Furthermore, survey data shows 43% of all projects have observed changes, either through their measurement tools or informally. These changes commonly include:

- positive impacts on carer wellbeing
- increased carer identification and support
- improved hospital discharge processes
- enhanced collaboration

Importantly, the presence of robust measurement systems and processes in the earlier stages of project maturity (levels 1 to 3) is associated with projects progressing to these higher maturity levels, as evidenced by both interviews and impact assessments.

Local impact assessments suggest that, as with the survey data, projects using existing work reported faster progress and early outcomes compared with those developing entirely new initiatives.

The type of project also influences the outcomes being measured and the type of evidence used. For example, technology-focused projects often track digital engagement metrics and use quantitative data, while Shared Lives projects focus on carer recruitment and placement numbers and favour qualitative feedback. Local impact assessments also indicate that Shared Lives and community-based models often rely on qualitative evidence and may take longer to demonstrate impact.

Outcomes

Despite the relatively short timescales and barriers, many projects are now reported to have achieved outcomes, based on feedback from consortia and project representatives, alongside evidence submitted in local impact assessments.

The main outcomes for which evidence of achievement is available - across survey responses, stakeholder interviews and local impact assessments for each project category (as described in the 'Implementation and delivery' section above) - are outlined below by project category group.

Setting up or implementing technology or digital platforms (41 projects)

Implementing technology and digital platforms is the most common project category group (category one), with many systems using the fund to:

- set up platforms to identify and provide support to carers

- provide online support functions such as service directories
- (in fewer cases) provide technological adaptations within homes

The projects that introduced online support platforms have received good engagement and are starting to use the new data being generated as a result. The projects introducing technological adaptations have shown early signs of finding more efficient ways of providing care.

These included the following examples:

- improved identification of carers: one project using an AI tool identified 2,000 previously unknown carers and another identified nearly 16,000. A third project achieved a 64% success rate in identifying carers at risk using AI
- increased carer engagement and empowerment: carers are engaging with digital tools as intended, feeling more in control of their lives. Digital platforms are facilitating earlier and more structured support at the point of hospital discharge
- improved access to information and services: some projects have provided a community directory which has evolved into a system-wide resource, incorporating health and social care partners
- adaptations providing more efficient, accessible support: a digital home care project using devices used to provide contact with carers and family members through touch screens reduced the need for physical domiciliary care visits, freeing up capacity and reducing social isolation
- data-driven insights: data from digital platforms is providing insights into carer needs and behaviours, informing service development and strategies

Identification and assessments for carers (20 projects)

At this stage, most projects involving identification and assessments for carers (category 4) are simply reporting that they have identified more carers, and that these carers are now accessing remote, online support. While only an output, this is having follow-on effects for some systems by allowing them to plan for unmet need and improve engagement in other important processes such as co-production. Such projects have cited:

- increased identification of hidden or unknown carers: several projects reported significant increases in the identification of previously unknown carers

- improved engagement with carers: co-production of carer assessment tools led to positive engagement and carers feeling heard. Outreach programmes resulted in in-depth conversations with carers and connections to relevant support. A project lead said:

  > “It’s allowing really quite light-touch support to them… we’re seeing some numbers come through of people who have then been referred onto a carer centre or onto the local authority.”

- increased referrals to support services: projects reported increased referrals to adult social care and other community-based support services

Providing carer breaks, respite or other forms of support for carers (35 projects)

The small number of projects supporting carers (category 2) demonstrate outcomes reported significant positive feedback from carers, and improved health, wellbeing and confidence. Often grants and other forms of support were used to provide respite or fund improvement that enabled unpaid carers to provide care more effectively and easily. These projects have reported:

- improved mental health and wellbeing: carers across several projects have reported improved mental health, reduced social isolation and increased time for themselves. Grants enabled sustainable improvements, such as purchasing technology or home improvements. A project lead relayed how a carer even became a self-employed driving instructor:

  > "We saw there was a carer who used the grant to help them to pay for driving lessons and then eventually become a driving instructor.”

- increased confidence and coping skills: carer breaks helped carers gain confidence to leave their cared-for person, preventing crisis and carer breakdown. Carer-led hubs and training provided practical skills, preventing injury and stress

- increased social contact and life satisfaction: one project reported a 69% increase in carers feeling they have enough social contact and a 52% increase in life satisfaction

Hospital discharge (11 projects)

This relatively varied and smaller group of projects focused on improving various aspects of the hospital discharge processes involved in care provision (category 5). Most commonly, these projects improved the sense of involvement and direction that carers had in these processes. Hospital discharge projects have reported:

- increased awareness of carers' roles: across several projects that involved training staff, hospital staff reported greater confidence in engaging with carers following awareness training

- increased referrals from hospitals: two projects saw a rise in referrals from hospitals that had not previously referred carers

- empowerment of carers: carers are more confident in asking questions and challenging discharge processes

- earlier and more structured support: projects facilitated earlier and more structured support for carers at the point of hospital discharge

Shared Lives (25 projects)

These projects were predominantly focused on the recruitment of Shared Lives carers (category 3). In most cases, they achieved this, with some isolated examples of projects finding it difficult to do so. Reported outcomes are:

- increased recruitment of Shared Lives carers: nearly all Shared Lives projects were focused on the recruitment of new carers, often targeted at recruiting Shared Lives carers for specific cohorts such as young people in receipt of care and care leavers. In many cases, projects have been successful in recruiting small numbers of new carers in targeted areas. Eight projects included in the survey responses reported this as an outcome

- enabling specific long-term placements: three individuals reaching adulthood were able to remain with their foster carers long term through the foster carers becoming Shared Lives carers

- improved person-centred planning: digital care records enabled more person-centred planning and engagement in Shared Lives placements

- improved collaboration between teams: one project led to improved collaboration between city and county Shared Lives teams, including shared assessments and joint recruitment

Community-based care models (9 projects)

Community-based projects (category 6) are the least common and most varied within the fund, and therefore harder to assess outcome achievement. Suggested outcomes include:

- improved local access to care: most commonly, these projects improved the range and access of community-care options to people and their carers

- empowerment of communities: community-based models empowered communities to manage care, and deliver support, independently of the council. A consortium representative said:

  > “People are getting information locally, avoiding and preventing delay in them coming into us… the biggest outcome is that they are enabled to sort things out like adaptations and community groups through other channels."

- development of specific local resources: in some isolated cases, projects led to the creation of local care directories, ID badges for volunteers and carers, helplines and community dinners

Which projects have been the most influential so far

Overall, projects related to technology or digital platforms and identification and assessments for carers, which have overcome procurement and other barriers and entered the delivery phase, appear to have had the biggest effects so far. For example:

- technology and digital platforms: procurement hurdles for these projects can be challenging, however once implemented they tend to produce quick results. These projects report outcomes across multiple areas, including cost savings, improved efficiency, better identification of carers, and empowerment of carers through information and control. The scalability of digital solutions likely contributes to their wider reach and impact. The data generated by these platforms also offers valuable insights for future service development

- identification and assessments for carers: many projects highlighted significant increases in identifying previously unknown carers. This suggests an emerging success in reaching a hidden population and connecting them with much-needed support and resources. This early intervention can potentially prevent escalation of needs and improve long-term outcomes for both carers and those they care for

The more rapid emergence of outcomes for technology and digital projects and identification and assessments for carers than for other project category groups is likely due to the fact that these types of projects could in many cases be set up and implemented quickly (once the service has been procured) and, therefore, are already producing meaningful outcomes.

However, projects focused on more complex delivery and requiring greater collaboration across local systems (including NHS and VCSEs), such as hospital discharge or setting up new community-based care models, may prove to have greater impact in time.

It is important to note that many projects are still in the early stages and further evaluation is needed to determine long-term impacts. However, these findings suggest that the ARF is contributing to positive changes across a range of areas in social care innovation.

Anticipated outcomes

Anticipated outcomes that have been reported by projects but have not yet been achieved include:

- long-term impact of carer breaks and support: while initial improvements in wellbeing and confidence are reported, the long-term effects on carer sustainability and prevention of carer breakdown need further evaluation and a longer time frame for outcomes to emerge

- full potential of technology or digital platforms: while early adoption and engagement are positive, the full potential of these platforms in transforming care delivery and outcomes needs further exploration. This includes assessing long-term cost-effectiveness and impact on quality of care

- system-wide change in hospital discharge: while projects show increased awareness and referrals, achieving system-wide change in hospital discharge processes to consistently prioritise carer needs requires ongoing effort and evaluation

- full potential of Shared Lives projects: some Shared Lives projects are in earlier stages of implementation, and their outcomes regarding long-term placements, person-centred planning and cross-sector collaboration need further evaluation

Assessment of the achievement of ToC outcomes by the fund

Tables 5a and 5b below provide an assessment of the extent to which the outcomes identified in the ToC for the fund are being achieved to date, and the evidence drawn upon to make this judgement.

Both of these tables use the following key when making a provisional assessment:

Wording in 'Provisional assessment' column	Definition
Strong evidence	Relatively strong evidence of outcome achievement (stronger evidence across most systems).
Limited evidence	Emerging or partial evidence of outcome achievement (mixed evidence across some, but not most systems).
No evidence	No evidence of outcome achievement, or direct evidence of it not being achieved (little to no evidence across most or all systems).

Table 5a: assessment of the extent to which the fund is achieving the short-term outcomes (STOs) identified in the ToC

Outcome	Provisional assessment	Summary
Greater collaborative working within consortia (STO1)	Strong evidence	Clear evidence of improved collaboration within consortia, as evidenced by direct feedback from most systems and the governance structures of projects involved multiple local authorities. At present, evidence of collaboration is strongest among local authorities, NHS delivery partners and to a lesser extent with VCSE organisations and social care providers.
Increased collaboration and data sharing with local partners that Local authorities choose to work with including local care providers and/or local health and community organisations (STO2)	Emerging or partial evidence	There are some examples of projects working in collaboration with local care providers and VCSE organisations successfully. However, feedback from systems on this type of collaboration is more mixed, and some have found this challenging. Data sharing between local authorities and external providers is a significant barrier (see the 'Barriers to implementation and delivery' part of the 'Implementation and delivery' section above), and this presents challenges to successful project delivery.
Increased knowledge across the sector around innovative approaches and their impacts (STO3)	Emerging or partial evidence	The fund is enabling the testing of innovative approaches to social care provision locally, and systems report testing new interventions as a direct result of the funding. However, there is a remaining evidence gap around the longer-term impacts and potential for scaling of most innovations.
Improved local capability for robust evidence collection and	Strong evidence	Most systems have an increased focus on collecting evidence of outcomes and evaluating their interventions locally. Local impact assessments demonstrate that the majority of systems are evaluating their activities and

Outcome	Provisional assessment	Summary
evaluation of innovation (STO4)		considering the evidence of their impact, even if at present it is too early to fully assess impact.
Stronger evidence on scaling specific innovations, and lessons for successful implementation (STO5)	Emerging or partial evidence	The fund has generated evidence of how specific innovations have progressed in their implementation and delivery stages and provided learning on the enablers and barriers to successful delivery. Evidence of the ongoing sustainability of these interventions and their longer-term impact is less well established.
Increased collaboration and co-production with unpaid carers and a better understanding of their needs (STO6)	Strong evidence	One of the outcomes from projects is a better understanding of the prevalence of and needs of unpaid carers. Some systems have successfully incorporated co-production into project design and delivery and have found it beneficial. Other systems report this being challenging but have generated learning about how better to approach this in the future.

Table 5b: assessment of the extent to which the fund is achieving the medium-term outcomes (MTOs) identified in the ToC

Outcome	Provisional assessment	Summary
Improved understanding of how to tackle the barriers to scaling innovation in local communities and more widely (MTO1)	Strong evidence	Local systems have generated learning around barriers to scaling innovation locally (see the 'Barriers to implementation and delivery' part of the 'Implementation and delivery' section above) and put in place measures taken to mitigate for or tackle them.
Change in commissioning locally towards	Emerging or partial evidence	The interventions being funded are broadly focused on scaling existing innovations or creating new ones, and there is a focus within

Outcome	Provisional assessment	Summary
more innovative models of care (MTO2)		systems on considering what can be continued sustainably beyond the fund. In some systems, the fund will lead to longer terms changes in commissioning priorities, due to the evidence generated by individual projects.
Improved understanding of the benefits of scaling innovations, including establishing a clearer economic case for investment in social care innovation (MTO3)	Emerging or partial evidence	Some systems are considering scaling new interventions locally (such as from one local authority to multiple neighbouring local authorities) after the fund, subject to securing sustainable funding. Learning is being generated on the risks and challenges associated with this, and how to overcome then. .
Improved understanding of how to identify and support the scale up of local innovation (MTO4)	Emerging or partial evidence	Only a small number of local impact assessments included an economic assessment of innovations - however, systems reported through interviews that value for money is a significant factor in decision making.
Improved understanding of how to mitigate risks when scaling social care innovations (MTO5)	Emerging or partial evidence	Evidence of scaling specific innovations beyond individual consortia footprints, how to mitigate risks associated with this, and the impact (including economic) is only just emerging and cannot be used to make recommendations about national scaling at this stage
Improved visibility of DHSC support for innovation and	Strong evidence	Systems appreciated the resources provided by DHSC through the fund, guidance linked to the 12 national priorities and support provided

Outcome	Provisional assessment	Summary
spreading best practice (MTO6)		by SCIE to spread, scale and sustain innovations.
Innovations leading to improvements in care provision are sustained locally (MTO7)	Emerging or partial evidence	Systems are using local evaluations to generate learning on emerging outcomes from innovations. How this will influence care provision in the longer-term locally remains unclear.

Impact

In most cases, wider impacts of projects funded by the fund remain anticipated and unmeasured at this stage.

This is because most of the impacts identified in the ToC (see 'Appendix 2: theory of change and mechanisms for change' below) are long-term systematic changes that would require a significantly longer time period to be assessed.

Furthermore, these changes are often based on multiple factors both within and outside the control of specific projects, so attribution is a particular challenge.

Interviews and local impact assessments identified the following anticipated impacts from projects and the evidence projects plan to use to assess these changes.

1. Reduced demand on domiciliary care and other services

Projects involving technology, such as wearable devices and AI-driven identification and assessment tools, aim to reduce the need for in-person assessments and light-touch support, freeing up resources for those with more complex needs.

Early indications suggest this is already happening in some areas, with reduced domiciliary care budgets and referrals into adult social care potentially preventing escalation of needs. This could lead to significant cost savings and more efficient use of resources within the health and care system.

Evidence includes:

- reduced domiciliary care budgets due to use of wearable devices

- increased referrals to adult social care through early intervention programmes
- anticipated reduction in demand on frontline services due to AI chatbot and online assessments

2. Improved carer wellbeing

Projects focusing on carer breaks, respite, and other support mechanisms aim to improve carer mental health, reduce stress and prevent burnout. This, in turn, enables carers to sustain their caring roles for longer, benefiting both themselves and the people they care for. Empowerment through training and access to information also contributes to carer resilience and confidence.

Evidence includes:

- carers reporting improved mental health
- reduced social isolation
- increased confidence
- feeling more enabled in their roles

An unpaid carer said:

> "It [an art course] helped me reconnect with my creativity. For my husband, it offered a sense of inclusion and social interaction… he was welcomed by the group and able to participate informally, which made us feel more relaxed and supported. It's made me value myself more, that I can create something that is lovely."

3. Enhanced system-wide collaboration and integration

Several projects emphasise collaboration between different parts of the health and care system, including hospitals, local authorities, carer support organisations and health partners.

This includes shared assessments, joint recruitment systems and the development of system-wide resources like community directories. Improved communication and understanding between different stakeholders can lead to more integrated and seamless care pathways.

Evidence includes:

- re-establishment of health and social care carers groups

- improved collaboration between city and county Shared Lives teams
- integration of health partners into community directories
- hospital discharge projects strengthening links between hospital teams and support services

4. Wider adoption of digital solutions and data-driven approaches

The success of early tech-enabled care projects is prompting other areas to emulate these approaches. This includes the adoption of care data monitoring teams and increased interest in digital transformation and prevention. The data generated by these platforms can inform service development and contribute to more evidence-based decision-making.

Evidence includes:

- care data monitoring teams being emulated by other cities
- increased referral rates for tech-first approaches
- broader conversations about digital transformation

5. Empowerment of carers and increased visibility of their needs

Many projects focus on empowering carers by providing them with information, support, and a stronger voice in care planning and decision-making. Increased awareness of carers' roles among health professionals is also contributing to better recognition of their needs. This can lead to more person-centred care and improved outcomes for both carers and those they care for.

Evidence includes:

- carers feeling more empowered to ask questions and challenge discharge processes
- increased awareness among hospital staff about carers' roles
- co-production of carer assessment tools
- carers feeling heard and involved

A SCIE representative said:

> "The inclusion of carers in hospital discharge planning sounds simple but is really revolutionary in terms of the outcomes it leads to and how they feel about the whole process."

6. Prevention and early intervention

By supporting carers earlier and addressing their needs proactively, projects aim to prevent crises, reduce the need for more intensive interventions and promote wellbeing. This includes early identification of carers at risk, providing light-touch support and connecting carers with relevant services.

Evidence includes:

- digital platforms reaching carers who had not previously accessed support
- projects supporting carers' mental health to prevent crises
- support provided to carers potentially preventing burnout

It is important to note that these long-term impacts are still anticipated and will require further evaluation to determine the extent to which they are realised.

The table below provides an assessment of the extent to which the outcomes identified in the ToC for the fund (see 'Appendix 2: theory of change and mechanisms for change') are likely to be achieved, and the evidence drawn upon to make this judgement:

Assessment of the achievement of ToC impacts by the fund

The table below provides an assessment of the extent to which the impacts identified in the ToC for the fund are likely to be achieved, and the evidence drawn upon to make this judgement.

Note: this table draws on the definitions in the key that can be found in the previous 'Assessment of the achievement of ToC outcomes by the fund' part of 'Outcomes'.

Table 6: assessment of the extent to which the fund is likely to achieve the impacts identified in the theory of change

Impact	Provisional assessment	Summary
Increased implementation of innovative types of social care support	Strong evidence	There are numerous examples of innovative approaches being implemented, including the effective use of technology enabled care, carer hubs and community networks, new assessment tools and remote care platforms.
A larger proportion of commissioning resource and spend on preventative, community-based models and away from reactive, residential or high intensity support of support	Emerging or partial evidence	While direct evidence of shifted commissioning resources is limited, the data suggests movement in this direction. Systems report the potential for preventative approaches and cost-savings leading to shifts in commissioning practices.
Improved outcomes for individuals who are supported by interventions	No evidence	No evidence of interventions being scaled at a national level. Broadly, the current evidence is not able to judge the extent to

Impact	Provisional assessment	Summary
which are effective and have been successfully scaled at a national level		which specific interventions should be scaled nationally, but provides learning on what is working, in which contexts, and why.
Scaling of successful social care innovations locally, and where appropriate, nationally	Emerging or partial evidence	The evidence provides some examples of local scaling and potential for wider adoption; care data monitoring teams being emulated by other cities, hospital discharge projects being replicated across multiple Trusts and tech-enabled care projects now generating wider, regional scaling based on initial examples of good practice.
Improved system outcomes from learning generated on how to delivery social care locally; reduction in emergency admissions, readmissions and referrals into residential care in particular	Emerging or partial evidence	Limited direct evidence of reduced admissions and referrals at this stage. However, some projects suggest potential for these outcomes, in particular the various innovations providing support for carers and technology-enabled care.
Improved health, wellbeing, and quality of life outcomes for people who draw on care and support, and their carers (where support was effective) through scaling of innovations, linked to the 12 national priorities	Emerging or partial evidence	Carers and care users are reporting improved quality of life and wellbeing across some projects. However, this evidence is not specifically linked to the scaling of innovations.

Assessment of mechanisms for change

Our evaluation scoping and design work, alongside the wider evidence base, identified significant barriers to social care innovation (see 'About the fund' above) that this fund aims to overcome or mitigate for. This is reflected in the ToC design for the fund, which identified various mechanisms for change (see 'Appendix 2: theory of change and mechanisms for change' below) required for core outcomes to take place.

Tables 7a to 7c below summarises the evaluation findings associated with the fund against the mechanisms for change in the ToC for the fund, which were identified as being necessary for outcomes to be achieved and innovation to take place within social care more widely. It provides an overall assessment of the extent to which these mechanisms are taking place, through which outcomes can be achieved.

Note: these tables draw on the definitions in the key that can be found in the previous 'Assessment of the achievement of ToC outcomes by the fund' part of 'Outcomes'.

Table 7a: mechanisms identified to achieve outcomes and summary of evidence that they are taking place - outputs to short-term outcomes

Mechanism for change	Provisional assessment	Summary
Local systems within consortia are able to work together to collaboratively identify appropriate innovations	Strong evidence	Strong evidence of improved collaboration within consortia building upon exiting relationships. The collaboration associated with the fund is mainly between local authorities and NHS organisations. Increasingly, there are some examples of collaboration with external social care providers. Projects involving hospital discharge and community-based care models require the highest degree of

Mechanism for change	Provisional assessment	Summary
		collaboration and have in some cases been harder to implement as a result.
Cross-sector collaborations within systems support local systems to identify and connect with existing resources in their network, working together to draw on the different skills, expertise and perspectives that exist across the local system to strengthen their ideas	Strong evidence	Strong evidence of collaboration between local authorities and NHS organisations, and of project leads drawing upon existing expertise within the system. There is some emerging evidence of meaningful collaboration with wider system and/or external partners, however this is spread across a small number of projects. Community-based care model projects, although more limited in number, provide excellent examples of drawing upon wider community and VCSE resources to deliver innovative care.
Local systems are enabled to take risks and question assumptions, strengthening their ideas and the wider social care innovation evidence base	Strong evidence	Strong evidence that systems are using the fund to pilot new approaches and test ideas that would not have been tested without the fund in place. Over half of projects (based on survey data) involve developing and testing new innovations.
Consortia and project leads engage with unpaid carers and those with lived experience as part of	Limited evidence	Some consortia report utilising co-design elements with unpaid carers within their projects. For some systems, incorporating meaningful co-production into

Mechanism for change	Provisional assessment	Summary
innovation design, and their knowledge of innovation problems and solutions is challenged and further informed by this		their project design and delivery has been challenging, however the fund has enabled progress in this area. Hospital discharge projects in particular include some good examples of meaningful co-production taking place.

Table 7b: mechanisms identified to achieve outcomes and summary of evidence that they are taking place - short to medium-term outcomes

Mechanism for change	Provisional assessment	Summary
Local systems will be able to overcome some of the identified challenges and barriers to social care innovation through effective design and implementation	Limited evidence	Strong evidence that systems are using the fund to specifically address the established challenges and barriers to social care innovation (see 'Barriers to implementation and delivery' above). However, there is also strong evidence that persistent barriers remain, such as sustaining innovations and procurement and data governance challenges (see 'Project implementation and delivery' above).
Projects are outcomes-focused, and teams collect initial evidence or data of outcomes and impact	Limited evidence	Most projects are specifically considering capturing outcomes as part of project design and delivery, including implementing plans to capture data and evidence. In total, 29 out of 42 systems submitted local impact assessments demonstrating a focus on capturing outcomes and evaluating projects. In many cases, outcomes identified in these returns were based on limited evidence, such as short-term outputs or a small number of case studies. Sixteen consortia accessed support from Ipsos on evaluation and measuring impact.
The delivery of social care innovation projects	Limited evidence	Evidence collected within the evaluation timeframe addresses many of the established social care

Mechanism for change	Provisional assessment	Summary
generates good quality evidence of what works, and how barriers to social care innovation can be overcome		innovation barriers specifically (see 'Barriers to implementation and delivery' above) - however, evidence on longer-term embedding and scaling of innovation remains limited. There are particular evidence gaps around how projects involving hospital discharge, Shared Lives and community care models impact those accessing care and unpaid carers in the longer term.

Table 7c: mechanisms identified to achieve outcomes and summary of evidence that they are taking place - medium-term outcomes to impacts

Mechanism for change	Provisional assessment	Summary
Consortia and local systems can see from funded projects that further investment in preventative, community-based models of care is beneficial	Limited evidence	In most cases, systems are already exploring options for funding the community-based care models that have been established through the ARF where possible. The fund has supported a small shift towards these care models by providing further evidence of what works and why.
Social care innovation projects are aligned to national priorities, and learning generated by them can be applied to scaling at a national level	Strong evidence	Strong evidence that projects are aligned to DHSC's 12 national priorities. Evidence and learning generated cannot be used to fully assess scaling of individual innovations or initiatives at a national level. Project activities, and therefore evidence, are too varied in typology and short-term at this stage.
Funded projects lead to better decisions and ways of working among consortia and local systems	Limited evidence	Some local systems are confident that ARF-funded initiatives will improve the evidence base for what works locally and enable improved decisions, service planning and longer-term funding of new and innovative best practice. However, evidence is currently anecdotal based on feedback from systems.

Unpaid carers and/or those in receipt of care engage with and see benefits from funded interventions, since they are relevant, fit-for-purpose, and are centred on those who use of provide care	Limited evidence	Unpaid carers are the most common beneficiaries of projects so far. Outcomes are emerging, but for unpaid carers include improved identification, understanding of their needs and access to support and resources. In particular, a small number of more advanced projects have delivered access to remote support from digital platforms, more control over discharge processes, grants or breaks and community support.

In summary, most of the mechanisms for change identified have been at least partially if not fully supported by this fund. There remains a lack of evidence related to the longer-term impact of initiatives, and the extent to which they represent an appropriate opportunity for scaling at a national level. Even if projects have not yet delivered outcomes, if they have involved important mechanisms such as co-production and improved collaboration, the system is now much better equipped to implement future innovations and developments. The fund has therefore enabled systems to focus more on longer-term innovation and address the more systematic barriers to innovation, potentially making more possible beyond what was in the ARF projects themselves.

Unintended outcomes and impacts

The following positive and negative unintended outcomes arising from the fund were identified by some systems:

- in a small number of areas, the creation of a ‘two-tier’ self-support care offer, whereby initial engagement with new digital tools and support offers is from younger, more able carers, whereas those who are older, more isolated and generally disadvantaged are less likely to engage with and access these tools. There is a fear this may expand the ‘care advocacy gap’ where those more likely to advocate for themselves and seek support now have access to a broader, more personalised care offer

- growing concern around the additional financial pressures on local systems, with the fund now finishing, as there is a continued need for more support (particularly among unpaid carers) and newly established precedent for providing new innovative approaches, without ongoing central funding. The identification of more unpaid carers has increased demand without there always being a corresponding increase in provision, though many consortia with identification projects also had carer break or support projects. Approaches and confidence around sustaining funding for new innovations on an ongoing basis remain mixed. A project lead said:

  > “We’ve got 16,000 more carers we can now support, who’s going to pay for that?... even this money is on the margins.”

- for carer identification projects, there has been an increase in local authority awareness of carers and in carers recognising themselves as carers. Where a project focused on carer identification, and assessment has not been accompanied by a project providing additional support to carers, there is potential for a mismatch between supply and demand. Even where there has been a parallel carer support project, if this is ended when ARF funding ends, there is a risk of an increased rather than reduced pressure on statutory services because more unpaid carers are in touch with their local authority

- particularly for hospital discharge projects, support for unpaid carers can result in a shift in power dynamics between carers and health professionals. As carers have become more confident in advocating for their needs, this has led to increased scrutiny of discharge practices. While this has introduced some friction between health and social care staff and between unpaid carers and staff, it is ultimately viewed as a constructive development that enhances the role of unpaid carers in the care process

- spending ARF funding on grants (either for community organisations or individual carers) means less control but more scope for creativity and individual level innovation can have unintended consequences. One example is of an unpaid carer using a grant

intended for respite to take a break from caring by spending the money on driving lessons. After passing their test, they were able to become a driving instructor and take on a flexible work role that fitted around their caring role, thus returning to employment

Scaling and embedding innovation

This section details findings related to the scaling and embedding of social innovations delivered through ARF funding.

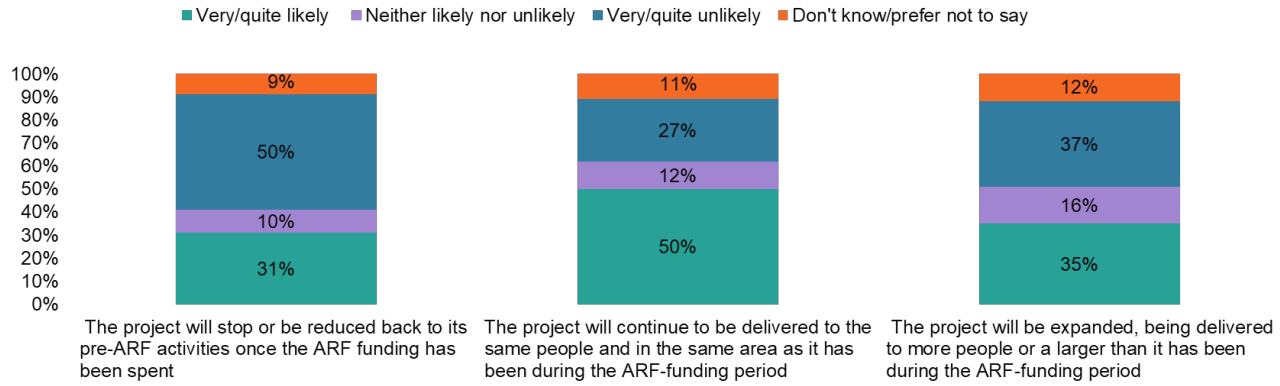
Summary of expectations for future embedding and scaling

Survey respondents were asked whether each of their projects is likely to:

- be expanded after the end of the ARF funding period (scaling)
- continue being delivered in the same way (embedding)
- be stopped or reduced back to pre-ARF activities

Figure 7: how likely, if at all, are each of the following?

Sample: all the projects represented by those participants who answered this question, 108 in total.



Projects expected to be stopped or reduced back to pre-ARF activities

Just under a third (31%) of projects are expected to be reduced back to their pre-ARF activities at the end of the funding period. Interviewees who expected the projects to be stopped or reduced generally pointed to a lack of continued funding as a large reason for this. Interviewees gave the following explanations for why they were not continuing:

- the fund had been used to set up a completely new project, rather than scaling something existing, so they had limited existing resource to fall back on to sustain the project

- they would have to take money from an existing service to fund the project, and this was not a priority

- the local authority did not have enough money to continue running the project

In other cases, systems described scaling back the projects to deliver a more financially viable and sustainable offer. Examples included:

- returning to a lower level of carer support that was being delivered pre-ARF to align with pre-existing funds available

- moving from offering an app to a website as the latter is cheaper to deliver and therefore more sustainable within local system funds

Projects expected to be sustained at the same level

Half (50%) of projects were reported as being very or quite likely to continue being delivered in the same way as has been done during the funding period.

Interviewees who expected their projects to be sustained or embedded gave the following several reasons for this:

- the sustainability of the project had been built into the design (12 of the 29 survey respondents who said at least one of their projects would be sustained cited this reason). Some built tools or their support offer to be self-sustaining - for example, using funding to build a digital tool and designing it in a way that minimises ongoing maintenance costs, or using funding to make one-time purchases of devices that could then be used for the foreseeable future. Of the survey respondents who said at least one of their projects would be sustained, 9 said their digital tools had been built specifically to be sustainable. A consortium lead said:

  > "Once it’s built, the company has then got marketable product to use elsewhere… there won’t be any continued maintenance fees.”

- they had gathered enough evidence to demonstrate the effectiveness and impact of the innovation and could use this to secure the local funding required, or had built a business case outlining the most appropriate and proportionate approach to take forward

- securing any type of buy-in from third parties or the community also enabled projects to be sustained (10 of the 29 survey respondents who said at least one of their projects would be sustained cited this reason)

- other funding had been secured (13 of 29 survey respondents cited this) or they could access alternative funding streams - for example, funding from other government departments, other funds such as the Better Care Fund, grant opportunities for voluntary sector partners, local fundraising or accessing local budgets. In some cases, partners (such as innovation providers) were planning to take the lead in securing additional funding. A project lead said:

  > "We're hoping that [partner provider] will be able to bid for some more money to continue doing activities, but in more places with more people across the county."

- the innovation could be integrated into business as usual (BAU) workstreams. This could be done where ARF-projects align with existing BAU programmes or roles, or where the value is demonstrated so clearly that a decision is made to integrate it into BAU workstreams and processes (6 of the 29 survey respondents explained that projects had been integrated or embedded)

- some saw the continuation of working arrangements and collaboration between system partners as sustaining the outputs of the fund

- in some cases, the learnings from the innovation were being embedded into future ways of working or commissioning processes

- some explained that their projects would be sustained because they had already scaled up to the maximum level so could not be scaled further. Those who said this tended to focus on scaling at a local level rather than a national level (for example saying it couldn't be scaled further because the innovation had already been rolled out to all hospitals within their county or had been rolled out across a whole ICB). A consortium lead said:

  > “We’ve done everything on a[n] [ICB] footprint. So, we wouldn’t really need to scale them beyond here.”

Projects expected to be scaled or expanded

Just over a third (35%) of projects are expected by survey respondents to be scaled (expanded) after the funding period.

Project and consortia representatives highlighted some concrete examples of how their ARF-funded projects had already begun being scaled, as well as evidence of their projects' potential to be scaled in the future.

Concrete examples of how projects had been scaled included:

- platforms or tools being broadened to cover more content - for example, expanding the content of a training course or additional modules being added to online support platforms to cover young carers, fall prevention and digital self-assessment tools

- broadening the initiative to cover a broader geographical area (12 of the 35 survey respondents who said at least one of their projects would be scaled up said this was likely to happen)

- broadening the initiative to cover other demographic groups(11 of the 35 survey respondents said this was likely to happen)

- expanding digital tools (9 of the 35 survey respondents said this was likely to happen). Examples included reaching more carers with their tool or adding additional resources to existing tools

- sharing learning with other areas within the consortium, encouraging them to develop initiatives locally that suit their specific needs rather than replicating their model exactly

Reasons given for being able to scale projects included:

- creating a revenue-generating model whereby training developed with ARF funding is being marketed out to other councils. Revenue from this would be used to further develop the training

- evidence of the impact of innovations reaching other councils and areas, eliciting interest in implementing similar initiatives. A project lead said:

  > “Other trusts could really see the benefit of the work… that’s actually, I think, great, because it'll be quite easy to evidence in terms of the sustainability… commissioners in those areas are really keen to find out more about the project… and if it’s something that they can introduce in future years.”

- support from SCIE to share the outputs of the work with other local authorities

Some systems had not yet scaled any projects but saw potential for their projects to be scaled, or talked about early steps they were taking that may enable them to scale in the future. This included:

- starting to share learning with other systems or areas which could support future scaling. 5 of 35 survey respondents who said at least one of their projects would be scaled up pointed to working with systems partners as a reason for this

- setting up long-term partnerships for joint working that would enable them to submit joint funding bids and secure additional funding
- starting to bid for additional funding to scale initiatives

How expectations differ by type of project

Qualitative insights from interviews provide a nuanced understanding of how expectations for project continuation vary across the 6 project category groups.

It is important to note that these expectations are based on interviewees' perspectives and may be influenced by factors such as funding availability, local priorities and emerging evidence of impact.

Setting up or implementing technology or digital platforms

These projects often demonstrate a strong drive towards both scaling and embedding, given the potential for digital tools to reach wider audiences and integrate into mainstream services. For example, a project lead relayed how their consortium aims to market their digital carers' card nationally:

> "One of the aspirations is for this to be a product which can be of benefit to other local authorities and other carers' centres."

However, sustainability concerns are also frequently raised, particularly regarding long-term funding and the resource demands of maintaining digital infrastructure. A consortium lead's comment about the resource demands of managing digital tools highlights this tension:

> "We don’t have the resource for somebody to manage 100 devices."

Identification and assessments for carers

These initiatives often prioritise embedding into existing systems and processes, with scaling being a secondary goal. For example, a project aims to integrate online carer self-assessments into mainstream social work pathways, with future scaling dependent on demonstrating effectiveness and securing ongoing support

Providing carer breaks, respite or other forms of support for carers

Sustainability is a major concern for these projects, as they often rely on short-term funding or one-off grants. One project's experience, where their enhanced grant scheme is being scaled back to pre-ARF levels due to funding constraints, exemplifies this challenge.

While some projects are exploring revenue generation or community ownership for long-term sustainability, the short-term nature of the funding often limits expectations for significant scaling.

Hospital discharge

These projects often focus on embedding innovations into existing discharge pathways, with scaling being considered if tangible impacts can be demonstrated. One project, for example, targeted specific wards and teams, aiming to achieve measurable results that could support future scaling.

Shared Lives

These projects primarily focus on expanding existing Shared Lives schemes or adapting the model to new contexts or populations. Embedding within local care systems is a main priority, with scaling often dependent on successful carer recruitment and securing long-term funding. One project's challenges with recruiting carers for temporary posts highlight the difficulties of building capacity within short-term funding cycles.

Community-based care models

These projects often leverage existing community resources and partnerships, which can enhance sustainability. However, demonstrating measurable impacts and securing ongoing funding can be challenging, potentially limiting scaling ambitions. One project's focus on community ownership and local fundraising offers a potential model for sustainable community-based care, but this approach may not be replicable in all contexts

How expectations differ by stage of delivery at the end of the funding period

Analysing project maturity level alongside future plans reveals further nuances.

While survey respondents reported that 35% of projects funded by the ARF were likely to be scaled, projects in stage 4 - impacts emerging show the lowest likelihood of reduction or cessation (10%). This suggests that demonstrated impact may contribute to greater confidence in long-term continuation, even if not necessarily expansion. Further analysis will be revealing as the number of projects demonstrating impacts grows.

As a project lead noted, their tech-enabled care project is generating positive results, and they are actively seeking funding to expand the care data monitoring team. This suggests that achieving measurable outcomes strengthens the business case for future investment and scaling, aligning with the overall narrative about the importance of evidence-based decision-making.

Projects at earlier stages (1 - scoping and design, 2 - implementation and set-up, and 3 - project delivery) exhibit a more balanced mix of expectations, with scaling and sustained delivery being equally likely, and a notable proportion anticipating reductions or cessation. This uncertainty reflects the challenges of demonstrating impact within the remaining timeframe and securing ongoing funding.

The delayed second tranche of funding has further complicated these challenges, as noted in interviews, pushing back timelines and creating uncertainty about long-term prospects. For example, one project, still in the design and procurement phase, acknowledges the difficulty of engaging with NHS partners facing financial pressures and staffing changes, which could impact their ability to scale and embed their digital tools.

This highlights the vulnerability of early-stage projects to external factors, and the importance of flexible funding and robust planning.

Conclusions and implications

This section sets out the conclusions and recommendations based on the findings from the evaluation, including the aims of any future evaluation research.

Conclusions

Drawing upon the main findings from the evaluation, and accounting for the wider context in which the fund has been delivered, including the initial programme aims, the following conclusions can be drawn.

Meeting the programme objectives

This programme aimed to support local systems to:

- effectively overcome barriers to adopting and scaling innovations
- support contributions to the evidence base for what interventions lead to better outcomes
- build on the evidence base for effective implementation of interventions in local places

The programme has shown some emerging impact on overcoming barriers to innovation and built the evidence base around implementing and producing better outcomes from innovations.

The evidence base around outcomes is only just emerging, and remains incomplete, as many projects have taken longer in practice to implement than was anticipated.

Furthermore, robustly understanding what works and why in a complex environment such as adult social care, with limited funding, is challenging for many systems despite this Fund. Examples of projects scaling from their original funded scope are isolated at this stage, and only within individual consortia.

Delivering innovation projects

Delivery

ARF-funded projects have demonstrated varied progress, influenced by project category group, local context and capacity. The end-of-grant reports reveal a mix of projects in various stages of maturity, ranging from full delivery with emerging outcomes through to those still in the scoping or implementation phases.

Around half of projects are now being delivered, but only around a further one in 10 projects is able to provide evidence of emerging outcomes and impacts. This shows innovative approaches take time to set up, and longer to understand the effects.

Barriers

Innovation projects have been affected by various challenges - most notably funding uncertainty, particularly the delayed second tranche, significantly impacted project planning and timelines.

In addition to this, procurement processes and data governance, particularly for digital innovations, emerged as persistent barriers, often requiring more time and resources than anticipated.

Collaboration across organisations has been challenging particularly where the same project crosses local authority boundaries.

Capacity constraints, including staff time and expertise, have limited project scope and ambition in most consortia, despite the funding made available.

While risk aversion was initially identified as a potential barrier, the fund's flexibility and 'permission to fail' appeared to mitigate this concern in many cases, though risk aversion was still observed in some of the procurement and data governance challenges.

Low service uptake was a concern for projects focused on recruiting carers, highlighting the importance of user-centred design and targeted outreach when supporting unpaid carers and recruiting new Shared Lives carers.

Many of these challenges were identified in the scoping stages of the evaluation and supported by the wider evidence base, with data governance emerging as the most prominent 'new' challenge. In many cases, innovations need longer funding and evidence cycles to demonstrate their value.

Enablers

Several features of the fund's design, alongside some local systems characteristics and activities, supported delivery.

The most important factors were the funding itself, coupled with flexibility in its use and the time during which it could be spent, which enabled systems to invest in innovation (including technological solutions to long-standing challenges) and pilot new approaches.

Furthermore, strong governance arrangements, pre-existing partnerships, and the development of new collaborative relationships facilitated project implementation.

Co-production, where effectively implemented, ensured that some projects were responsive to the needs of carers and people with care and support needs.

Peer learning and knowledge exchange, facilitated by SCIE and through informal networks, helped some systems address challenges and share best practices.

Supporting innovation

The funding model and guidance

The ICS footprint model encouraged collaboration and resource pooling, enabling the development of shared infrastructure and learning. However, it also introduced complexities in co-ordinating across multiple local authorities with varying procedures and priorities.

The lack of set budget allocations per project created difficulties in resource distribution for some systems. Therefore, the success of the ICS model depended on:

- the number of local authorities involved
- pre-existing relationships
- dedicated project management
- effective communication

The 12 national priorities, particularly the emphasis on unpaid carers, effectively shaped project selection and design, resulting in a diverse range of carer-focused interventions. The flexibility within the priorities allowed for local adaptation and innovation.

Overall, the fund was well designed for its purpose and has fostered an environment of both collaboration and innovative practice.

The SCIE support offer

The SCIE support offer evolved over time, responding to feedback and emerging needs. Engagement with the support offer was generally good - however, engagement by projects was often limited by the relatively early stages of project delivery and capacity within systems to engage with it.

The support during the EoI phase had high engagement from all 42 ICSs and was well received. The targeted support and CoPs were also well received, facilitating peer learning and providing valuable expertise.

However, challenges remained in communication, accessibility and tailoring support to specific project needs (including having up-to-date information to do this effectively).

Limited resources and data access constrained SCIE's ability to provide more in-depth and individualised support.

The short timeframe of this more widespread support offer, and the enforced pause in communications pre, during and post-general election, also limited its potential for long-term impact.

The support offer improved in its relevance to systems and impact upon their progress over time, as it became more focused on peer learning and one-to-one support.

Future support offers of this nature should continue to focus on these elements, which most systems feel are more valuable.

As the end of the support period was reached, there was a flurry of approaches from systems for support. This is now being met, in part, by the reduced offer provided by SCIE and funded by DHSC, and by systems directly approaching SCIE for a funded offer.

SCIE has summarised emerging learning that it has collected through delivering the support offer in its Embracing change: scaling innovation in social care in practice report.

Outcomes and impacts

Only a relatively small proportion of projects are able to evidence outcomes at this stage, with many more able to identify anticipated outcomes.

Projects demonstrated a range of positive outcomes. The most commonly observed outcomes included:

- increased carer identification and support
- improved access to information and services
- enhanced digital support
- better assessment and discharge processes
- the development of community-based care models

The fund has significantly expanded the evidence base around how different types of projects can contribute to strategic outcomes across adult social care.

While long-term impacts on system-wide change, carer wellbeing and cost-effectiveness require further evaluation, early indications suggest the potential for positive and sustainable change.

However, the longer-term outcomes and impacts of innovation may be more challenging to measure and attribute because they tend to be outcomes across the wider and complex health and care system.

Unintended consequences

Unintended outcomes, such as the potential for a 'two-tier' support system, based on digital literacy and increased financial pressure on local systems post-funding, represent emerging risks to the lack of sustained funding for progression certain initiatives.

Projects that targeted unpaid carers have potentially created new demand that now must be met by existing services or innovations being sustained.

Innovations associated with the most significant outcomes

The spread and variation of projects mean that comparing different types of innovations, in terms of the extent to which outcomes can be achieved, is limited.

Projects focusing on technology or digital platforms and identification and assessments for carers have demonstrated the most significant outcomes to date, due to the extent to which they can implemented and adopted quickly (once any procurement challenges have been overcome).

This does not, however, mean they will prove to be the most impactful in the long-term. Conversely, projects that face more implement challenges outside of the control of the immediate project team. such as hospital discharge, may eventually prove to be more impactful to systems and care users. Some Shared Lives projects have struggled so far to meet their core aim of recruiting more Shared Lives carers.

However, there is no evidence at this stage that certain types of innovation do not work - rather it is simply that they take longer to implement and are less able to evidence outcomes at this stage (due to their complexity).

Scaling and embedding

One of the main objectives of the fund is to create the conditions for scaling and embedding innovation, which the adult social care sector has struggled to do historically.

While many systems expressed intentions to sustain or scale ARF-funded initiatives, the absence of a sustained funding source continues to present a significant challenge.

The evaluation itself has contributed to identifying scaling opportunities and sharing best practices, and the opportunities and challenges for scaling and embedding, for different project types.

The extent to which projects are likely to be sustained is mixed. Local systems and commissioners within them generally remain risk averse in an environment of relatively scarce resources, and the case for change can be hard to establish clearly.

Beyond the specific funded projects, ARF has enabled systems to focus more on overcoming systemic barriers to innovation, such as a lack of integration, and the development and strengthening of mechanisms for innovation, such as co-production and collaboration. This means consortia are better placed than before to develop and adopt future innovations.

How project category groups differ in their potential for scaling and embedding

Projects involving digital platforms are most geared towards scaling, due to the inherent potential of digital tools to reach wider audiences and integrate into mainstream services. However, their actual scaling is hindered by sustainability concerns, particularly long-term funding and resource demands.

Projects focused on carer identification, assessments and hospital discharge prioritise embedding into existing systems, with scaling dependent on demonstrated success. Carer support and Shared Lives projects face similar sustainability issues due to short-term funding, impacting their ability to scale and recruit carers.

So far, projects introducing digital tools feel most ready to be scaled - however, longer-term assessment of outcomes may lead to a growing case for scaling carer identification and hospital discharge projects. Regional scaling has been successful or is being planned in several areas. However, these examples are too varied and it is too early to make judgements on the appropriateness of specific types of innovation for national scaling.

Recommendations

The evaluation findings have influenced the following recommendations for DHSC and local systems:

Table 8a: recommendations arising from the evaluation findings for DHSC

Recommendation for DHSC	Learning from which this recommendation arises	How to put into action
Consider establishing a mechanism for ongoing support for the scaling and embedding of successful ARF projects and to sustain innovation in adult social care more broadly	Even relatively successful ARF projects report that they might struggle to sustain innovations. This creates a risk that examples of good practice will be lost. The need for further support varies by type of project with funding for digital innovation, support for carers and Shared Lives being needed for long enough for cost saving impacts in the system to emerge, measured and used to make a business case for local funding.	Target areas of innovation that have proven benefits (based on this and any future evaluation work) with further forms of grant programme support.
Enhance the availability and sharing of best practice within social care innovation	The fund has created many examples of good practice taking place in social care innovation across a wide range of disparate areas.	Provide continued support for systems, focusing on tailored guidance, peer learning, and knowledge exchange.

Recommendation for DHSC	Learning from which this recommendation arises	How to put into action
	Local systems are keen to hear about what works well elsewhere, and why.	Consider establishing a dedicated support function within DHSC or a partner organisation to provide ongoing expertise and resources for social care innovation across areas for which there is established potential for widespread adoption.
Adopt the ARF funding model for other programmes exploring a wide range of innovations	The funding model has generally worked well and is liked by local systems. It allowed for contingency when projects were delayed (through rolling over funding) and fostered genuine innovative practice (by being non-ringfenced). It encouraged collaboration at an ICS-footprint level. Some systems felt there was a lack of clarity about how funds should be used, or their strategic purpose.	Future programmes focused on a 'test and learn' model can be designed in a similar way. For future funds and programmes in social care innovation, provide clearer and more consistent communication to systems and providers regarding funding timelines, reporting requirements, and long-term ambitions for future funding and policy focus.
Require sustainability planning (and outcome measurement) from local areas	In many cases, local systems do not appear to have made proactive plans for sustaining innovations beyond the funding period.	For any future funds, consider requiring systems to develop long-term sustainability plans as part of project design and implementation.

Recommendation for DHSC	Learning from which this recommendation arises	How to put into action
	Sustaining projects is a primary concern in most areas, with local commissioners awaiting evidence of what works before committing further funding.	Provide guidance and support on developing business cases, exploring diverse funding models, and integrating innovations into mainstream services.
Consider adopting a narrower, more targeted approach to funding local areas through national programmes of this nature	Every ICS-region and upper-tier local authority received some ARF funding. The range of priorities for innovation spending were broad and far-reaching. Projects are widely spread, making them difficult to quantify, categorise and understand what has worked best.	Any further funding programmes targeted at social care innovation could be specifically aimed at building upon areas of emerging good practice; digital support for unpaid carers would benefit from a more standardised national approach, for example.
Improve the guidance, information and communication available around social care innovation and DHSC's strategy for spreading best practice	Some systems expressed uncertainty around how funding should be prioritised and spent. They were also unsure about the extent to which specific types of innovations were valued, and therefore which might be the focus of further support in the future. There is particular uncertainty around digital innovations and the use of AI; which tools should be procured, and how they should be used.	Provide continued support for systems, focusing on tailored guidance, peer learning, and knowledge exchange, including outlining a clear strategy focused on adoption of specific innovations. Consider establishing a dedicated support function within DHSC or a partner organisation to provide ongoing expertise and resources for social care innovation across areas for which there is

Recommendation for DHSC	Learning from which this recommendation arises	How to put into action
		established potential for widespread adoption.
Introduce more standards and guidelines around the adoption of digital tools	At present, the market for digital tools to support unpaid carers is diverse, with a lack of clarity around which tools are most appropriate and how best to use them. Providers themselves feel there should be more co-ordinated direction about using tools. Procurement and data governance processes for projects introducing new digital tools were particularly challenging, and local authorities' interpretations of how data governance should be applied was wide ranging.	Provide clear guidance and support to systems on navigating data protection and information governance requirements, particularly for AI-driven innovations.

Table 8b: recommendations arising from the evaluation findings for local systems

Recommendation for local systems	Learning from which this recommendation arises	How to put into action
Streamline procurement and data governance processes	In many areas, the procurement process and establishment of data governance agreement was a significant challenge. The variation in interpretations of applying data protection legislation for digital tools is wide ranging. Many project leads and consortia representatives felt that at times these processes were disproportionate and overly risk averse.	Develop simplified procurement processes for digital tools and address data sharing concerns to facilitate faster and more efficient implementation of technology-enabled care.
Address the potential for a 'digital divide'	Some systems identified the risk of an unexpected consequence emerging whereby those who were more 'digitally literate' (generally younger, better educated, more affluent) would have access to new online support and an improved ability to self-direct care processes to their needs. Those not comfortable with using digital tools would receive a worse service as a result.	Develop strategies for ensuring equitable access to digital tools and resources, addressing digital literacy and infrastructure limitations. Promote inclusive design and consider alternative support mechanisms for digitally excluded carers.

Strengthen co-production processes	The fund explicitly encouraged co-production, as did the SCIE support offer. While this was a strength in some projects, other systems struggled to implement meaningful co-production into their project design and delivery. These systems expressed a desire for understanding how it had been implemented effectively in other areas. SCIE identified this as a significant support need for some systems.	Support peer learning and develop national guidance and resources for local authorities on effective co-production methods, addressing challenges in carer and service user engagement. Explore strategies for mitigating carer burden and ensuring inclusive participation, using examples of best practice from confident systems. Draw together and share evidence of how effective co-production leads to better outcomes and impacts.
Improve evaluation capacity, with a focus on attribution and longer-term impacts	Most local systems were able to submit local impact assessments, including a theory of change and basic evaluation framework. However, many are unsure about how to understand the long-term effects of complex innovations, and how to attribute these specifically to a certain intervention.	Adopt evaluation principles and practice into change management processes, including specific plans and frameworks around evaluation before a project starts. Ensure timely and robust data collection processes, ideally as part of interoperable systems that allow for analysis of how people accessing care interact with the wider system.

Future evaluation

The implications and areas of focus for any future follow-up evaluation of the ARF are as follows.

Undergo further evaluation

Over the next year, it is highly likely that the majority of projects will progress to a stage where they can assess outcomes. Given this, there is a strong case for further evaluation to capture this, and to further explore patterns of outcomes relative to projects' activities.

Focus on long-term outcomes

Future evaluation work should prioritise assessing the impacts of innovations beyond the funding period, particularly focusing on impacts that require longer timescales to be observed such as impacts on:

- carer breakdown
- reduced demand for domiciliary care

Furthermore, future evaluation work should more rigorously examine the additionality and attribution of impact associated with individual projects, likely through more detailed and targeted interviews and/or impact assessments. Any future update of projects' impact assessments should emphasise attribution and measuring and assessing actual rather than planned outcomes and impacts.

In addition, there is very little evidence of consortia using comparison or control groups to aid evaluation of projects. While not practical in some cases, this is possible for some interventions, such as those introducing new technologies.

Explore the ongoing sustainability of projects beyond the funding period

This would explore the extent to which projects have continued by:

- using unspent ARF funds (particularly for projects that have not yet reached the delivery stage)
- using alternative longer-term funding
- embedding into local practices that do not require additional funding (such as awareness of unpaid carer voice and role during hospital discharge)

In addition, explore whether and how systems are using evidence from the fund projects to make a business case for future funding or sustaining of projects. Capture best practice in case making and share this across the sector.

Explore the role of contextual factors on long-term delivery and sustainability

Investigate how local context, leadership and system capacity influence the successful implementation and scaling of innovations. Further investigate the impact of known enablers and barriers on long-term outcomes being achieved. Explore how embedding and scaling of different types of innovation works in practice.

Explore how longer-term outcomes and impacts are associated with project type

Focus on whether the project types that have so far shown fewer clear outcomes or impacts (because of the complexities of the anticipated impacts) start to do so given a longer time period.

Investigate the relationship between mechanisms for change and innovation

Explore the extent to which mechanisms for change identified through this evaluation, which have been developed and strengthened by the fund, are continuing to support innovation in social care systems. An example would be exploring the extent to which new collaborations within ICS footprints have had wider ongoing benefits for integration, and development of other innovations and new initiatives within consortia.

Gather more diverse perspectives including unpaid carers and care users

Include the perspectives of carers, people with care and support needs, frontline staff, and innovation providers in research to gain a more holistic understanding of the impact of innovations. This could be through primary research with these groups and also by drawing on emerging evidence collected by systems on the impacts on these groups.

Develop a more robust assessment of the potential for innovations to be more widely scaled to inform national policy and guidance

Longer-term assessment of the impact, sustainability and more widespread adoption of initiatives can be used to inform the extent to which widespread adoption should be encouraged through national policy and further programmes. This would involve exploring the extent to which learning across consortia through CoPs or other peer learning has been sustained in a way that would facilitate regional or national scaling.

Do not overlook less tangible outcomes

Explore the extent to which less tangible outcomes, such as reduced risk aversion in innovation, have been developed by the fund and demonstrated in subsequent activities within consortia.

Appendix 1: evaluation methodology

This appendix describes the methodological approach to the evaluation.

Further details about each evaluation activity are outlined below.

Evaluation questions

The following evaluation questions were co-developed with DHSC:

Process

1. Has the fund supported local areas to create the conditions for the embedding and scaling of innovations in adult social care?

    1.1. What are the main barriers to scaling innovation?

    1.2. What aspects of the fund enable local areas to innovate within adult social care?

    1.3 What aspects of the fund enable local areas to overcome these barriers and create conditions for the embedding and scaling of innovations?

    1.4. How has the fund increased collaboration between local system partners (such as local authorities, care providers or VCSE organisations)?

    1.5 Did the choice to allocate funding via consortiums within ICS footprints affect the extent to which the fund was impactful?

    1.6 Was the department's setting of 12 national priorities appropriate and effective in guiding local priorities?

    1.7 What is needed for local areas to be able to deliver innovative approaches in a sustainable way post-delivery of the fund?

2. Has the fund and/or the SCIE support offer helped local areas to overcome barriers and to embed and scale innovation in adult social care?

    2.1 Has the fund and/or the support offer helped local areas to effectively design, implement and deliver projects?

    2.2 Has the fund and/or the support offer gathered evidence on how to embed and scale innovation and overcome barriers?

2.3 Has the support offer helped local areas to identify challenges and opportunities for scaling?

2.4 Has the support offer helped facilitate partnership building between local system partners (such as local authorities, care providers or VCSE organisations)?

2.5 Has the fund and/or the support offer helped local areas to co-produce projects with people with lived experience and carers?

2.6 Has the fund and/or the support offer helped facilitate peer learning, sharing and support within and/or between consortia?

2.7 Has the fund helped local areas effectively collate, report and capture their project progress, outputs and outcomes?

Impact

3. What are the impacts of embedding and scaling innovative approaches to delivering care and supporting unpaid carers?

3.1 What specific innovations deliver positive or negative outcomes and for whom, and how do these outcomes vary across local areas and stakeholder group?

3.2 What are the different outcomes that are being measured and achieved as part of the scaling and embedding of existing innovative approaches, and how do these outcomes vary across local areas and stakeholder group?

3.3 What contextual factors (such as local leadership, engagement from local people, demand and capacity) influence the successful implementation and positive outcomes associated with different interventions?

3.4 Have any of the innovative approaches had an impact on the wider health and care system (such as workforce changes or reduction in demand for NHS services)?

Scoping and evaluation design

To gain a comprehensive understanding of the fund and its main activities, a scoping and design phase was undertaken. Three familiarisation activities were carried out:

- document review: engagement and communication plans, local consortia EoIs, policy and strategy documents, and support programme plans
- scoping interviews: 6 scoping interviews were conducted with representatives from DHSC and SCIE, identified by the DHSC ARF team
- co-design workshops with DHSC and SCIE

The scoping and evaluation design report, finalised in July 2024, described the overall context for the evaluation and its full methodological approach and the design of the 3 waves of research which followed. A ToC was also developed as an output, and this forms the basis of the evaluation.

Survey of consortia representatives

Across all 3 waves of the evaluation, an online survey of consortia representatives, including consortia leads, project leads and delivery partners, was conducted.

Table 9: dates of surveys conducted in each fieldwork wave

Wave	Dates of fieldwork
Wave 1	8 July to 9 August 2024
Wave 2	1 November to 12 December 2024
Wave 3	28 April to 23 May 2025

An open link to the survey was sent to each consortium representative, as identified by DHSC, asking them to take part. Representatives were encouraged to share the survey link with their delivery partners and other ARF colleagues to gather a wider range of perspectives. At waves 2 and 3, this sample was extended to include project leads, as identified by DSHC.

Two reminder invites were sent over each fieldwork period. These were sent to the entire sample thanking them for their involvement, if they had taken part, and asking them to share the invite within their consortium.

Each wave of the survey included a mixture of open and closed questions, covering topics that mapped to the programme ToC and evaluation objectives:

Wave 1 consisted of 26 questions that covered:

- EoIs and developing project ideas
- funding
- the SCIE support offer
- embedding and scaling innovation

Wave 2 consisted of 34 questions that covered:

- reporting and funding
- the SCIE support offer
- embedding and scaling innovation
- project progress to date

In addition, participants who had not responded in wave 1 were asked about the EoIs and developing project ideas.

Wave 3 consisted of 32 questions. In this wave, participants were also asked questions about each of their specific projects, the topics included:

- project background and progress to date
- the SCIE support offer
- collaboration and co-production
- outcomes and impact
- future planning and sustainability

Over the 3 surveys, the following responses were received:

Table 10: survey responses by fieldwork wave

Fieldwork wave	Total responses	Number of partials	Number of consortia (out of 42)	Number of projects represented
Wave 1	40	6	28	Not applicable
Wave 2	90	5	35	Not applicable
Wave 3	56	6	31	120

To increase the response rate across all 3 waves of the survey, partial responses were included in analysis, as shown in the above table. These included responses from participants who had completed over half of the survey questions.

To ensure data integrity, partial responses were checked to ensure they did not duplicate any complete responses. These partial completes have been included in reporting, so the base for each question differs depending on whether or not they were completed by any of the respondents who partially completed the survey.

Interviews with consortia leads

Consortia lead interviews were conducted to gather in-depth insights into the overall experience of the fund from the perspective of those with responsibility for strategic oversight at an ICS footprint level. The interviews represented a range of different ICSs and local authorities. The following sampling criteria were also used:

- rural-urban classification
- number of local authorities involved
- size of ICS area
- engagement with SCIE support offer

Over the course of the 3 waves, 18 consortia lead interviews were conducted.

An invitation was sent to all consortia leads, as identified by DHSC, and selected based on availability and an agreed list of sampling considerations. Interviews were carried out Microsoft Teams, with each interview lasting approximating 60 minutes.

Wave 1

Wave 1 interviews were carried out from 6 July to 21 August 2024. A total of 10 in-depth interviews were conducted. The topics covered included:

- broader national and local context around innovation in adult social care
- rational behind consortiums ARF project design
- initiation and set-up of the fund
- ARF delivery progress to date

Wave 2

Wave 2 interviews were carried out from 15 November 2024 to 4 January 2025. A total of 10 in-depth interviews were conducted. Half of the interviewees had been interviewed during wave one. The topics covered included:

- ongoing ARF project design rationale
- receipt of funding and ongoing management of the fund
- the SCIE support offer
- ARF delivery progress to date
- scaling, embedding and peer learning

Wave 3

Wave 3 interviews took place from 11 April to 29 May 2025. The evaluation team initially planned to interview 12 consortia leads during this phase - however, due to interviewee availability, a total of 8 in-depth interviews were conducted. Three of the interviewees had been interviewed during both wave 1 and wave 2, and a further 2 interviewees had been interviewed at wave 2. Three had not been interviewed previously. The topics covered included:

- ongoing ARF project design rationale
- receipt of funding and ongoing management of the fund
- the SCIE support offer
- ARF delivery progress to date
- scaling, embedding and peer learning

Interviews with project leads

Project lead interviews were conducted to explore the ongoing experience of the fund from the perspective of those working on individual projects. They covered how projects were being delivered, enablers and barriers to innovation in adult social care, and their engagement with the fund and the SCIE support offer. Wave 3 interviews also covered evidence gathering and impacts.

All interviews were carried out using Microsoft Teams, with each interview lasting approximately 60 minutes.

Wave 1

At wave 1, an invitation was sent to all project leads, as identified by DHSC, and selected based on availability and an agreed list of sampling considerations.

Interviews took place from 1 to 28 August 2024. The evaluation team conducted a total 24 in-depth interviews. This included 17 one-to-one interviews and 7 group interviews, overall, the evaluation team spoke to 32 project leads across 23 individual ARF-funded projects. These projects include representation across all 12 DHSC priority areas, unpaid carer projects and a range of different consortia.

The topics covered included:

- project context and rationale
- planned project activities, outputs, outcomes and impacts
- enablers barriers and risks

Wave 2

Projects were chosen as case studies for inclusion in wave 2 fieldwork using agreed sampling criteria. The interviews were carried out from 22 November to 20 December 2024. Projects were preselected and individually contacted using the sampling considerations.

The evaluation team initially planned to carry out 12 interviews covering the range of ARF projects. However, due to interviewee availability and project set-up, 11 interviews were carried out with 16 interviewees.

The topics covered included:

- funding and reporting processes
- ARF project progress to date including

- project activities, outputs, outcomes and impacts
- enablers, barriers and risks

Wave 3

Project leads were approached based on their involvement during wave 2 fieldwork. The interviews were carried out from 7 April to 28 May 2025.

The evaluation team had initially planned on interviewing representatives from the same 11 projects and adding one additional project. However, due to interviewee availability, 10 interviews were carried out with 14 individuals. Eight of the projects had been interviewed at wave 2. Two new projects were interviewed at wave 3 based on agreed-upon sampling criteria and the consortia's involvement in the evaluation.

Detailed 'Accelerating Reform Fund: case studies' of these projects have been published alongside this report.

They topics covered included:

- project progress, outputs, outcomes and impacts
- enablers and barriers, including impact of the SCIE support offer
- lessons learned and opportunities for scaling and embedding
- evidence gathering
- overall reflections on the fund

Interviews with SCIE representatives

Interviews were conducted with members of the SCIE support team to gather in-depth insights into their overall experience of delivering the support offer and implementing innovation in social care.

These in-depth interviews were carried out on Microsoft Teams and lasted approximately 60 minutes.

Table 11: interviews with SCIE representatives by wave

Fieldwork wave	Number of interviews	Number of interviewees	Date
Wave 1	2	4	August 2024

Wave 2	2	4	November 2024
Wave 3	2	4	April 2024

The main topics explored during wave 1 were:

- embedding and scaling innovation in adult social care
- ARF project design rationale
- initiation and set-up of ARF
- ARF delivery progress to date

The main topics explored during wave 2 were:

- support offer delivery progress to date
- ARF delivery progress to date

The main topics explored during wave 3 were:

- overall reflections on support delivery
- lessons learned
- support offer engagement
- scaling and embedding innovations
- overall reflections on the fund

Interviews with innovation partners

Interviews with innovation partners were held in wave 3 to gather insights from the providers of innovation tools or products linked to ARF-funded projects. The evaluation team had initially planned to carry out 8 interviews. However, due to interviewee availability, three innovation partner interviews were conducted in total.

The main themes covered were:

- opportunities and outcomes associated with innovations
- enablers and barriers to implementation of innovations

- potential for embedding and scaling innovations
- how DSHC and the government more widely could further support and facilitate innovations with adult social care

These in-depth interviews were carried out from 8 to 17 April 2025. An invitation was sent out to an agreed list of innovation partners provided by DSHC. The interviews were carried out on Microsoft Teams and lasted approximately 60 minutes.

Interviews with unpaid carers and care users

Interviews were conducted with unpaid carers during wave 3 to gather insights into the experiences of those who have accessed the services funded by the ARF locally. Interviewees were approached through project leads. Initially the evaluation team had planned to conduct 6 interviews. However, due to interviewee availability among this group during the fieldwork period, three interviews were carried out. The main topics explored were:

- services accessed and used
- barriers and challenges associated with accessing social care support
- potential benefits of engaging with the service or intervention

The interviews took place between 8 to 17 April 2025. An incentive was offered to interviewees. The in-depth interviews were carried out on Microsoft Teams and lasted approximately 45 minutes.

Analysis and reporting

The survey results were processed by Ipsos and analysed by the evaluation team. Likert-scale responses were charted as percentages and open-ended responses were thematically analysed and coded.

All in-depth interviews were recorded before being transcribed. The transcripts were thematically analysed against the evaluation questions using an agreed coding structure linked to the evaluation questions.

The evaluation team held internal analysis and triangulation meetings to consider:

- how the different evidence sources addressed the evaluation questions
- how they mapped against one another
- the overarching evaluation objectives and ToC

Synthesised data was analysed to assess whether there were any patterns in relation to type of project and their level of development.

Evaluation support

Ipsos provided consortia with various types of support to develop and complete their impact assessment as described below.

Workshops and support with preparing local impact assessments

Ipsos ran a workshop with consortia and project leads to:

- outline the findings from wave
- explain the requirements related to local impact assessments
- provide advice and information on developing a theory of change, measuring outcomes and impacts and reporting on them

A second workshop after wave 2 provided updated findings and built on the support for completing local impact assessments.

At both workshops, a breakout session allowed participants with similar project types to share experiences and ideas for measuring impact.

Following the workshops, and during the period in which consortia were preparing their impact assessment, further support and feedback on the forms was provided to consortia on request.

One-to-one support

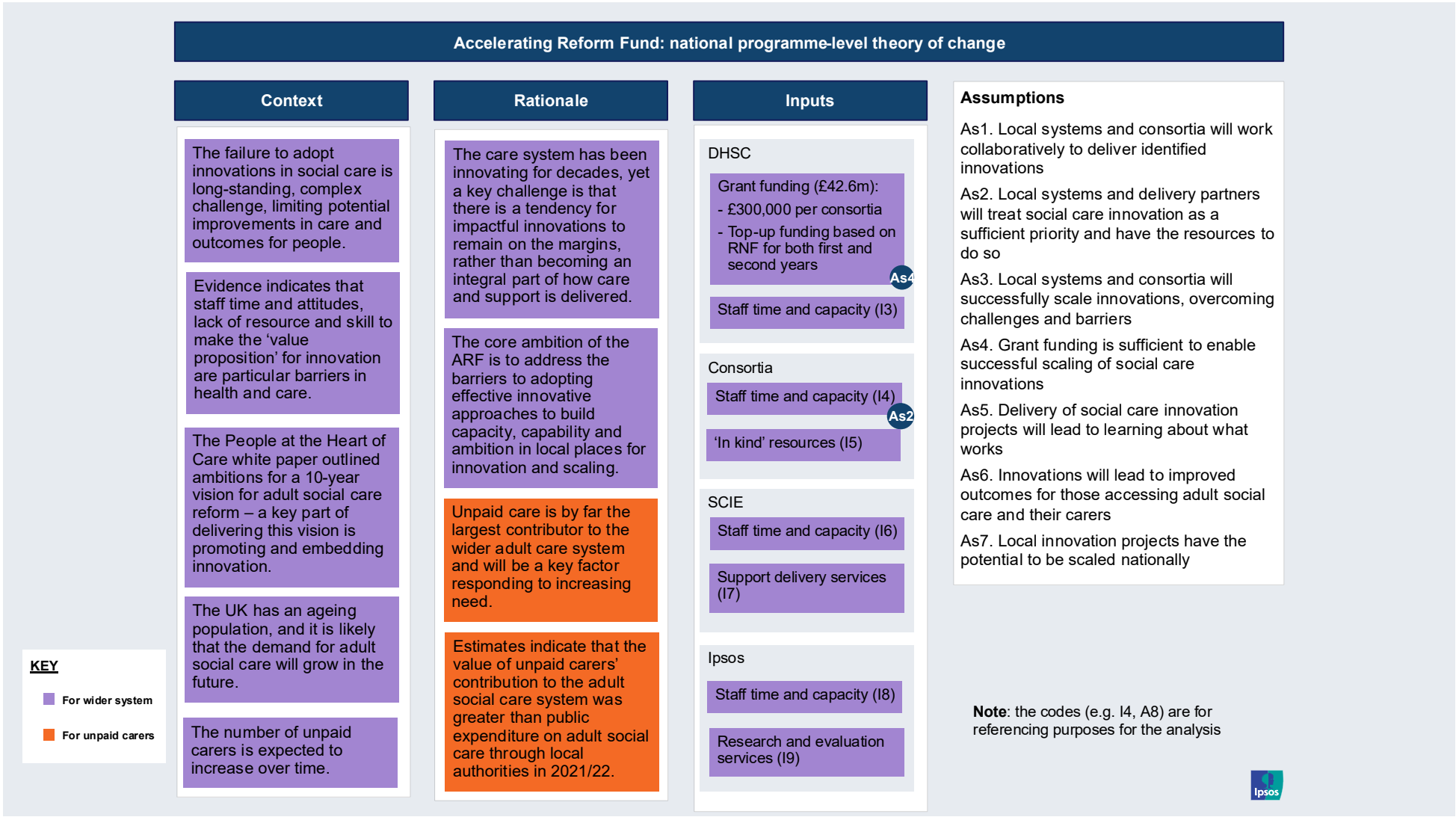
To help with the development of the impact assessments, the evaluation team delivered direct support to each consortium. Over the course of the evaluation period, Ipsos held 22 individual support sessions with 16 consortia, and 2 group sessions with consortia accessing the same digital platform with their ARF funding.

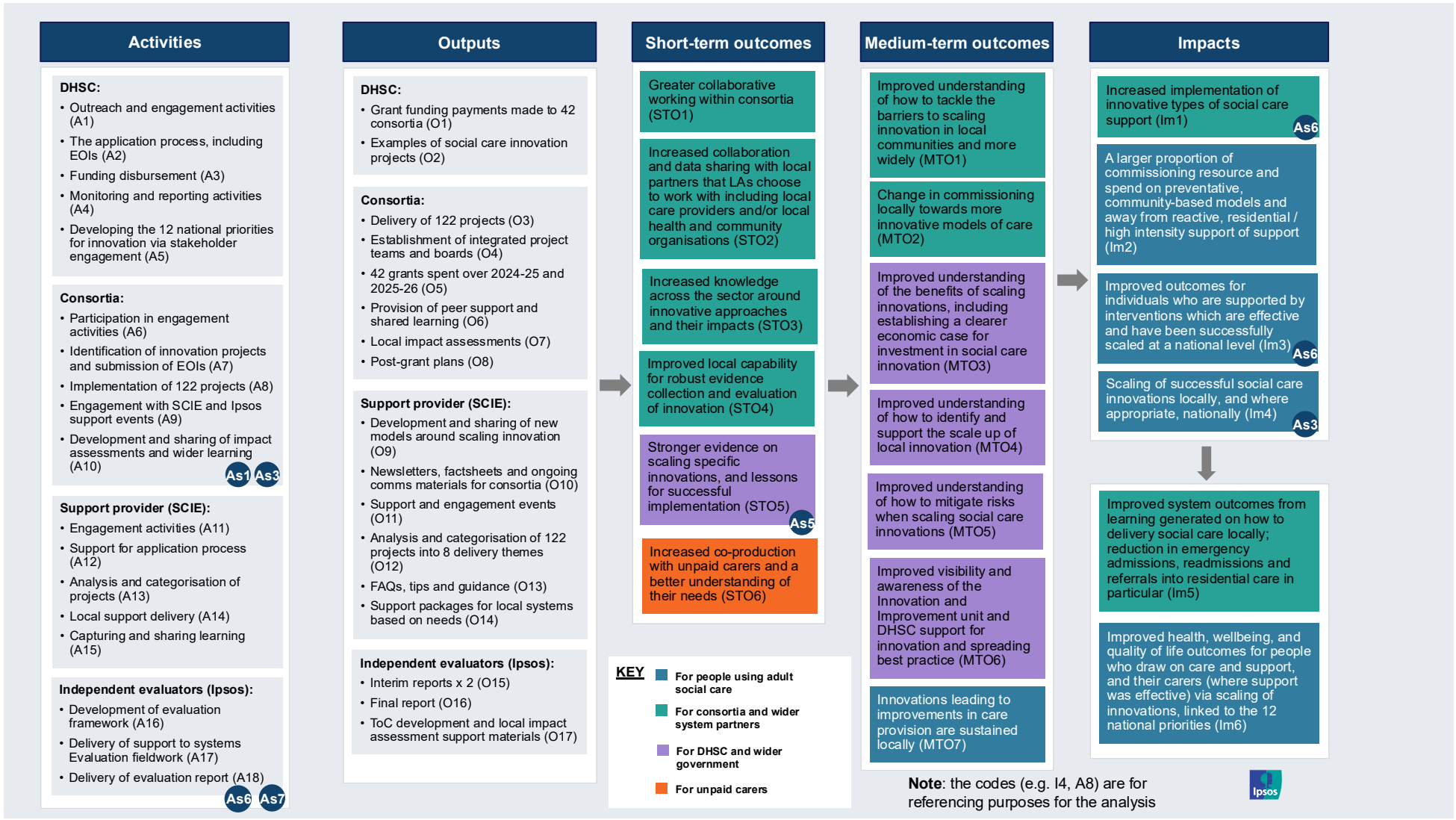
Many of these sessions covered ToC and evaluation framework development. Discussions also covered how to situate local evaluations in the national context while supporting a robust local evaluation approach. The consortia taking part in these sessions were often in the early stages of their evaluation process and so were not yet measuring outcomes.

Appendix 2: theory of change and mechanisms for change

On the next page, Figure 8 is a theory of change (ToC) for the ARF programme, which captures the main elements of change as described below.

Figure 8: full theory of change for the fund




Activities
DHSC:
• Outreach and engagement activities (A1)
• The application process, including EOIs (A2)
• Funding disbursement (A3)
• Monitoring and reporting activities (A4)
• Developing the 12 national priorities for innovation via stakeholder engagement (A5)
Consortia:
• Participation in engagement activities (A6)
• Identification of innovation projects and submission of EOIs (A7)
• Implementation of 122 projects (A8)
• Engagement with SCIE and Ipsos support events (A9)
• Development and sharing of impact assessments and wider learning (A10)
As1 As3
Support provider (SCIE):
• Engagement activities (A11)
• Support for application process (A12)
• Analysis and categorisation of projects (A13)
• Local support delivery (A14)
• Capturing and sharing learning (A15)
Independent evaluators (Ipsos):
• Development of evaluation framework (A16)
• Delivery of support to systems Evaluation fieldwork (A17)
• Delivery of evaluation report (A18)
As6 As7
Outputs
DHSC:
• Grant funding payments made to 42 consortia (O1)
• Examples of social care innovation projects (O2)
Consortia:
• Delivery of 122 projects (O3)
• Establishment of integrated project teams and boards (O4)
• 42 grants spent over 2024-25 and 2025-26 (O5)
• Provision of peer support and shared learning (O6)
• Local impact assessments (O7)
• Post-grant plans (O8)
Support provider (SCIE):
• Development and sharing of new models around scaling innovation (O9)
• Newsletters, factsheets and ongoing comms materials for consortia (O10)
• Support and engagement events (O11)
• Analysis and categorisation of 122 projects into 8 delivery themes (O12)
• FAQs, tips and guidance (O13)
• Support packages for local systems based on needs (O14)
Independent evaluators (Ipsos):
• Interim reports x 2 (O15)
• Final report (O16)
• ToC development and local impact assessment support materials (O17)
Short-term outcomes
Greater collaborative working within consortia (STO1)
Increased collaboration and data sharing with local partners that LAs choose to work with including local care providers and/or local health and community organisations (STO2)
Increased knowledge across the sector around innovative approaches and their impacts (STO3)
Improved local capability for robust evidence collection and evaluation of innovation (STO4)
Stronger evidence on scaling specific innovations, and lessons for successful implementation (STO5)
As5
Increased co-production with unpaid carers and a better understanding of their needs (STO6)
KEY
For people using adult social care
For consortia and wider system partners
For DHSC and wider government
For unpaid carers
Medium-term outcomes
Improved understanding of how to tackle the barriers to scaling innovation in local communities and more widely (MTO1)
Change in commissioning locally towards more innovative models of care (MTO2)
Improved understanding of the benefits of scaling innovations, including establishing a clearer economic case for investment in social care innovation (MTO3)
Improved understanding of how to identify and support the scale up of local innovation (MTO4)
Improved understanding of how to mitigate risks when scaling social care innovations (MTO5)
Improved visibility and awareness of the Innovation and Improvement unit and DHSC support for innovation and spreading best practice (MTO6)
Innovations leading to improvements in care provision are sustained locally (MTO7)
Impacts
Increased implementation of innovative types of social care support (Im1)
As6
A larger proportion of commissioning resource and spend on preventative, community-based models and away from reactive, residential / high intensity support of support (Im2)
Improved outcomes for individuals who are supported by interventions which are effective and have been successfully scaled at a national level (Im3)
As6
Scaling of successful social care innovations locally, and where appropriate, nationally (Im4)
As3
Improved system outcomes from learning generated on how to delivery social care locally; reduction in emergency admissions, readmissions and referrals into residential care in particular (Im5)
Improved health, wellbeing, and quality of life outcomes for people who draw on care and support, and their carers (where support was effective) via scaling of innovations, linked to the 12 national priorities (Im6)
Note: the codes (e.g. I4, A8) are for referencing purposes for the analysis
Ipsos

A full text alternative (narrative description) to the ToC outlined in Figure 8 follows.

Inputs

Inputs are defined as the resources committed to the activities involved in the programme. Broadly, 3 types of inputs have been identified: strategy and planning, funding, and staff time and expertise.

National inputs (DHSC, SCIE and Ipsos)

National inputs are as follows:

- the funding itself:
    - a £300,000 ‘floor’ per ICS consortium (sample size of 42) intended to cover some core project start-up costs and will be provided in full in the first year
    - top-up funding, totalling £30 million for all local authorities in England intended to cover some programme costs and is calculated based on the adult social care relative needs formula (RNF) at a local authority level and summed to the ICS at a consortium level
- the SCIE support programme funding
- independent evaluation (delivered by Ipsos) funding
- DHSC, SCIE and Ipsos staff resource

Local inputs (consortia: local authorities and system partners)

Local inputs are as follows:

- local authority staff resource
- ‘In kind’ resources within local authorities, such as estate and use of existing digital tools

Activities

Activities can be described as the things that have happened or that we expect to happen in the delivery of the programme. Across the ARF, activities are undertaken by 4 main stakeholder groups: DHSC, local systems or consortia, the support provider (SCIE) and the independent evaluator (Ipsos).

DHSC

DHSC's activities are:

- developing the 12 national priorities for innovation through stakeholder engagement
- outreach and engagement activities with local systems and consortia
- the application process, including submission and assessment of EoIs
- funding disbursement
- monitoring and reporting of grant spending and activities

Local systems or consortia

Systems' activities are:

- pre-grant funding participation in engagement activities
- identification of innovation projects and submission of EoIs
- establishing local commissioning and governance arrangements
- implementation of 122 projects – covering 12 national priorities
- engagement with SCIE support events and support for ToC development and impact assessment
- development and sharing of impact assessments, post-grant plans and wider learning between systems

Support provider (SCIE)

SCIE's activities are:

- development of webpage and ongoing support events
- webinars and engagement activities for application process
- Q&A webinar to support applications and ad-hoc support or responding to queries from systems
- analysis and categorisation of projects into delivery themes
- local support delivery tailored to respond to consortia needs
- capturing and sharing learning from systems and projects

- independent evaluator (Ipsos)
- development of evaluation framework and approach
- delivery of support to systems for ToC development and local impact assessments (1 national workshop and 42 webinars for individual systems and consortia)
- 3 waves of interviews and surveys
- delivery of evaluation report and recommendations and learning

Outputs

Outputs can be described as what is delivered or produced as a result of the programme. Across the ARF, outputs are associated with 4 main stakeholder groups: DHSC, local systems or consortia, the support provider (SCIE) and the independent evaluator (Ipsos).

DHSC

DHSC outputs are:

- grant funding payments made to 42 consortia
- detailed examples of social care innovation projects across 12 national priorities and all 42 ICSs

Local systems or consortia

Systems' outputs are:

- development of 122 social care innovation scaling projects – covering 12 national priorities
- establishment of local collaboration and partnerships - through integrated project teams and boards
- increased dialogue and learning both within and between systems
- 42 grants spent over 2023 to 2024
- provision of peer support and shared learning through SCIE events, local ToC development workshop and others events for national knowledge sharing
- local impact assessments
- post-grant plans outlining how scaling innovation will continue

Support provider (SCIE)

SCIE's outputs are:

- development and sharing of new models around supporting and scaling innovation.
- newsletters, factsheets and ongoing comms materials for consortia
- support and engagement events
- analysis and categorisation of 122 projects into 8 delivery themes
- frequently asked questions, tips and guidance
- support packages for local systems based on needs

Independent evaluator (Ipsos)

Ipsos's outputs are:

- final evaluation report
- ToC development and local impact assessment support materials

Outcomes

Outcomes are the intended and unintended changes that are experienced by stakeholders as a result of the programme. Outcomes for the ARF can be grouped into short and medium-term.

Short-term outcomes

Short-term outcomes are:

- greater collaborative working within consortia
- increased collaboration and co-production with local partners that local authorities choose to work with including local care providers and/or local health and community organisations on their chosen option(s)
- stronger evidence on scaling specific innovations, and lessons for successful implementation
- increased knowledge across the sector around innovative approaches and their impacts

- improved local capability (in terms of evaluation skills, drafting business cases and understanding potential for scaling and sustaining innovations)

Medium-term outcomes

Medium-term outcomes are:

- programme innovations are scaled up and successfully sustained locally
- improved understanding of how to identify and support the scale up of local innovation
- improved understanding of the benefits of scaling innovations, including establishing a clearer economic case for investment in social care innovation
- improved understanding of how to tackle the barriers to scaling innovation in local communities and more widely
- improved visibility and awareness of DHSC support for innovation and spreading best practice
- improved understanding of how to mitigate risks when scaling social care innovations
- change in commissioning locally towards more innovative models of care

Impacts

Impacts are the long-term, sustainable changes at a system level. 4 shorter-term impacts have been identified, which will then subsequently lead to 2 overarching longer-term impacts. Firstly:

- increased implementation of innovative types of social care support
- a larger proportion of commissioning resource and spend on preventative, community-based models and away from reactive, residential or high intensity models of support
- improved outcomes for individuals who are supported by interventions that are effective and have been successfully scaled at a national level
- scaling of successful social care innovations locally, and where appropriate, nationally

Leading to:

- improved health, wellbeing and quality of life outcomes for people who draw on care and support, and their carers (where support was effective) through scaling of innovations, linked to the 12 national priorities

- improved system outcomes from learning generated on how to delivery social care locally: reduction in emergency admissions, readmissions and referrals into residential care in particular

Risks and assumptions

The following risks and assumptions have been identified as those associated with the ARF:

Risks

Risks identified to the outputs, outcomes and impacts identified for the national ARF programme as part of the ToC development process included the following.

For the programme:

- grant is not ringfenced and therefore can be spent inappropriately
- ICSs or other system leaders and partners not viewing the ARF as a good opportunity
- communications activity not responding to local needs and circumstance
- insufficient stakeholder confidence in the long-term success and sustainability of the programme and scaling social care innovation more widely

For projects:

- local disagreements, competing ICS bids and a lack of effective partnership working
- insufficient capacity within local systems to deliver innovation projects, or lack of broader resource (outside of the fund) to deliver sustainable projects beyond the life of the fund
- proposal (EoI) scope too great or diverse to deliver on time and/or maximise impact
- people in community not suitably engaged in design of new or scaled up services
- limitations in the provider market and/or workforce acting as a barrier to innovations being unable to be scaled up in certain areas despite the demand being there

Assumptions

Assumptions identified that can be associated with causal links included in the ToC:

- local systems and consortia will work collaboratively to deliver identified innovations

- local systems and delivery partners will treat social care innovation as a sufficient priority and have the resources to do so
- local systems and consortia will successfully scale innovations, overcoming challenges and barriers
- grant funding will enable successful scaling of social care innovations
- grant funding will be spent on innovative social care projects
- delivery of social care innovation projects will lead to learning about what works
- innovations will lead to improved outcomes for those accessing adult social care and their carers
- local innovation projects have the potential to be scaled either locally or nationally (depending on what is most appropriate

ToC mechanisms

The table below details the mechanisms and assumptions involved in the causal links between different elements within the ToC, which will be tested through the evaluation framework (see Figure 8 above):

Table 12: mechanisms and assumptions associated with the fund's ToC

ToC stage	Outcomes or impacts and associated mechanisms (references in brackets link to theory of change diagram)
Outputs to short-term outcomes (STOs)	Greater collaborative working within consortia (STO1): local systems within consortia are able to work together to collaboratively identify appropriate innovations. Increased collaboration and data sharing with local partners that Local authorities choose to work with including local care providers and/or local health and community organisations on their chosen option(s) (STO2) and improved local capability for robust evidence collection and evaluation of innovation (STO4): cross-sector collaborations within systems support local systems to identify and connect with existing resources in their network, working together to draw on the different skills, expertise and perspectives that exist across the local system to strengthen their ideas. Increased knowledge across the sector around innovative approaches and their impacts (STO3) and improved local capability for robust

	evidence collection and evaluation of innovation (STO4): local systems are enabled to take risks and question assumptions, strengthening their ideas and the wider social care innovation evidence base. Increased collaboration and co-production with unpaid carers and a better understanding of their needs (STO6): consortia and project leads engage with unpaid carers and those with lived experience as part of innovation design, and their knowledge of innovation problems and solutions is challenged and further informed by this.
Short-term outcomes to medium-term outcomes (MTOs)	Improved understanding of how to tackle the barriers to scaling innovation in local communities and more widely (MTO1) and improved understanding of how to mitigate risks when scaling social care innovations (MTO5): local systems will be able to overcome some of the identified challenges and barriers to social care innovation, through effective design and implementation. Improved understanding of the benefits of scaling innovations, including establishing a clearer economic case for investment in social care innovation (MTO3): projects are outcomes-focused, and teams collects initial evidence and data of outcomes and impact. Improved understanding of how to identify and support the scale up of local innovation (MTO4): the delivery of social care innovation projects generates good quality evidence of what works, and how barriers to social care innovation can be overcome.
Medium-term outcomes to impacts (Im)	A larger proportion of commissioning resource and spend on preventative, community-based models and away from reactive, residential and/or high intensity support of support (Im2): consortia and local systems can see from Funded projects that further investment in preventative, community-based models of care is beneficial. Scaling of successful social care innovations locally, and where appropriate, nationally (Im4): social care innovation projects are aligned to national priorities, and learning generated by them can be applied to scaling at a national level. Improved system outcomes from learning generated on how to delivery social care locally; reduction in emergency admissions, readmissions and referrals into residential care in particular (Im5): funded projects lead to better decisions and ways of working among consortia and local systems.

	Improved health, wellbeing, and quality of life outcomes for people who draw on care and support, and their carers (where support was effective) through scaling of innovations, linked to the 12 national priorities (Im6): unpaid carers and/or those in receipt of care engage with and see benefits from Funded interventions, since they are relevant, fit-for-purpose, and are centred on those who use of provide care.

Appendix 3: evaluation framework

The table below indicates the specific evidence and judgment criteria to be applied against each of the proposed evaluation questions, and the source (or sources) of this evidence.

Evidence sources and judgement criteria for each evaluation question

Table 13a: process - 1. Has the fund supported local areas to create the conditions for the embedding and scaling of innovations in adult social care?

Evaluation question	Evaluation source(s)	Judgement criteria
1.1. What are the main barriers to scaling innovation?	Surveying of consortia leads and partners. Interviews with SCIE representatives. Interviews with consortia representatives. Case study interviews with project leads.	SCIE representatives reporting on what they see as the main barriers to scaling social care innovation at a national level. Consortia representatives reporting on the main barriers they have encountered and/or are present in their respective systems. Project leads reporting on the main barriers encountered or expected to be encountered by their individual projects.

Evaluation question	Evaluation source(s)	Judgement criteria
1.2 What aspects of the fund enable local areas to innovate within adult social care?	Interviews with SCIE representatives. Interviews with consortia representatives.	Consortia leads and SCIE representatives report on how specific aspects of the fund's design and delivery have enabled innovation within adult social care.
1.3 What aspects of the fund enable local areas to overcome these barriers and create conditions for the embedding and scaling of innovations?	Surveying of consortia leads and partners. Interviews with SCIE representatives. Interviews with consortia representatives. Case study interviews with project leads. Review and synthesis of local impact assessments.	Stakeholders reporting on what would help them overcome the barriers presented by embedding and scaling social care innovation. Stakeholders report on the barriers they have overcome locally, describing how the fund enabled this success when compared with before the fund was in place. The impact of projects locally indicates that barriers to scaling and embedding innovations have been overcome, and why this is the case in comparison with non-ARF contexts.
1.4 How has the fund increased collaboration between local system partners (such as local authorities, care providers, VCSE organisations)?	Surveying of consortia leads and partners. Interviews with consortia representatives.	Stakeholders report an increase in collaboration and data sharing between local system partners as a result of ARF funding. Stakeholders report that project design and implementation has included collaboration between local system partners.

Evaluation question	Evaluation source(s)	Judgement criteria
	Case study interviews with project leads. Review and synthesis of local impact assessments.	Stakeholders reporting on aspects of the fund that contribute towards collaboration between local system partners. Local impact assessments include evidence of increased collaboration between local system partners in design and/or delivery.
1.5 Did the choice to allocate funding through consortiums within ICS footprints affect the extent to which the fund was impactful?	Interviews with SCIE representatives. Interviews with consortia representatives. Review and synthesis of local impact assessments.	Stakeholders report impacts of the fund linked to consortia funding model. Evidence from local impact assessments that funding through consortia and/or ICS footprints has affected project outcomes, and why.
1.6 Was DHSC's setting of 12 national priorities appropriate and effective in guiding local priorities?	Surveying of consortia leads and partners. Interviews with consortia representatives. Case study interviews with project leads.	Consortia representatives report that local priorities were influenced by 12 national priorities. Project plans and delivery align with 12 national priorities. Stakeholders leading project reporting in the appropriateness and effectiveness of applying one or more of the 12 national priorities to their individual projects.

Evaluation question	Evaluation source(s)	Judgement criteria
1.7 What is needed for local areas to be able to deliver innovative approaches in a sustainable way post-delivery of the fund?	Interviews with SCIE representatives. Interviews with consortia representatives. Case study interviews with project leads. Review and synthesis of local impact assessments.	Stakeholders (consortia and SCIE) reporting on the requirements for sustainable delivery of innovations post-Fund, including scaling and/or embedding either locally or nationally. Project leads reporting on what factors have led to their project delivering innovative approaches in a sustainable way. Local impact assessments demonstrate that some projects will deliver innovative approaches in a sustainable way post-Fund and detail the factors locally that have supported this.

Table 13b: process - 2. Has the fund and/or the SCIE support offer helped local areas to overcome barriers and to embed and scale innovation in adult social care?

Evaluation question	Evaluation source(s)	Judgement criteria
2.1 Has the fund and/or the support offer helped local areas to effectively design, implement and deliver projects?	Surveying of consortia leads and partners. Interviews with SCIE representatives.	Stakeholders report that the fund and SCIE support offer has supported gathering evidence on how to embed and scale innovation and overcome barriers.

	Interviews with consortia representatives. Case study interviews with project leads. Review and synthesis of local impact assessments.	SCIE support outputs include wide ranging and robust evidence on how to embed and scale innovation and overcome barriers. Local impact assessments demonstrate that SCIE support has enabled projects to overcome barriers to scaling and embedding innovation.
2.2 Has the fund and/or the support offer gathered evidence on how to embed and scale innovation and overcome barriers?	Surveying of consortia leads and partners. Interviews with SCIE representatives. Interviews with consortia representatives. Case study interviews with project leads. Review and synthesis of local impact assessments.	Stakeholders report that the fund and SCIE support offer has supported gathering evidence on how to embed and scale innovation and overcome barriers. SCIE support outputs include wide ranging and robust evidence on how to embed and scale innovation and overcome barriers. Local impact assessments demonstrate that SCIE support has enabled projects to overcome barriers to scaling and embedding innovation.
2.3 Has the support offer helped local areas to identify challenges and opportunities for scaling?	Surveying of consortia leads and partners. Interviews with SCIE representatives.	Stakeholders report on the comparative scaling challenges and opportunities they encountered, and how the support offer helped identify these.

	Interviews with consortia representatives. Case study interviews with project leads. Review and synthesis of local impact assessments.	Local impact assessments demonstrate how the support offer enabled projects to identify potential challenges and opportunities from innovations.
2.4 Has the support offer helped facilitate partnership building between local system partners (such as local authorities, care providers or VCSE organisations)?	Surveying of consortia leads and partners. Interviews with SCIE representatives. Interviews with consortia representatives. Case study interviews with project leads.	Stakeholders report an increase in collaboration and data sharing between local system partners linked to the support offer. Stakeholders report that project design and implementation has included collaboration between local system partners. Local impact assessments include evidence of increased collaboration between local system partners in design and/or delivery.
2.5 Has the fund and/or the support offer helped local areas to co-produce projects with people with lived experience and carers?	Surveying of consortia leads and partners. Interviews with SCIE representatives. Interviews with consortia representatives.	Stakeholders report that project design and implementation has included co-production with people with lived experience and carers, and link this to the support offer.

	Case study interviews with project leads.	
2.6 Has the fund and/or the support offer helped facilitate peer learning, sharing and support within and/or between consortia?	Surveying of consortia leads and partners. Interviews with SCIE representatives. Interviews with consortia representatives. Case study interviews with project leads. Review and synthesis of local impact assessments.	Stakeholders report on how the fund and/or support offer has facilitated peer learning, sharing and support. SCIE representatives reporting on how the support offer was structured and designed to facilitate peer learning, sharing and support. Local impact assessments demonstrate evidence of peer learning and sharing across systems and projects that has informed project design or delivery.
2.7 Has the fund helped local areas effectively collate, report and capture their project progress, outputs and outcomes?	Surveying of consortia leads and partners. Interviews with SCIE representatives. Interviews with consortia representatives. Case study interviews with project leads.	Stakeholders report on the extent to which the fund has enabled successful delivery and implementation of projects. Stakeholders report that projects have effectively collated, reported and captured their project progress, outputs and outcomes, and that the support offer has enabled this. Local impact assessments demonstrate that project progress, outputs and outcomes have been collated and reported effectively.

	Review and synthesis of local impact assessments.	

Table 13c: impact – 3. What are the impacts of embedding and scaling innovative approaches to delivering care and supporting unpaid carers?

Evaluation question	Evaluation source(s)	Judgement criteria
3.1 What specific innovations deliver positive or negative outcomes and for whom, and can these outcomes be found across multiple local areas or consortia?	Surveying of consortia leads and partners. Interviews with SCIE representatives. Interviews with consortia representatives. Case study interviews with project leads. Review and synthesis of local impact assessments.	Stakeholders report specific positive and negative outcomes being generated by projects and which groups these projects affect. Stakeholders report on the extent to which common outcomes are taking place across multiple local areas and consortia. SCIE support offer identifies common themes around outcomes linked to different types of projects. Local impact assessments demonstrate positive and negative outcomes across multiple projects, local areas and/or consortia. They also provide evidence of how these outcomes affect different groups. Local impact assessments demonstrate common themes or patterns in the outcomes experienced across multiple local areas and consortia implementing similar innovations.

Evaluation question	Evaluation source(s)	Judgement criteria
3.2 What are the different outcomes that are being measured and achieved as part of the scaling and embedding of existing innovative approaches, and how do these outcomes vary across local areas and stakeholder group?	Surveying of consortia leads and partners. Interviews with SCIE representatives. Interviews with consortia representatives.	Stakeholders report on the use of different outcome indicators for projects and how these were established. Local impact assessments demonstrate the range of outcomes being captured across projects.
3.3 What contextual factors (such as local leadership, engagement from local people, demand and capacity) influence the successful implementation and positive outcomes associated with different interventions?	Surveying of consortia leads and partners. Interviews with SCIE representatives. Interviews with consortia representatives. Case study interviews with project leads. Review and synthesis of local impact assessments.	Stakeholders report on how the presence (or absence) of strong local leadership, both within communities and organisations, impacts the implementation and effectiveness of interventions. Stakeholders report on the extent to which active participation and engagement from local people influences the success and sustainability of interventions. Local impact assessments demonstrate how contextual factors influence the successful implementation and positive outcomes associated with different projects.

Evaluation question	Evaluation source(s)	Judgement criteria
3.4 Have any of the innovative approaches had an impact on the wider health and care system (such as workforce changes or reduction in demand for NHS services)?	Surveying of consortia leads and partners. Interviews with consortia representatives. Case study interviews with project leads. Review and synthesis of local impact assessments.	Stakeholders report on how projects have impacted wider health and care system and provide examples of this across multiple themes and/or projects. Local impact assessments demonstrate wider impacts upon health and care system as identified in ToC.

Appendix 4: sampling considerations

The following sampling considerations were accounted for when selecting consortia representatives and project leads for interviews. Considerations have been listed in the order of their relative importance, categorised by the stakeholder groups to be included.

Consortia representatives

Sampling considerations for consortia representatives in order of relative importance:

- 5 of the 10 interviews will be longitudinal, with representatives who were included in the first wave of fieldwork. The other 5 interviews will be with consortia who were not included in the first wave of fieldwork
- most consortia should have projects which have been implemented and are now being delivered in some form
- we will aim to include 1 to 2 consortia who are experiencing difficulties with project set-up and delivery to understand why
- we will aim to include 2 consortia who have co-produced their projects outside of the more common NHS partners, either with those with lived experience or VCSEs
- most consortia should have engaged with at least one of the different forms of support from SCIE (including the recent intensive and/or targeted support offers), Ipsos and DHSC
- we will aim for a range of demographic and economic factors within the ICS footprint, such as geographical region, urban vs. rurality, relative levels of deprivation, and the size of the ICS areas (including the number of local authorities within the area
- we will aim for a mix of consortia that received different levels of funding through the RNF

SCIE representatives

Given the limited number of interview slots, we aim to conduct 2 paired interviews with SCIE representatives who are most involved in ARF support delivery. We will consult with SCIE to ensure that the most appropriate individuals are chosen.

Project leads

Sampling considerations for project leads in order of relative importance:

- most projects will have been implemented and are now being delivered in some form
- we will aim to include one to 2 projects which are experiencing difficulties with project set-up and delivery to understand why
- all projects will be from different consortia (and therefore the case studies will cover 12 consortia in total)
- we aim to include initiatives from all 12 DHSC priority areas
- projects will cover a range of outcome areas and a range of maturity levels
- at least one project will be using the project to scale an innovation within their local areas
- at least 2 projects will include collaborative working with care providers and/or VCSE organisations
- at least 2 projects will have included elements of co-production in their design and/or delivery. This co-production will have included people with lived experience of care and support and/or carers. We will ensure that in these projects, we speak to an unpaid carer or person with care needs involved at least to some extent in co-production

Appendix 5: case study selection

Case studies were selected for this evaluation based on agreed sampling criteria (see 'Appendix 3: evaluation framework' above) and availability of project leads and care users for interviews. The table below identified the final case studies chosen, their category and their delivery stage (on the basis set out previously in 'Implementation and delivery'). 'Accelerating Reform Fund: case studies' have been published alongside this evaluation.

Table 14: projects selected as case studies

Project name	Consortium	Project category
Shared Lives expansion	Birmingham and Solihull	5. Shared Lives
Develop digital directories of services and pilot micropayments for social prescribing	Buckinghamshire, Oxfordshire and Berkshire West	1. Setting up or implementing technology or digital platforms
End-of-life support for carers	Cambridgeshire and Peterborough	3. Providing carer breaks, respite or other forms of support for carers
Support carers for people with dementia	Cornwall and the Isles of Scilly	3. Providing carer breaks, respite or other forms of support for carers
Carers and hospital discharge	Coventry and Warwickshire	4. Hospital discharge
Co-produce approach to support local carers	Derbyshire	2. Identification and assessments for carers
Hospital discharge	Hereford and Worcestershire	4. Hospital discharge

Arts, heritage and nature activities offer	Lincolnshire	6. Community-based care models
Pathway to short breaks for carers and and Enhanced wellbeing grants	Mid and South Essex	3. Providing carer breaks, respite or other forms of support for carers
Mobilise rollout and innovation fund	North East and North Cumbria	1. Setting up or implementing technology or digital platforms
Scaling up Shared Lives and developing a carers' app	South Yorkshire	1. Setting up or implementing technology or digital platforms
Sussex carers' overarching programme of digital or technology-enabled services	Sussex	1. Setting up or implementing technology or digital platforms

Appendix 6: acknowledgements

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