Department of Health & Social Care

Accelerating Reform Fund: local impact assessment synthesis report

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Executive summary

This report summarises evidence included in local impact assessments submitted by 29 out of 42 consortia participating in the Accelerating Reform Fund ('the fund'), a social care innovation grant programme launched in October 2023. A final 'Evaluation of the Accelerating Reform Fund: main report' has been published on the Evaluation of the Accelerating Reform Fund page.

Context and methodology

The fund aims to support local authorities and their integrated care system (ICS) partners in scaling and embedding innovative care approaches, with a focus on unpaid carers, alongside a series of other national priorities.

Ipsos UK, commissioned by the Department for Health and Social Care (DHSC) in March 2024, conducted this evaluation, alongside providing evaluation support to consortia, some of which was targeted at developing these local impact assessments.

For analytical purposes, projects were categorised by their level of development (scoping and design, implementation and set-up, project delivery, and impacts emerging) and by activity type (technology or digital platforms, carer identification and assessment, carer breaks or support, hospital discharge, Shared Lives, and community-based care models).

This report supplements the main summative evaluation report.

Quality of evidence

Of the 42 consortia included in the Accelerating Reform Fund (ARF), 29 submitted local impact assessments, covering 142 projects. The quality and completeness of the evidence included varied. Most sections were well-completed, particularly those related to project aims and rationale. All submissions included a theory of change and monitoring and evaluation framework. However, information on challenges, barriers, and unintended consequences was less consistently provided.

Evidence of achieved (rather than anticipated) outcomes was provided for 36 projects, ranging from robust quantitative data to anecdotal feedback. Many projects, especially those in earlier development stages, had not yet reached the point of measuring outcomes. The variety of data collection methods and self-reported nature of some data has a range of potential limitations, including most notably attribution and a lack of quantitative data.

Project aims and rationale

Project aims and rationales fell into one of 6 broad categories as follows:

- technology projects aimed to improve access to information and support for carers
- carer identification and assessment projects focused on reaching hidden carers and improving assessment quality
- projects providing carer breaks aimed to alleviate stress and sustain caregiving roles
- hospital discharge projects sought to improve carer involvement in discharge planning
- Shared Lives projects aimed to expand the model and offer person-centred care
- community-based care models focused on strengthening local networks and promoting preventative approaches

Project activities and delivery

Main project activities included:

- digital transformation
- carer support initiatives
- co-production with stakeholders
- service development and scaling
- recruitment and training
- marketing and awareness campaigns
- data and evaluation
- partnership building

Project delivery progress reported as part of local impact assessments varied, with:

- 5% still being scoped and designed
- 39% being set up and implemented
- 30% were being delivered

- 25% were demonstrating some impact

More projects were assessed as being in the scoping and designing stage in end-of-grant reporting returns, likely indicating that projects that are being scoped and designed were less likely to be included in local impact assessment submissions.

Of the established project categories, those implementing hospital discharge, Shared Lives and community-based care models are most advanced at this stage.

Digital technology projects often faced lengthy implementation phases. Projects providing carer breaks and support showed quicker progress towards delivery but faced challenges in measuring outcomes. Shared Lives projects experienced delays in demonstrating impact due to the time required for carer recruitment and onboarding. Community-based care models demonstrated a wide range of delivery experiences.

Outcomes and impacts achieved to date

Overall, a quarter of projects are demonstrating outcomes. This represents around half (46%) of projects that have reached the delivery phase. However, the short timeframe and varying project maturity limited the ability to capture long-term impacts and definitively attribute changes to ARF interventions.

The main impacts identified for each category of projects included:

- technology projects show increased carer engagement and early indications of cost savings, with outcomes relatively easy to measure
- carer identification and assessment projects have successfully identified more hidden carers and improved access to assessments
- projects providing carer breaks report positive impacts on carer wellbeing
- hospital discharge projects show improved carer involvement in discharge planning
- Shared Lives initiatives have increased carer recruitment and expanded scheme access
- community-based models demonstrate positive impacts on carer wellbeing and social connection

However, longer-term outcomes across all categories require more time and are harder to measure. Local impact assessments did not address the question of whether outcomes could be attributed to projects, and this is a limitation to the evidence base given the complex environment in which the fund operates.

Challenges, barriers and unintended consequences

Primary challenges included:

- carer engagement with digital tools and initiatives
- partnership working across local authorities
- data sharing limitations
- technology procurement and implementation
- capacity constraints
- funding delays
- internal governance processes
- difficulties measuring long-term outcomes identified by local impact assessments

A common unintended consequence was increased demand for services as more carers were identified, raising sustainability concerns. Other unintended consequences were project specific and less widespread.

Context and methodology

The fund

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 support to local populations. Ipsos UK was commissioned by DHSC, in March 2024, to conduct an evaluation of the fund.

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 voluntary and community sector groups, are given responsibility by the fund to take forward projects relevant to their local contexts. Decision-making by local areas on how to spend the funding is guided by a published list of 12 priorities, which includes illustrative innovative interventions deemed suitable for scaling.

The fund has been designed to support at least 2 projects in each ICS area, with at least one having a particular focus on unpaid carers.

The 12 fund priorities, as defined by DHSC, are listed in detail in the ‘About the fund’ section of the ‘Evaluation of the Accelerating Reform Fund: main report'.

The evaluation

The evaluation of the fund, and the associated support offer, is 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.

A final report with the main summative findings from the evaluation has been published in the ‘Evaluation of the Accelerating Reform Fund: main report'.

Local impact assessments

As part of the national evaluation, all consortia were asked to submit local impact assessments in May 2025. These assessments were submitted using a proforma template agreed with DHSC (for the full content see the appendix).

Systems were encouraged to use this template as an overarching structure for reporting their local impact. The template was designed to provide guidance on how to report evidence of local impact, while also allowing for local variation in context and project category groups and preferences for the way that impact is collected and reported. It included the development of a theory of change and basic evaluation framework.

Some systems completed one template for each of their ARF projects, whereas others completed a single template for all their ARF-funded activities. In total, 29 out of 42 consortia submitted local impact assessments to the evaluation team.

In addition to conducting the national evaluation, Ipsos was contracted to support consortia in submitting local impact assessments and conducting local evaluation work. In total, 16 individual consortia were supported on a one-to-one basis through Microsoft Teams calls and email correspondence. Furthermore, 2 support sessions were held targeted at multiple consortia implementing the same digital tool.

Categorising projects

To structure the analysis, and understand the programme more deeply, projects were categorised in 2 ways - by:

- their level of development
- the nature of the activity they are delivering

In consultation with DHSC, and following an initial analysis of the end-of-grant reporting and local impact assessments, maturity scores for projects' progress were developed:

1. Scoping and design: establishing project aims and objectives. This is the initial planning phase.
2. Implementation and set-up: getting projects set up and acquiring necessary resources (such as hiring staff or developing tools). This is the preparation phase where resources are gathered.
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. This phase shows demonstrable results.

Projects were categorised into 6 project category groups. These categories are not intended to be mutually exclusive as, in many cases, projects could 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. These categories were designed to reflect the range of projects that were developed in practice. These align with the 12 fund priorities (shown in brackets for each type) though it should be noted that individual projects could also involve multiple priorities.

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 and assistive technology solutions. (Priorities 2, 5 and 9.)

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 and remote support. (Priorities 7, 11 and 12.)

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 and information and advice projects. (Priorities 4 and 12.)

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 and access to community discharge support. (Priority 8.)

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 programs, improving matching and efficiency across schemes. (Priority 1.)

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, and community hubs. (Priority 3, 6 and 10).

About this report

This summative report is a synthesis of all the data, evidence and learning submitted from systems through local impact assessments. It is not intended to provide conclusions, recommendations or wider learning about the fund as a whole - this is provided in the ‘Evaluation of the Accelerating Reform Fund: main report'.

Purpose

The specific objectives of this report are to:

- provide a summary of the content of local impact assessments, including the nature and standard of evidence, rationale of projects and their activities, outcomes, impacts and challenges or barriers
- provide an assessment of the extent to which different types of project have progressed further and achieved different outcomes
- highlight the challenges, barriers and unintended consequences associated with different types of project and delivery stages
- act as a supplement and additional evidence source to the main final evaluation report

Structure

The structure of this report is as follows:

- 'Quality of evidence' details findings related to the quality of evidence submitted
- 'Project aims and rationale' details findings related to project aims and rationale
- 'Project activities and delivery' details findings related to project activities and delivery
- 'Outcomes and impacts' details findings related to project outcomes and impacts
- 'Challenges, barriers and unintended consequences' details findings related to challenges, barriers and unintended consequences

Quality of evidence

Overall number of impact assessments submitted

Of the 42 consortia in receipt of the fund, 29 submitted an impact assessment.

How consortia completed the impact assessments was left to individuals based on local projects and their set-up. While some consortia submitted one assessment for all projects, others submitted a return for each local authority. Overall, the submissions identified 142 individual projects from the 29 consortia included.

During the original expression of interest process for the fund, 122 projects were agreed across all 42 consortia. However, as projects progressed, consortia organised some projects into sub-projects reflecting different geographies or activities.

In this report, projects have been analysed as they were reported in local impact assessments, reflecting how consortia are assessing their impacts.

Completion rates for individual sections and quality of completion

Overall, the impact assessments were comprehensively filled out. The completeness and quality of sections did vary across some submissions, making analysis more challenging in certain instances. The most common section where information has not been provided was 'Section F: challenges, barriers, and unintended consequences'. However, comparable information was collected on a national level through surveys and interviews.

The sections related to the aims and rationale associated with projects were well completed, with specific rationales sometimes directly referencing fund priorities. All projects provided a theory of change, demonstrating that the outcomes associated with projects, and their causal mechanisms, had been considered and defined. Generally, causal pathways were logical and well established, with assumptions and risks identified. For more complex theories of change, there was some evidence of co-development with wider system partners and those with lived experience.

In some cases, consortia recorded anticipated rather than achieved outcomes and impacts in their local impact assessment submissions. Where this was identified, the data has been analysed to reflect the fact that these outcomes have not been achieved yet. In a few cases, the outcomes section was not completed at all. In these cases, it has been assumed that outcomes have not yet been achieved, but it should be noted that this is an assumption.

Extent to which evidence has been provided on achieved outcomes and why

Around 36 projects across 22 consortia have provided evidence for achieved outcomes. The evidence provided by systems is both qualitative and qualitative. Some projects have robust data collection and analysis in place while others are still in the early stages of data gathering. Some projects are using anecdotal evidence (unstructured feedback collected in informal ways) to show outcomes. In all cases, consortia were able to report both achieved and anticipated outcomes - however, many of the longer-term outcomes fell into the latter category.

In some cases, projects are still focused on reporting outputs and have yet to provide outcomes data. Many project entries, especially those in earlier stages of development (maturity levels 1 and 2), have 'No - still in set-up phase' or similar comments in the 'Has outcome been observed yet?' column. This indicates a lack of evidence for achieved outcomes at the time of reporting, which is expected for projects that are still being implemented. Other projects note 'No evidence provided' or 'Data collection and evaluation pending', suggesting that data collection might be planned but not yet executed.

The reasons for these differences are varied and range from:

- stage of project implementation
- data collection and evaluation delays
- challenges in attributing outcomes
- project delivery specific challenges

Types of evidence provided by systems

Systems have used a variety of methods and have worked with different organisations to produce their impact assessments. These include:

- internal systems – care management systems, performance reports or Adult Social Care Outcomes Framework (ASCOF) data
- external platforms – Mobilise, Bridgit or Carefree
- surveys and feedback – carer surveys, staff interviews and/or focus groups
- other sources – project reports, financial reports, website data and/or external evaluators

This variety of data collection methods and sources, and a lack of standardised reporting, could lead to issues with the quality of the detail. It is also important to note that, as these

were submitted by the consortia themselves, there is a potential for reporting bias - there may be a tendency to complete the forms in a way that demonstrates the progress they have made. In a small number of cases, the impact assessment was completed by an external consultant or evaluator.

There is also the potential for subjectivity in the review and analysis of the reports and the assignment of maturity scores by the Ipsos evaluation team. It should be noted that the end-of-grant report assessment of project delivery is based on self-assessment of the delivery by systems using the standard scale. The impact assessment score for project delivery is based on qualitative assessment by the Ipsos evaluation team of open text information provided by systems.

The consistency of evidence and how it is assessed is also affected by the type of project and the intended outcomes as set out in their theory of change. For example, some projects have co-production activities as an outcome while for others this is considered as a mechanism or an implementation step. Some projects define something as an outcome (uptake of training or engagement activities), while the same thing would be regarded as an output by another project. The evaluation team quality assured information submitted to ensure that processes and outcomes were categorised correctly.

Project aims and rationale

Local impact assessments required systems to submit details of the aims and rationale behind their ARF-funded projects.

Within each project category group, there are a range of aims, depending on the specific focus of the project. The details of their aims and rationale are provided below.

1. Setting up or implementing technology or digital platforms (30 projects)

Projects in this category aimed to:

- improve access to information
- streamline assessments
- enhance support for carers through digital tools

Rationales included:

- increasing digital confidence
- enabling self-service
- reducing administrative burdens
- improving the timeliness and personalisation of support

Many projects also sought to integrate digital platforms with existing services to create more cohesive care pathways. The majority of projects in this category were related to identifying, assessing and supporting unpaid carers (implying strong links with types 2 and 3). There were a few projects designed to support people with care and support needs directly - one to improve volunteer recruitment and one to increase the care workforce.

2. Identification and assessments for carers (35 projects)

These projects focused on improving the early identification of unpaid carers and enhancing the quality and accessibility of carer assessments. The rationales emphasised the need to:

- reach hidden or underrepresented carers

- reduce crisis situations
- ensure carers receive timely and appropriate support

Several initiatives aimed to co-produce new assessment models with carers and professionals to ensure relevance and inclusivity. These projects sometimes involved digital tools, though those with digital tools as their main focus were categorised in type one.

3. Providing carer breaks, respite or other forms of support for carers (30 projects)

Projects in this category were designed to alleviate carer stress and burnout by offering flexible, accessible respite options. Rationales given included a need to:

- improve carer wellbeing
- sustain caregiving roles
- increase the availability and variety of break options

Some projects also aimed to address specific gaps, such as support for carers of people with dementia or those in rural areas.

4. Hospital discharge (11 projects)

These projects aimed to improve the experience and outcomes for carers during hospital discharge processes. Rationales included:

- enhancing communication between health and social care
- involving carers in discharge planning
- ensuring carers are identified and supported at critical transition points

The goal was to reduce readmissions and improve continuity of care. These were related to identification of carers in the specific setting of hospitals.

5. Shared Lives (20 projects)

Shared Lives projects sought to expand and diversify the service, improve recruitment and retention of Shared Lives carers, and increase awareness of the model. Rationales focused on:

- offering more person-centred, community-based alternatives to traditional care
- improving outcomes for both carers and those they support
- achieving cost savings through preventative approaches

6. Community-based care models (16 projects)

These projects aimed to strengthen local networks and support systems, often through partnerships with voluntary, community, and social enterprise (VCSE) organisations or provision of grant funding. Rationales included:

- increasing community resilience
- reducing reliance on formal care
- promoting preventative approaches

Many projects emphasised co-production and local tailoring to ensure services met the specific needs of their populations.

Project activities and delivery

Systems were required to provide an up-to-date assessment of their project activities and delivery progress as part of local impact assessments.

Overall, projects described delivering carer support, digital platform development, service expansion and improvement, co-production with stakeholders (especially carers), recruitment and training and marketing and awareness campaigns as main activities. Project activities take place at scoping, implementation and delivery phases.

The most common project delivery activities associated with these submissions across all project category groups included:

- digital transformation: significant investment in procuring digital tools and platforms, including online resources, mobile apps, carer portals, and digital assessment tools. This includes ambitions to moving towards more accessible and personalised support for carers, using tools to provide initial assessments and personalise support

- prevalence of support projects for carers: a wide range of initiatives directly target carer wellbeing and support, including grants, respite care, training, peer support networks, online communities, and dedicated support roles. A focus on identifying and supporting hidden carers is evident

- co-production and stakeholder engagement: in some consortia, there is a strong emphasis on co-designing services and resources with carers and other stakeholders (such as professionals and VCSEs). This participatory approach aims to ensure services are relevant and meet the needs of the target groups. For some projects, co-production was a main project activity or output and so implementation of co-production was a sign of the project being in the delivery phase. For other projects, co-production was a part of the project scoping or design to support the development of later project delivery activities

- service development and scaling: projects included those focusing on scaling existing services to new groups in an area, while others involve introducing new activities in an area, based on established models which exist elsewhere within or outside the consortia. This includes expanding Shared Lives schemes, introducing digital tools, domiciliary care pilots, crisis response services, and hospital discharge support

- recruitment and training: significant investment in workforce development, including recruiting dedicated carer support roles, social workers, commissioning officers, community link workers, and training staff on new processes and digital tools. Delays in some recruitment processes are noted across several project categories

- marketing and awareness: numerous marketing and awareness campaigns are underway, using various channels (such as online, social media, radio or billboards). These aim to raise awareness of available support and reach hidden carers, as well as to recruit new Shared Lives carers

- data and evaluation: data collection, analysis, and evaluation are integral to many projects. This includes developing data-driven models, conducting surveys, developing case studies and implementing impact measurement tools

- partnership building: collaboration and partnership working are prevalent in many consortia, with projects involving local authorities, healthcare providers, VCSE organisations and various innovation providers. Some projects within a consortium are confined to an individual local authority, while other projects cross local authority boundaries

Project delivery and activities by project category group

Table 1 below shows the distribution of individual projects identified in all local impact assessment submissions by category and delivery phase.

Note that this differs from the analysis in Table 2 of the 'Implementation and delivery' section of the main evaluation report, which is based on the end-of-grant returns from a larger number of consortia and with a slightly different classification of projects. For the purpose of assessing impact, consortia tended to split projects into a greater number of sub-projects.

Another important difference is that the information in the table below is based on Ipsos's assessment of progress drawing on evidence provided by systems (rather than systems classifying their delivery progress into these categories themselves). Overall, the evaluation team's assessment of project delivery based on local impact assessments is that projects are behind where they have been self-assessed as through end-of-grant reports in terms of embarking on delivery (though not in terms of demonstrating impacts). This suggests that consortia may be over-reporting their project delivery to date in some cases when submitting end-of-grant reports to DHSC.

In the end-of-grant reporting returns:

- 16% of projects were still being scoped and designed

- 23% were being set up and implemented

- 50% were being delivered

- 11% were demonstrating some impact

More projects were assessed as being scoped and designed in the end-of-grant reports and fewer were assessed as being in the set-up and implementation phase compared with the local impact assessments.

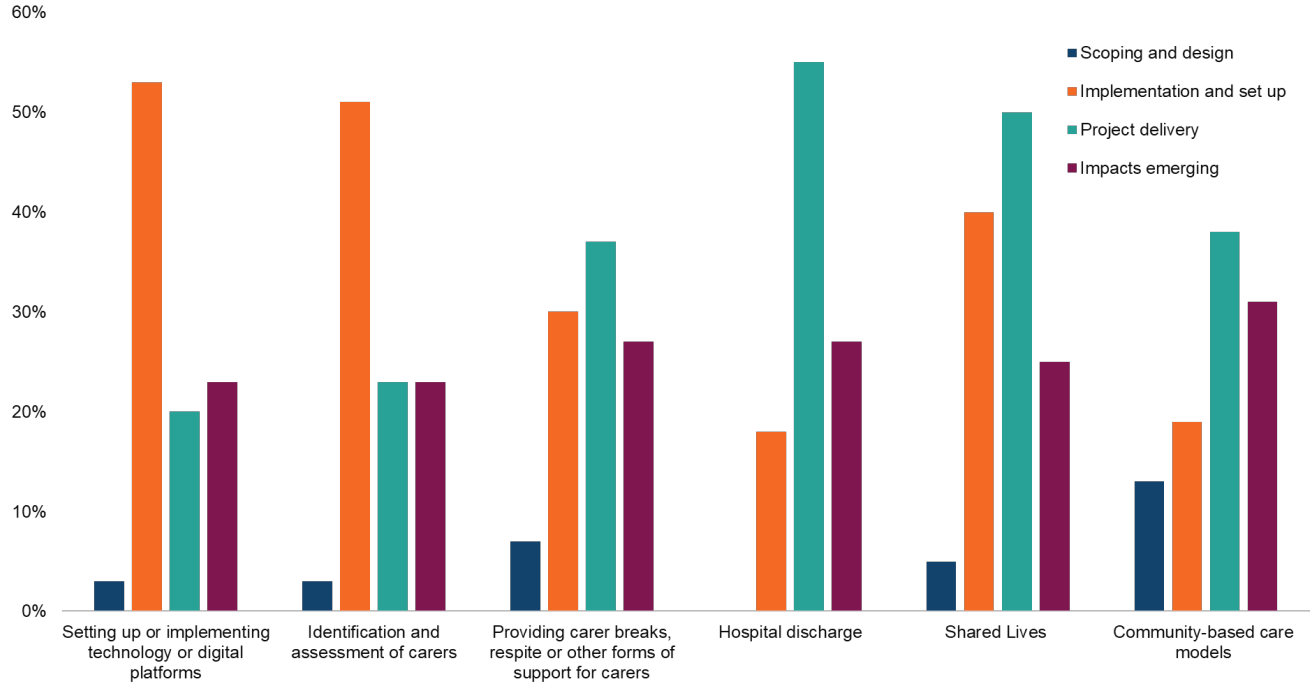
Although more projects were reported as being in delivery, fewer projects were assessed as demonstrating impact in the end-of-grant reports, suggesting that projects in earlier stages of delivery were less likely to be included in local impact assessments. It may also reflect how project delivery and outcomes were assessed - end-of-grant reports were self-assessed and local impact assessments were assessed by the evaluation team based on information provided for each project.

Table 1: projects and sub-projects identified in local impact assessments by project category group and delivery phase

Project category	Scoping and design phase (number of projects)	Scoping and design (% of projects)	Implementation and set-up phase (number of projects)	Implementation and set-up phase (% of projects)	Project delivery phase (number of projects)	Project delivery phase (% of projects)	Impacts emerging phase (number of projects)	Impacts emerging phase (% of projects)	Total projects
1. Setting up or implementing technology or digital platforms	1	3%	16	53%	6	20%	7	23%	30
2. Identification and assessment of carers	1	3%	18	51%	8	23%	8	23%	35
3. Providing carer breaks, respite or other forms	2	7%	9	30%	11	37%	8	27%	30

of support for carers									
4. Hospital discharge	0	0%	2	18%	6	55%	3	27%	11
5. Shared Lives	1	5%	8	40%	6	30%	5	25%	20
6. Community-based care models	2	13%	3	19%	6	38%	5	31%	16
Total across all categories	7	5%	56	39%	43	30%	36	25%	142

Figure 1: proportion of projects and sub-projects identified in local impact assessments by category and delivery phase



Project delivery progress varied across project category groups, but several significant themes emerged:

1. Setting up or implementing technology or digital platforms

Projects in this category typically involved platform development, procurement, testing, and training, which take place at the implementation phase. Set-up and scoping activities included co-design with carers and consideration integration with existing systems. Delivery activities involved release of the tool and digital marketing to promote awareness and use.

Over half of projects in this category were assessed as being in the implementation and set-up phase (53%) indicating the challenges and time required to scope and procure appropriate technology. In addition, just one project was in the scoping and design phase. Among those projects of this type that had reached the delivery phase, over half were reporting observable outcomes and impacts.

These types of projects may take time to set up but, once in delivery, it is relatively easy to measure outcomes and impacts, and change is experienced quite rapidly.

2. Identification and assessments for carers

Activities during scoping include conducting co-production workshops and stakeholder engagement. During implementation and set-up, projects developed new assessment tools and communications campaigns. The delivery phase activities include launching communications campaigns and staff training.

Half of projects in this category are in the implementation and set-up phase (51%) and just one project in scoping and design. Among the 46% of projects assessed to have reached the delivery phase, half are delivering but not yet showing impacts (23%) and half are showing at least some early outcomes and impacts (23%).

Since an important short-term outcome is identification of more carers (often focused on a particular under-represented cohort of carers), measuring this outcome is relatively straightforward as part of the delivery process.

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

Projects delivered a wide range of activities, from launching grant schemes to providing respite services to unpaid carers. Scoping and design activities included developing partnerships with local providers and carers. Implementation activities include recruiting local providers to deliver breaks and respite, and developing toolkits and training programmes. Delivery activities include launching breaks schemes, and delivering training and toolkits.

Under a third of these projects were still at the implementation phase (30%) and 2 projects (7%) were in the scoping and design phase. Over 6 in 10 projects were at delivery or beyond, with 37% delivering but not yet demonstrating impacts and 27% showing emerging outcomes and impacts.

Compared with digital solutions and carer identification, these types of projects may take longer to show outcomes, and outcomes may be harder to measure and attribute, since they are related to impacts of the support on carers and those they support.

4. Hospital discharge

Scoping sometimes involved carer input. Implementation activities included recruiting discharge co-ordinators, developing discharge toolkits and training hospital staff. Project delivery often involved collaboration with NHS partners and focused on improving carer involvement in discharge planning.

There were only 11 projects in this category. None were at the scoping phase and only 2 were at the implementation and set-up phase. Over half of projects were at project delivery

stage but not yet showing outcomes (6) and over a quarter were demonstrating outcomes and impacts (3).

Because these types of projects involve educating staff or assigning carer support roles in hospitals, these are relatively straightforward to set up.

Since the intended outcomes of these projects are reduced pressure on health and social care services, improved discharge pathways or positive impacts on carers, the outcomes are more difficult to attribute to specific interventions and take longer to realise and observe than some other types of projects. Impact evidence provided by these projects included post-discharge surveys with carers, evidence of co-production, and support or training delivered.

5. Shared Lives

Scoping and design stages involved regional collaboration and co-production and service re-design. Shared Lives projects undertook implementation and set-up activities such as design of marketing campaigns and digital platform development. The main delivery activities were rollout of marketing campaigns to recruit new Shared Lives carers and digital platforms to support existing Shared Lives carers.

Eight Shared Lives projects were in the implementation and set-up phase, and one project was in the scoping and design phase. Six were delivering but not seeing outcomes, and a quarter (5) were observing outcomes and impacts.

Although projects were seeing early signs of interest in becoming a Shared Lives carer, it takes time to fully recruit and onboard a carer, and even longer to observe impacts such as benefits for people care and support needs. For projects in the delivery phase, it was too soon for them to demonstrate outcomes.

6. Community-based care models

These projects implemented a diverse range of activities, including establishing local hubs, launching grant programmes, developing directories of services and supporting Homeshare. Many emphasised co-production and local engagement and involved these activities at the scoping and design phase.

While the sample is small, the impact assessment data suggests that a slightly higher proportion of projects in this category were at the scoping and design stage (2) compared with other project category groups. This was also the project category group most likely to be at the stage of observing impacts. The wide range of project activities and partners involved in this type of project contribute to this diversity of project delivery experience.

Outcomes and impacts

This section analyses the observed outcomes and impacts reported by ARF projects as part of local impact assessments, exploring variations across project categories and maturity levels.

Summary

Projects that have been in the delivery stage for longer are more likely to report tangible outcomes than those projects that have only just started to deliver, where a common outcome report was 'too early to see outcomes'.

Specifically, of the 80 projects at maturity levels 3 and 4, just over half (51%) reported observed outcomes or impacts. However, even for projects that moved relatively quickly into the delivery stage, challenges remain in measuring long-term impacts and attributing changes specifically to ARF interventions.

The diversity of project types also influences the nature of outcomes observed. Technology-focused projects, which have successfully reached delivery, often demonstrate faster and more quantifiable results. In fact, over half of these projects (58%) have already reported observed outcomes.

Community-based and relational projects involving carers tend to focus on qualitative changes in carer wellbeing and support networks where it is harder to measure outcomes and takes longer for them to emerge.

Measurement of outcomes and ability to record anticipated outcomes

As shown in the previous section, many projects are at the scoping and delivery and implementation and set-up phases (44%). However, over half have moved into delivery (56%) and beyond. In exploring outcomes, the proportion of projects in the delivery phase and demonstrating outcomes is to be assessed.

Overall, a quarter of projects are demonstrating outcomes. This represents around half (46%) of projects that have reached the delivery phase. It should be noted that many projects recorded as having reached delivery had only just done so, meaning there was limited scope to demonstrate even short-term outcomes. For example, it takes time to understand whether a project providing breaks for carers has had a beneficial impact on preventing crisis and carer breakdown.

Measurement of outcomes also uses data from multiple parts of the system including:

- qualitative feedback from carers and those with support needs

- survey data on carers (from surveys that only take place every 2 years)
- records of people approaching adult social care for support
- data on use of health services, which takes time to collect and analyse

Projects varied in the extent to which outcomes were actively being measured. Outcomes built into digital tools, collected as part of carer identification, or related to provision of services or records of engagement were easiest to measure.

Outcomes relying on more dispersed data sources or requiring more resource to set up (such as surveys) were less likely to be being measured currently.

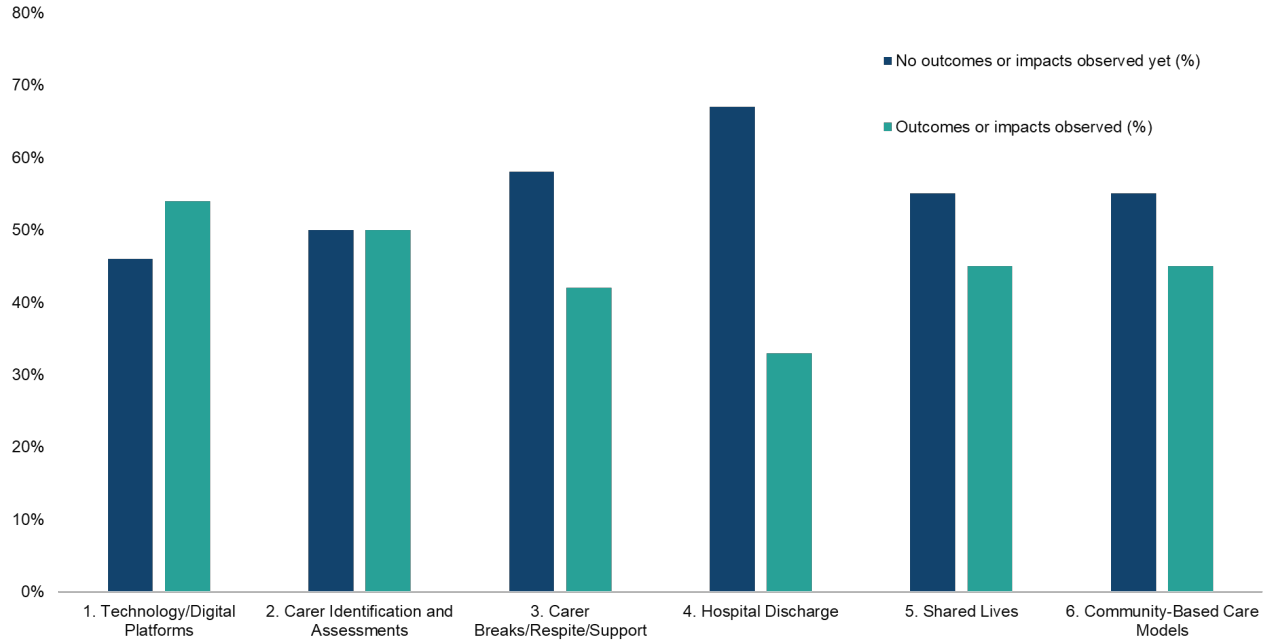
Observed outcomes and impacts achieved to date

Table 2 on the next page summarises the number of projects already in delivery reporting observed outcomes by project category group.

Table 2: projects observing either ambitions or achieved outcomes by project category group for projects that have reached the delivery stage

Project category	No outcomes or observed yet (number)	No outcomes or impacts observed yet (%)	Outcomes or impacts observed (number)	Outcomes or impacts observed (%)	Total
1. Setting up or implementing technology or digital platforms	5	42%	7	58%	12
2. Carer identification and assessments	6	33%	12	67%	18
3. Carer breaks, respite or support	11	58%	8	42%	19
4. Hospital discharge	5	62%	3	38%	8
5. Shared lives	5	45%	6	55%	11
6. Community-based care models	7	58%	5	42%	12
Total	39	49%	41	51%	80

Figure 2: proportion of projects observing either ambitions or achieved outcomes by project category group for projects that have reached the delivery stage



The types of outcomes associated with each project category group were:

Setting up or implementing technology or digital platforms

For this category, over half of projects (58%) in project delivery stages 3 or 4 are demonstrating short-term outcomes. These include:

- increased carer engagement with digital tools
- improved access to information and resources
- early indications of cost savings

The proportion of projects evidencing outcomes is relatively high compared with other project categories, as data on outputs and short-term outcomes is relatively easy to access and interpret.

Often digital products come with analytical tools that can be used to access and engagement, such as the following.

Carer identification and assessment

Projects in this category are demonstrating a relatively high proportion of observed outcomes, with two-thirds (67%) of projects in their delivery phase already demonstrating short-term outcomes. These outcomes include:

- increased identification of hidden carers
- improved access to assessments
- more timely support for carers

Longer-term outcomes such as reduced carer breakdown or access to education and employment are yet to be observed.

Carer breaks, respite or support

Of the projects in this category that have reached the delivery phase, 42% are demonstrating observed outcomes or impacts. Despite the challenges of sustainability, projects in this category are showing positive impacts on:

- carer wellbeing, including reduced stress and increased confidence
- improved ability to manage caring responsibilities

Longer-term outcomes such as reduced crisis admissions and improved quality of care are not yet evident.

Hospital discharge

Just over a third (38%) of hospital discharge projects in the delivery phase are demonstrating observed outcomes or impacts. These projects are showing improvements in:

- carer involvement in discharge planning
- better co-ordination of support services
- increased access to assistive technology

It will take longer to demonstrate outcomes such as reduced readmissions and reduced carer breakdown.

Shared Lives

Over half (55%) of Shared Lives projects at delivery stages are demonstrating observed outcomes or impacts. These observed outcomes in this category include:

- increased carer recruitment
- expansion of Shared Lives schemes into new areas
- improved access to respite care for carers

Projects in this category were showing positive signs of increased interest in Shared Lives caring. Longer-term benefits resulting from the increase in Shared Lives carers generally, or to support specific groups such as care leavers, will take longer to emerge and are more difficult to measure.

Community-based care models

42% of community-based care model projects in the delivery phase are demonstrating observed outcomes or impacts. These projects are demonstrating:

- positive impacts on carer wellbeing and social connection
- increased engagement with community-based support services

Data on hospital discharge times from hospital and wider benefits such as increased levels of wellbeing in the community will take longer to observe.

While the ARF has enabled a diverse range of projects to demonstrate positive changes, the short timeframe and varying levels of project maturity limit the ability to draw definitive conclusions about even short-term outcomes (where projects have only just entered the delivery phase), and certainly long-term impacts (particularly where these involve multiple stakeholders or parts of the system or are challenging to measure).

Attribution of outcomes and impacts

The impact assessments did not address the question of whether outcomes could be attributed to projects. Given the short timeframe for the evaluation, the types of outcomes reported on tended to be accessible metrics on immediate outcomes such as:

- number of carers identified
- number of staff training in identifying carers during discharge
- number of people engaging with a digital tool

Where qualitative evidence was provided, it tended to be small scale and based on case studies or individual stories about the impact of support. For these types of outcomes and evidence, attribution is relatively straightforward.

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.

Any future update of impact assessments for the fund projects should emphasise the importance of considering attribution, and measuring and assessing outcomes and impacts.

Furthermore, there is limited to no 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.

Challenges, barriers and unintended consequences

This section details the challenges, barriers and unintended consequences reported by systems in local impact assessments.

Challenges and barriers

In the early stages of project delivery, data sharing, procurement and governance processes were the primary challenges impacting systems' abilities to get projects set up.

Challenges related to levels of engagement by carers and those accessing care and support then came through during the delivery phase, manifesting in low levels of uptake and use of services.

Partnership working across local authorities was a challenge early on when developing the projects and plans but continued throughout the project life cycle for some systems, presenting ongoing challenges - for example, as a result of different communication styles or misaligned timelines.

Capacity issues were an ongoing challenge for many systems. This related to challenges in recruiting staff, which delayed implementation and set-up, and ongoing pressure and impacts on delivery where project tasks were taken on by existing staff on top of their usual activities.

The financial impacts of the second tranche of funding being delayed also impacted projects during the set-up or delivery phases, depending on which stage they were at during this time.

The main challenges and barriers identified in local impact assessment submissions are described below. Of those listed, challenges related to capacity and expertise as well as carer and initiative use engagement often came through.

Carer and initiative user engagement

Challenges relating to carer and initiative user engagement included:

- carers' ability to engage with digital tools, including lack of digital literacy or accessibility issues for older carers
- low engagement with initiatives from specific groups, specifically among male carers and those who are younger

- lack of awareness of tools and services among carers and other professionals
- difficulty engaging carers using chosen terminology, examples include carers disliking the use of the word 'burden' in a tool designed to score 'carer burden', and difficulties encouraging carers to complete a 'supported self-assessment' when this is a term they're not familiar with
- carer reluctance to engage with initiatives - for example, guilt or anxiety limiting willingness to take breaks
- carer reluctance to self-identify
- high volumes of late cancellations for courses
- challenges reaching carers not known to services
- limited feedback being received from carers to inform the development of initiatives, including low survey response rates

Partnership working

Partnership working challenges included:

- limited stakeholder engagement, such as from providers and social prescribers
- priorities and aims being misaligned across individual partners
- differences in ways of working across authorities slowing or hindering projects. Examples include differences in terms of:
    - governance processes
    - legal processes
    - information technology
    - communication styles
- timelines and speed of work being misaligned across partners

Technology

Technological challenges included:

- questions about use of artificial intelligence (AI): including nervousness among stakeholders about its use, ethical implications and concerns of using AI in triage processes

- challenges commissioning digital technology due to unclear processes for doing so

Data sharing

Data-sharing challenges included:

- minimal data being shared between authorities, sometimes due to limitations around what can be shared

- data privacy concerns - for example, carers involved in co-producing digital solutions expressing concerns about how their personal data was stored, shared and used, potentially impacting trust in the platform

- project implementation being delayed due to working out data-sharing approaches or dealing with concerns

Capacity and expertise

Capacity and expertise challenges included:

- recruitment delays or lack of capacity required to recruit new staff

- staff turnover or restructuring delaying implementation

- absence of important personnel

- lack of capacity to release staff for training sessions

- Care Quality Commission inspections taking up staff time

- difficulties recruiting volunteers or some volunteers not being eligible to help with the initiative

- difficulties identifying a provider with the required expertise to deliver the project, including challenges securing co-production partners

Financial impacts

Financial challenges included:

- delays in receiving the second tranche of funding and uncertainty around funding

- funding only being available in the short term

Governance processes

Internal governance processes-related challenges included:

- governance processes delaying project implementation
- challenges defining key performance indicators and reporting specifications

Procurement

Procurement challenges included contracting processes delaying projects (often related to technology projects or cross-local authority projects).

Administration

Administrative challenges included difficulties:

- finding accessible venues for courses
- scheduling meetings for partners

Challenges specific to adult social care

Challenges associated with implementing adult social care initiatives included:

- the need for initiatives to be localised delaying project implementation - for example, localising modules within the Bridgit platform delaying launch plans
- referral processes - for example, the processes being unclear, not receiving many referrals or inappropriate referrals
- discharge-planning challenges, such as around communications, carer involvement and expectations
- the breadth of areas being covered requiring more resource and staff time to cover it all
- lack of understanding of Shared Lives at a national and local level, requiring a communications campaign to inform stakeholders about it

Unintended consequences

The most commonly reported unintended consequences included:

- increased demand for services
- requests for carer support increasing as more carers were identified, raising sustainability concerns
- the provision of the carer break guide, which led to increasing demand for carer breaks

Other examples of unintended consequences were uncommon and specific to individual projects. These included:

- concerns from fostering teams that Shared Lives was trying to poach their foster carers - dialogue with fostering teams helped mitigate this
- carers requiring housing support identifying a lack of resources - links were developed with local housing services to enable more referrals
- appointment of new positions (such as chair and vice chair), which elicited interest by other staff outside of the existing partnership - this was remedied by taking time to introduce them to the project teams and governance processes

Appendix: local impact assessment template

All consortia were asked to submit local impact assessments. Here, we reproduce the proforma template shared with systems. You can read more about how this template was designed and used under 'Local impact assessments' in the previous 'Context and methodology' section.

Section A: project rationale

Please describe the rationale behind your ARF-funded projects or interventions, with a specific focus on the outcomes you hoped to achieve (one page max per submission).

Section B: project activities

Please describe the activities undertaken as part of your ARF-funded project delivery to date, including their current status and/or progress (one page max per submission).

Project name	Description	Delivery progress to date

Section C: theory of change

Please use the below template to construct a theory of change for the ARF-funded activities taking place within your consortia. You may choose to develop one for each project, or groups projects under a common theme or set of strategic aims. A theory of change is a visual aid that shows the steps towards a desired goal, and the connection between these steps in terms of cause and effect.

Example template with definitions

Inputs	Activities	Outputs	Outcomes	Impacts
Resources that go into the intervention. Could be financial or non-financial. Can be intangible, such as expertise or networks.	Activities the intervention undertakes that will generate the outputs and outcomes. These describe what the strategy is practically doing. Examples might include providing training, developing resources, running a workshop.	What happens as a direct result of an intervention, such as a new service being rolled out or a certain number of people receiving training. Closely related to the activities. For example, the activity of training could lead to an outcome of X number of people trained. Tend to be the things that interventions monitor because they are a way of accounting for the activities carried out - such as remote support accessed or sessions run.	Changes that are expected to happen. This may encompass change in individuals (attitudes, knowledge or behaviours), organisations, or strategic stakeholders, depending on the focus of the intervention. These are typically divided into those that are short-term and those that take longer to emerge or require other changes to happen first - for example, unpaid carers supported or rapid discharge.	The high-level goals the intervention is expected to contribute to. These are often things written down in an organisation's mission statement. They are often long-term, and it may not be possible to evaluate in the lifetime of the intervention whether it has had such impact, in which case longer term follow up would be required - for example, waiting lists reduced, unpaid carers better supported

Template for completion

Inputs	Activities	Outputs	Outcomes	Impacts

Section D: monitoring and evaluation framework

Please use the below template to describe how you plan to or have collected evidence of the outputs or outcomes and impacts described in your theory of change. It's okay if some are not being collected – please still list them and note that there is no data being collected for them.

Element of theory of change	Primary indicators	Definition: how is it calculated?	Primary data source	Frequency of data collection	Supplementary notes
Output 1					
Output 2					
Outcome 1					
Outcome 2					
Impact 1					
Impact 2					

Section F: challenges, barriers and unintended consequences

Please use this section to describe any challenges, barriers and unintended (negative) consequences associated with the ARF-funded activities to date within your consortia, and how you have mitigated for or overcome these.

Project(s) or activity	Challenge, barrier or unintended consequence	Mitigating action (if any)