British Journal of Social Work (2024) **00**, 1–22
https://doi.org/10.1093/bjsw/bcae010

Downloaded from https://academic.oup.com/bjsw/advance-article/doi/10.1093/bjsw/bcae010/7606671 by guest on 13 March 2024

Ready, Willing and Able? Local Perspectives on Implementing Prevention in Social Care in England

Joanna Marczak *, Gerald Wistow and Jose-Luis Fernandez

Care Policy and Evaluation Centre (CPEC), London School of Economics and Political Science, London WC2A 2AE, United Kingdom

*Corresponding to Joanna Marczak, Care Policy and Evaluation Centre (CPEC), London School of Economics and Political Science, Houghton Street, London WC2A 2AE, United Kingdom. E-mail: j.marczak@lse.ac.uk

Abstract

There is a growing emphasis on prevention to reconcile demographic pressures, resource scarcity and expectations of better quality care and support. The Care Act 2014 placed a statutory duty on English local authorities to prevent and delay the development of needs for care and support. However, evidence suggests that the prevention approach has secured less impact than intended. Given that existing approaches have achieved such limited results, new ways of addressing this apparently intractable challenge should be considered. We argue here that theory-based models that support the understanding of, and responses to, implementation barriers and facilitators can provide tools to support the development of more successful implementation. Drawing on in-depth interviews ($n = 20$) in selected English councils and analyses of their policy documents, we explore the 'Ready, Willing and Able' (RWA) model, which posits that those three preconditions must be satisfied before new practices can be implemented sustainably. We argue that RWA can provide a straightforward and parsimonious framework for identifying implementation barriers and facilitators. Using the model to identify potential bottlenecks prior to the implementation can help local actors clarify baseline barriers to progress. RWA could help to inform opportunities to target identified problems, by reinforcing facilitators and moderating barriers.

© *The Author(s) 2024. Published by Oxford University Press on behalf of The British Association of Social Workers.*
This is an Open Access article distributed under the terms of the Creative Commons Attribution License (https://creativecommons.org/licenses/by/4.0/), which permits unrestricted reuse, distribution, and reproduction in any medium, provided the original work is properly cited.

BASW
The professional association for social work and social workers
www.basw.co.uk

Keywords: health and social care integration, implementation models, social care, prevention, ready willing able

Accepted: January 2024

Introduction

Faced with population ageing, predicted increases in the number of frail older people with long-term care needs, rising expectations for the quality of care and most recently coronavirus disease 2019 (COVID-19), the sustainability of care systems has been increasingly questioned. More attention has been focused within the UK and internationally on how, and how far, such challenges might be met through prevention strategies that aim to keep people healthier and living more independently for longer (Meijer *et al.*, 2017; Cylus *et al.*, 2019; Read *et al.*, 2023; Rostgaard *et al.*, 2023, Tew *et al.* 2023). The European Commission (2021), OECD (2017) and World Health Organization (Marczak *et al.*, 2019a) have all advocated the development of prevention and provided examples of services that have adopted this approach.

Within the UK, social care policy has increasingly focused on prevention as a means of promoting well-being, multi-agency working and simultaneously, constraining demand for resources (Marczak *et al.*, 2017; Read *et al.*, 2023). For example, Social Services and Well-being (Wales) Act 2014 highlights prevention and early intervention as one of the five core principles at the heart of the Welsh programme of change for social services. However, the programme's government-funded evaluation found that the funding of preventative initiatives was hampered by the necessity of funding services in crisis (Llewellyn *et al.*, 2023).

Prevention became a statutory requirement in England with the implementation of the Care Act 2014, though many English councils had funded such services since the1990s (Wistow and Lewis, 1997). The 2014 Act placed a new duty on English local authorities (LAs) with responsibility for adult social care (ASC) to prevent and delay the development of (higher level) needs for care and support. It also included a requirement to consider whether individuals might benefit from preventative services, before assessing their eligibility for statutory support (HM Government, 2014). Implementation guidance recognised that effective prevention depended on involving many agencies, including the National Health Service (NHS), Public Health, housing and voluntary sectors (Department of Health, 2014). The emphasis on partnerships to promote preventative approaches was reinforced by expectations of their systems' wide role in helping to mitigate the impact of fiscal austerity and population ageing by reducing demand for more intensive care (Miller, 2014). Such expectations recognised the

Downloaded from https://academic.oup.com/bjsw/advance-article/doi/10.1093/bjsw/bcae010/7606671 by guest on 13 March 2024

potentially complex causal relationships between investment and return, typified by the belief that social care investments could reduce demand on the NHS.

The introduction of statutory duties does not guarantee their adoption or intended results. There is little evidence about how councils translated their prevention duties into practice, existing evidence suggests the Act's vision is not being fully realised (for exception see Carers Trust, 2015; Tew *et al.*, 2019). Field (2017) found that most councils further developed prevention strategies and procedures after 2014 but identified few improvements in provision, whilst collaboration with health partners remained limited. Declining LA resources were identified as a common obstacle in implementing Care Act responsibilities, including duties towards prevention (Hastings *et al.*, 2015; NAO, 2015; Tew *et al.*, 2019). In addition, the breadth and diversity of meanings attached to the concept of prevention—within and across agencies—and a related lack of consensus over service models and investment strategies also posed implementation challenges (Starfield *et al.*, 2008; Lombard, 2013; Marczak *et al.*, 2019b).

Whilst evidence about the implementation of the Care Act's provisions for extending prevention is limited, there is considerable evidence about factors that generally constrain the adoption of new ideas and practices into organisations. For example, failure to adopt new practices at all or to do so in ways that produce expected and sustainable results is often attributed to limitations in stakeholders' capacity and capability that have been identified through the analysis of factors, which impede and facilitate the adoption of new policies and programmes (Fullan, 2003; Flaspohler *et al.*, 2012; Tew *et al.*, 2019). However, the adoption of theory-based analyses of barriers and opportunities for the successful implementation of prevention policies in local councils is in its early stages.

Research objectives

This article draws on case studies of selected English councils to better understand how councils may translate prevention objectives and policies into effective practice. We employ the 'Ready, Willing and Able' (RWA) model (Coale, 1973; Lesthaeghe and Vanderhoeft, 2001) as a theoretically grounded, conceptually straightforward and accessible tool for policymakers, analysts and practitioners to identify potential obstacles and facilitators in order to understand necessary preconditions for implementing new practices.

Ready, willing and able

We employ the RWA approach as an organising framework for identifying and potentially modifying barriers and facilitators to the sustained adoption

Downloaded from https://academic.oup.com/bjsw/advance-article/doi/10.1093/bjsw/bcae010/7606671 by guest on 13 March 2024

of new practices. RWA has been employed in demography since the 1970s to understand the adoption of new practices and behaviour within a defined population (Coale, 1973; Lesthaeghe and Vanderhoeft, 2001). More recently, the model has been applied to analyse the adoption of new practices in different healthcare and national contexts (Shultz and Jimbo, 2015; Bunzli *et al.*, 2017; Dearing and Cox, 2017). As illustrated in Figure 1, the RWA model specifies three preconditions that need to be satisfied before a new practice can be adopted successfully:

- *Readiness* (R): the perceived utility of a given/new practice, that is the overall perceived benefit of the new practice must outweigh the perceived disutility/cost of securing its adoption.
- *Willingness* (W): the perceived legitimacy of the new practice, the question here is to what extent new practices run counter to established traditional practices and codes of conduct, and to what extent there is a willingness to modify them.
- *Ability* (A): capabilities for adopting new practices given available technical, legal or financial means.

An important component of the RWA model is the bottleneck principle (weakest link); namely, for a new practice to be adopted in a sustained way, all three components (R, W, A) must be present: missing elements act as 'bottlenecks' limiting the effective and sustained implementation of a new practice.

The use of the RWA has the benefit of linking insights from economics focused on the R condition and other disciplines that pay more attention to normative and cultural aspects vital for the W condition (Coale, 1973; Lesthaeghe and Vanderhoeft, 2001). Furthermore, whilst

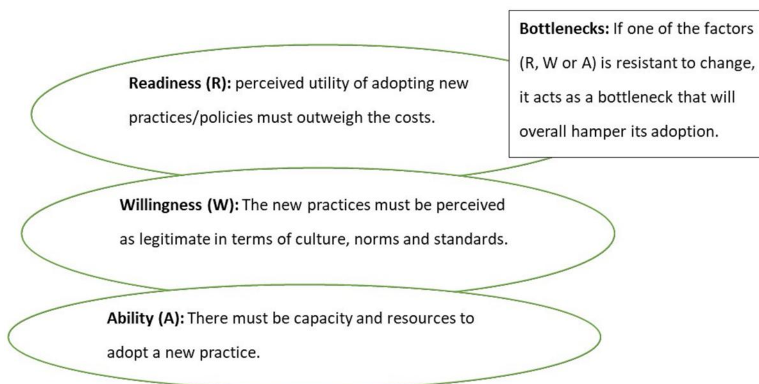

Figure 1. Ready, willing and able model.

Downloaded from https://academic.oup.com/bjsw/advance-article/doi/10.1093/bjsw/bcae010/7606671 by guest on 13 March 2024

conceptually concise, the model is sufficiently broad to permit critical analysis from a systems-based approach at the organisational level (Shultz and Jimbo, 2015).

RWA and other conceptual models

Implementation research has increased its use of theoretical approaches to provide a better understanding and explanation of how and why implementation succeeds or fails. Many frameworks exist to describe the diffusion and implementation of new policies and interventions in health care and public sector settings more generally (Rogers, 1995; Hartley, 2005; Osborne and Brown, 2011). For example, Greenhalgh *et al.*'s (2004) model identified eleven key attributes of innovations in health care to explain variations in their adoption, including relative advantage; compatibility; complexity; trialability; observability; reinvention; fuzzy boundaries; risk; task issues; knowledge; augmentation/support. Whilst this influential model assesses implementation from a comprehensive perspective, it is not particularly user friendly and its complexity can itself be a barrier to executing an effective implementation strategy (Fuller *et al.*, 2020). In contrast, RWA is a conceptually simple and intuitive tool that enables those implementing a new policy to assess the necessary preconditions for its adoption (Shultz and Jimbo, 2015). Current funding and demand pressures on local services also support the value of an easily understood and applied model.

The Production of Welfare (POW) model has been used specifically in social care prevention (Marczak *et al.*, 2019b) and establishes theoretical expectations about the relationship between needs, services and outcomes at the individual level. It also emphasises the need to understand local processes and structures explaining why and how change takes place (Davies and Knapp, 1981; Knapp, 1984). POW can underpin estimations of cost–effectiveness for specific prevention interventions but is silent on the willingness and ability dimensions, which may be vital in determining how far implementation will succeed. Given the potential challenges of implementing prevention policy and interventions (Greenhalgh and Papoutsi, 2019; Tew *et al.*, 2019), RWA has a particular utility in identifying implementation-related bottlenecks and in exploring whether and how these could be addressed.

Materials and methods

This article draws on findings from a broader study, funded by the NIHR School for Social Care Research, which aimed to develop an evaluation framework for English councils to review the prevention effects of local

Downloaded from https://academic.oup.com/bjsw/advance-article/doi/10.1093/bjsw/bcae010/7606671 by guest on 13 March 2024

services. The study employed qualitative case study and economic evaluation methods, we report here on the former and present qualitative data from in-depth, semi-structured interviews ($n = 20$) with stakeholders in two English councils, and detailed analysis of policy documents in six councils.

Interview sample

Invitations to participate were sent to Councils identified through the research team's knowledge of authorities' work in prevention, including an earlier exploratory study (Marczak *et al.*, 2019b). Six local areas expressed an interest in participating. Following initial discussions with all of them, and based on the local capacity to provide resources for the study, we secured an agreement for two to be full participants. Key informants within the two case study authorities were selected purposively to provide a heterogeneous set of contexts for policy implementation and practice development. Twenty key informants were interviewed in total. Interviewees in each area included personnel with policy and project implementation responsibilities (see Table 1 for councils' and informants' characteristics).

Interviews

Interviews focused on exploring barriers and facilitators to implementing and evaluating social care prevention policies and interventions (Lincoln and Denzin, 2000; Patton, 2002; Ritchie and Lewis, 2003). Separate interview guides were developed for conducting interviews with senior managers, data analysts and those engaged in individual projects (question guides are available from the authors). Respondents were asked to elaborate on local understandings of prevention goals and local prevention policies, commissioning strategies, implementation partnerships, barriers encountered and delivery successes. We also asked about ongoing evaluations of prevention, including services covered, outcomes and indicators prioritised, cross-agency collaboration, etc. Interviews were conducted by the authors in 2016 and 2017. Interviews were recorded, transcribed verbatim, and material was entered into the qualitative data management software: NVivo 11 (QSR International Pty Ltd, 2015).

Data analysis of interview material

Thematic analysis was used to organise and interpret interview data by systematically focusing on the identification and reporting of response patterns and themes across the whole data-set (Boyatzis, 1998; Braun and Clarke, 2006). Initial codes were generated by breaking the transcript contents down into smaller components, coding them in a

Downloaded from https://academic.oup.com/bjsw/advance-article/doi/10.1093/bjsw/bcae010/7606671 by guest on 13 March 2024

Table 1. Sampled local authorities and informants' characteristics.

No.	Type of local authority	Informants' roles
LA 1	Non-metropolitan county	R1: CCG Director R2: Public Health, Older People Lead R3: Corporate Business Intelligence R4: ASC Service Director R5: ASC Director of Commissioning R6: Carers Lead R7: Strategic Development Manager Older Adults R8: Service Director R9: Programme Manager R10: ASC Commissioner R11: Voluntary Sector Senior Operations Manager and Prevention Programme Lead
LA 2	Non-metropolitan county	R12: Assistant Director Integrated Planning R13: Director of Commissioning R14: Deputy Chief Fire Officer R15: Director of Public Health R16: Voluntary Sector Programme Development Manager R17: CCG, Programme Quality Manager R18: LA, Head of Integrated Accommodation R19: LA, Project Officer, Integrated care R20: Provider Association Integration Manager

systematic manner and collating passages relevant to each code. Coded data were used to develop themes and sub-themes amongst implementation facilitators and barriers and then grouped within the ready, willing and able framework categories (see Table 3 for details). These resultant themes and sub-themes were checked and revised to ensure that passages gathered under a theme formed a coherent pattern. Extracts that did not fit were reviewed and either re-assigned to different themes or to newly generated themes (Boyatzis, 1998).

Documentary analyses

An analysis of local policy documents was conducted in the six authorities expressing initial interest in the study to understand approaches to prevention policy locally and contexts for their implementation (see Table 2).

Documents were analysed individually using the steps highlighted by Ritchie and Spencer (1994): familiarisation; identification of thematic framework; indexing of evidence in line with identified themes; charting of the themed evidence; and mapping and interpretation of the evidence emerging. Documentary data from the six areas were amalgamated, synthesised and categorised into themes and sub-themes and then grouped within the RWA framework categories (see Table 3, illustrating the themes and sub-themes).

Downloaded from https://academic.oup.com/bjsw/advance-article/doi/10.1093/bjsw/bcae010/7606671 by guest on 13 March 2024

Table 2. List of policy documents analysed in sampled local authorities.

No.	Type of local authority	Documents analysed
LA 1	A non-Metropolitan County Council in East of England	Older People Strategy Transforming Lives Strategy ASC Framework Document Better Care Fund (BCF) 2016/2017; BCF annual report 2015/16 Joint Health and Wellbeing Strategy (JHWS) Sustainability and Transformation Plan (STP)
LA 2	A non-Metropolitan County Council in East of England	Ageing Well BCF 2016/2017 JHWS STP
LA 3	A non-Metropolitan County Council in East Midlands	ASC Strategy BCF 2016/2017 JHWS STP
LA 4	A non-Metropolitan County Council in South East England	Policy for Assessment and Support Plans, ASC ASC Business Strategy BCF 2016/2017 JHWS STP
LA5	A non-Metropolitan County Council in South West England	Growing Older Strategy, ASC ASC Strategy BCF 2016/2017 JHWS STP
LA6	A non-Metropolitan County Council in South East of England	Council Prevention Strategy Commissioning Strategy, ASC BCF 2016/2017 JHWS STP

Ethical consideration

The project obtained ethical approval from The Social Care Research Ethics Committee (REC reference: 15/IEC08/0052) and was endorsed by ADASS. Informed consent to participate in and to record the interviews was obtained from all respondents. Participants were provided information verbally and in writing about their rights and the obligations of the researcher and given an opportunity to ask questions before signing the written consent form. LAs and interviewees were anonymised to protect confidentiality.

Results

To our knowledge, this study is the first which used RWA as an organizing framework to identify facilitators and potential barriers (bottlenecks) in the implementation of prevention policies and schemes within English local authority settings. Such barriers and facilitators to the implementation were

Downloaded from https://academic.oup.com/bjsw/advance-article/doi/10.1093/bjsw/bcae010/7606671 by guest on 13 March 2024

Table 3. Application of Ready Willing Able model to implementing and evaluating social care prevention interventions.

Over-arching theme/ RWA criteria	Themes	Sub-themes
Ready	Demand management	Facilitators: • Prevention can reduce health and social care needs leading to reduction in demand for services • Investment in prevention can lower long-term social and health care costs
	Population health and well-being	Facilitators: • Prevention can empower individuals to live healthier for longer • Prevention can reduce health inequalities
Willing	Definition/understanding of prevention	Barriers: • Absence of common understandings of prevention aims and intended outcomes undermine emergence of common purpose and commitment to implementation of prevention policies
	Availability of evidence	Barriers: • Insufficient evidence around effectiveness of prevention hampered the willingness to invest
	Individuals/professional attitudes	Facilitators: • Commitment of key stakeholders often enabled local areas to make progress in the prevention agenda, despite obstacles. Barriers: • Where individuals (and agencies) attach different meanings to purpose and content of prevention it can lead to complexities of implementing policies and practices within and across agencies
Able	Care Act 2014	Facilitators: • The statute motivated new prevention investments, and/or legitimised already existing prevention initiatives
	Availability of financial resources	Barriers: • Shortages of finance for services aiming to prevent and reduce future needs, as people with the higher levels of existing needs were prioritised • Absence of mainstream funding for prevention mediated by short-term project-based funds undermines sustainable development of prevention strategies Facilitators: • Short-term funding (e.g. from BCF) enabled councils to invest in limited prevention projects which might demonstrate feasibility and benefits of preventive services

(continued)

Downloaded from https://academic.oup.com/bjsw/advance-article/doi/10.1093/bjsw/bcae010/7600671 by guest on 13 March 2024

Table 3. (continued)

Over-arching theme/ RWA criteria	Themes	Sub-themes
	Availability of resources to conduct evaluations	Barriers: • Inadequate manpower to conduct local evaluations of prevention schemes • Inadequate locally available evaluation tools • Lack of joint IT systems for individual pathways hampered evaluation of prevention across health and social care

grouped by the research team into salient themes and sub-themes using the RWA model as shown in Table 3.

Were LAs 'ready'?

Readiness to adopt prevention initiatives includes perceived contributions to managing demand and promoting population health and well-being.

Demand management

Demand management was considered as the main driver for, and benefit of, investing in prevention. Emphases on prevention as a potential tool for reducing budgetary pressures were frequent. Documents and interviews across all areas emphasised the potential for prevention to 'square the circle' between increasing need and decreasing supply. Some respondents recognised that prevention would require increased spending, at least initially (see also section below on ability/financial austerity), but generally believed that such spending would reduce demand and costs over time:

> … a lot of time we're talking about management of demand—but it's all really about prevention or reducing escalation of needs, or slowing down the speed at which people's needs will increase … [LA1, R4]

Population health and well-being, reducing health inequalities

Improving health and well-being locally was not generally identified in our documentary sources as the main benefit of prevention with the exception of the statutory Joint Health and Wellbeing Strategies (JHWS) where it was a central justification for prevention investments. Some

Downloaded from https://academic.oup.com/bjsw/advance-article/doi/10.1093/bjsw/bcae010/7606671 by guest on 13 March 2024

interviewees also defended such expenditure to maintain health and independent living. Some respondents considered prevention as the optimal form of social care, precisely because it empowered individuals to live more full and independent lives:

> … this is about making things better for people …And really empowering people… it might be a combination of… improving their quality of life and their well-being in a sustainable way… [LA1, R6]

The reduction of health inequalities was another advantage of prevention identified in documents and interviews.

Were they 'willing'?

Three themes were identified during data analysis for the willing criterion: (i) understanding of prevention within and across agencies; (ii) available evidence to invest in prevention; and (iii) individuals' commitment to prevention.

Conceptualising prevention

Comprehensive prevention strategies were often absent from the documents that we analysed and approaches to prevention tended to be 'scattered' across different strategy documents, for example for older people, housing, ageing well, etc. (Tew *et al.*, 2019, see also Tew *et al.*, 2023). This could lead, in turn, to difficulties in developing a coherent approach based on shared understandings and spending priorities.

Some interviewees identified services as preventative where there was a direct link to the problem and/or evidence that they could reduce or delay levels or severity of need (e.g. reablement, falls prevention and home adaptations). Others defined prevention as a broad term to describe a wide range of interventions that had the potential to enhance independence and well-being, such as information and advice, home care, housing, fire safety checks for older people, assistive technology including telecare, handyperson services, meals on wheels, enhanced care provided by social care staff (e.g. in care homes), together with activities intended to increase social participation and reduce loneliness.

Documentary analyses also indicated a wider disjunction between ASC and health agencies' prevention goals. Whereas ASC prevention activities frequently related to interventions maximising independence for individuals, NHS agencies' prevention agendas often focused on individual health conditions, such as cardiovascular diseases or smoking. Analyses of STPs similarly found them focused around conditions such as cancer, cardiac problems and stroke, with some also covering hypertension, substance abuse, smoking and obesity (Ham *et al.*, 2017). Only

Downloaded from https://academic.oup.com/bjsw/advance-article/doi/10.1093/bjsw/bcae010/7606671 by guest on 13 March 2024

three of the six STPs covering our authorities referred to falls prevention, increasing independence or reablement and contained limited reference to social determinants.

The different understandings of prevention could become a crucial bottleneck as it suggests that greater progress is difficult without greater consensus about the role of prevention and the necessary components of prevention strategies. As another respondent argued:

> … a lot of my NHS colleagues would look at the preventative work … being the work you would do once somebody's had a fall … rather than the work you might have done earlier on in the continuum to try and prevent the fall in the first place. [LA1, R5]

Availability of evidence to demonstrate prevention effects

Even where the potential utility of prevention investments was recognised, the lack of evidence about which interventions worked best and for whom continued to be an obstacle. As in our earlier study (Marczak *et al.*, 2019b), respondents reported that commissioners favoured immediate evaluations to demonstrate rapid results rather than more robust evaluations capable of capturing cumulative, longer term effects. Moreover, we found different understandings of what constituted sufficiently 'robust' evidence to justify spending. NHS respondents generally highlighted the 'weak' quantitative evidence base for social care interventions whilst social care respondents tended to emphasise that such evidence was often unattainable for low-level, prevention services (e.g. information and advice, support groups), because benefits of such interventions are often hard to quantify.

Individuals' attitudes

Respondents frequently highlighted examples where the commitment, drive and passion of key individuals and their willingness to deliver prevention agendas were significant facilitators:

> … we've benefited from having a good leader who is very committed, very passionate, very vocal and that has really helped to drive prevention forward … we had [different]challenges … you name it, but at the core of it is that passion, that commitment to [prevention]. [LA2, R19]

Individuals are not passive recipients of new policies and practices, they find meaning in them (or not), challenge them, complain about them, and modify them—often through dialogue with others. This highlights the complexities of jointly implementing policies and practices

Downloaded from https://academic.oup.com/bjsw/advance-article/doi/10.1093/bjsw/bcae010/7606671 by guest on 13 March 2024

where agencies and individuals operate in contexts where differences in interpretation and meaning are active elements in local organisational cultures (Greenhalgh *et al.*, 2005).

Were councils 'able' to deliver prevention agendas?

For the ability criterion, the most prevalent themes identified during data analyses were (i) Care Act 2014, (ii) financial resources and (iii) resources to conduct evaluations.

The Care Act 2014

Policies and legislation often constitute an enabling mechanism in RWA models because they establish infrastructures to underpin implementation (Lesthaeghe and Vanderhoeft, 2001; Bunzli *et al.*, 2017). The Care Act 2014 obligations were often mentioned in ASC documents as drivers for investing in prevention. Informants reported that the Act's emphasis on prevention enabled some longer term investments for previously short-term initiatives. However, some respondents perceived the Act as achieving a little more than the retrospective legitimation of preventative activity, which had existed locally prior to the statutory obligations.

Financial resources

Although many respondents identified investment in prevention and early intervention as amongst the most important priorities in managing demand and resources, lack of funding was commonly cited as constraining local implementation capabilities:

> … as resources get even more tight, to make that case that we should free up some more very scarce resource and put it (in)to this thing [prevention], it is hard … currently … (we are) just dealing with what's hitting our doorstep. [LA2, R12]

Consequently, as local budgets became tighter, the tension between prioritising statutory duties to meet the highest needs and the duty to invest in services that prevented and reduced future needs was becoming more difficult to manage and was creating an implementation bottleneck (see also Tew *et al.*, 2019, 2023).

Having to rely on short-term funding was reported to be a considerable barrier to sustainability because it discouraged recruitment and retention. However, it was also noted that such funding, including that provided through the Better Care Fund (BCF) at least provided the opportunity to develop, learn from and make a stronger case for longer

Downloaded from https://academic.oup.com/bjsw/advance-article/doi/10.1093/bjsw/bcae010/7606671 by guest on 13 March 2024

term funding for schemes that might not otherwise have been able to get underway.

Resources to conduct evaluations

Notwithstanding the demand for local evidence to justify prevention investments, respondents often reported that councils had limited abilities to evaluate existing prevention schemes due to inadequate manpower, including shortages of analysts with advanced statistical capabilities. They often highlighted the limitations of evaluation tools and the lack of resources to develop them. Furthermore, evaluations across ASC and health services faced challenges in accessing data due to, for example, confidentiality issues and different patient IDs or IT systems. Consequently, it was often impossible to analyse the impact of schemes across sectors and authoritatively identify the different points where costs and benefits might fall within care systems.

Discussion

Investment in prevention has been advocated in English ASC for some time as a means of mitigating the challenges of population ageing. The Care Act 2014 embedded prevention as a statutory duty of such services. Despite this, knowledge about how far English local councils have implemented prevention remains limited. This study employed the RWA framework to identify facilitators, barriers and, thus, potential bottlenecks (weakest links) to implementing prevention locally. By helping to identify the potential bottlenecks, we anticipated that RWA might extend understandings of implementation deficits and provide focal points for mitigating actions.

We identified several potential bottlenecks in the willing and able categories. Conversely, the readiness criterion appeared to have been met as the hopes for prevention to manage demand and improve population health and well-being were perceived as having great value and there was a broad consensus amongst interviewees that investing in prevention was worthwhile, even if current pressures on services meant that meeting current demand took priority over proactive investment to reduce or delay future needs.

The willingness criterion, which related to the perceived legitimacy of developing and implementing local prevention approaches and programmes, was significantly underdeveloped, particularly in relation to definitions of prevention and availability of evidence. Definitions and understandings of legitimate prevention activities were contested and not supported by beliefs and codes of conduct prevalent in different

Downloaded from https://academic.oup.com/bjsw/advance-article/doi/10.1093/bjsw/bcae010/7606671 by guest on 13 March 2024

agencies. Over the years, the term prevention has been found to describe a wide range of objectives and interventions (Godfrey, 2001; Starfield *et al.*, 2008; Lombard, 2013) and our findings suggest that shared meanings remain elusive. The Care Act's Statutory Guidance notes that there is no single definition of prevention and that different local approaches to prevention may be developed (Department of Health and Social Care, 2018). Our study indicates that, in so far, as the meaning of prevention is ambiguous or open to conflicting interpretations in particular cases and contexts, what is to be implemented and evaluated may also remain contested.

The validity of evidence to justify investment in prevention was disputed by social and healthcare agencies because of differences in conceptualising prevention and the appropriateness of different evaluation methodologies. Because economic evidence was often required to secure procurement, interventions where qualitative prevention effects are more observable and feasible to gather may receive less support. When the desired standard for evidence-based commissioning in the health sector is quantifiable clinical and financial data as well as local evaluations (Glasby, 2012; Wye *et al.*, 2015), social care commissioners may find it challenging to convince healthcare partners to invest in jointly funded prevention schemes for which quantifiable data are lacking and/or may be inappropriate. Individuals' attitudes were the third theme vital for the willingness criterion. Individuals carry cultural, professional and individual beliefs, mindsets, norms and interests; they are not passive recipients of policies, but they have agency and can have significant impacts on implementation outcomes as facilitators or obstructors (Greenhalgh *et al.*, 2004; Greenhalgh *et al.*, 2005; Damschroder *et al.*, 2009).

RWA could help to identify strategies to overcome frequently occurring bottlenecks by reinforcing facilitators and moderating barriers and we use our findings to illustrate how some of the facilitators could be employed to overcome barriers. For example, as Figure 2 indicates some of the barriers in the willingness criterion (e.g. the lack of evidence) may be overcome by strong leaders and their commitment to prevention. Key commissioning professionals can influence the utilisation and interpretation of evidence by making common sense or expert opinion judgements about its application and applicability (Orton *et al.*, 2011). The RWA framework can also be valuable in helping structure the identification of factors that reinforce facilitators and undermine barriers, thereby highlighting areas where the strengthening of implementation capacities and capabilities should be prioritised. However, further research is needed to establish specific interventions and implementation programmes to put such insights into effect.

The ability criterion, which relates to the capability to adopt a practice given legal and financial means, was partly met. Whilst the Care Act 2014 appeared to facilitate and/or legitimise investment in prevention,

Downloaded from https://academic.oup.com/bjsw/advance-article/doi/10.1093/bjsw/bcae010/7600671 by guest on 13 March 2024

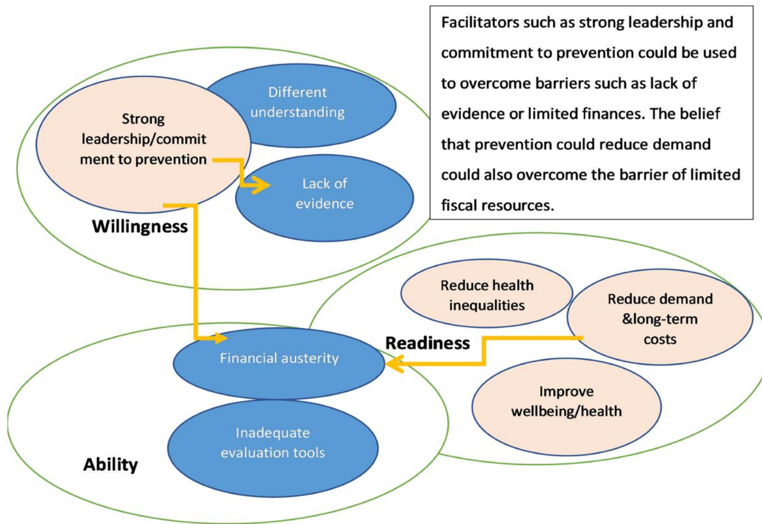

Figure 2. Facilitators (light/peach background) which could potentially overcome some of the barriers (dark/blue background) are illustrated with an arrow.

the reported lack of financial resources and evidence for investments in prevention have been found to be significant barriers (Tew *et al.*, 2019). Over the last decade, managing financial scarcity has become perhaps the overriding task for local government, posing major—and sometimes conflicting—dilemmas and challenges for councils and their partners. In this study, some of the same interviewees who identified financial resources as a barrier to implementing prevention interventions also considered that investment in prevention would pay off long term as it could reduce demand in the future. This apparent paradox between the perceived utility of investing in prevention, and the apparent lack of resources to do so, reflects the complexity of prevention investment decisions and not least the tension between immediate costs and longer term benefits, especially where financial benefits fall to budgets, which have not incurred commensurate costs. However, as Figure 2 suggests, beliefs that investing in prevention could reduce demand and long-term costs, combined with strong leadership and commitment to prevention, could help to secure investment in prevention.

The RWA model enables critical analysis from a systems-based, multi-levelled perspective. For example, at the individual level, the framework can be applied to professionals, providers and service users; at the organisational level, it can be applied to local councils, care systems, and voluntary sector organisations; whilst at the local and national policy levels, it can be applied to care policy, the economics of social care or the legal umbrella under which care is managed. The implementation of prevention strategies and services at the local level requires multiple

Downloaded from https://academic.oup.com/bjsw/advance-article/doi/10.1093/bjsw/bcae010/7606671 by guest on 13 March 2024

stakeholder interests to be aligned across different agencies and administrative levels and each stakeholder needs to have a degree of readiness, willingness and ability to facilitate the necessary change. The implementation process is dynamic and iterative, with influences from one level shaping other levels. Consequently, some factors influencing prevention implementation may apply to more than one of the criteria (R, W, A) or to more than one level (individual, organisational, policy) concurrently (Shultz and Jimbo, 2015).

Notwithstanding our findings suggesting the value of RWA as a heuristic framework, the study's limitations must be recognised when interpreting its results. First, it is important to note that distinctions between the three core elements may, at times, appear somewhat contrived, since a given item may sometimes be categorised under more than one heading. For example, although we have coded the availability of evidence to justify prevention investment, as part of the willingness criterion, because it is strongly related to stakeholders' willingness to invest in prevention, it could also be seen as part of readiness as it impacts perceptions of the utility of prevention. The purpose, however, of representing a given component of the model, is not to exhaust every possible contingency, but to summarise findings and create a useful heuristic that can inform critical thinking about potential obstacles to implementation.

Secondly, some authors have argued for a conceptualisation of social care prevention that recognises the role of structural or systemic influences on outcomes (Verity *et al.*, 2020). The breadth and parsimony of the RWA model may limit in-depth analyses of such complexities as 'the causes of the causes' of barriers and facilitators to developing and implementing policies and implementation programmes (see also Marmot *et al.*, 2010). Although such factors may be explored in RWA through the ability component, a more fundamental analysis than the model allows may be required to identify the underlying nature of presenting barriers and opportunities.

Finally, whilst effort was made to capture a diverse range of local views, opinions and practices related to the prevention agenda in a variety of contexts, the exploratory nature of the study and the small sample size may be thought to limit the generalisability of its findings. The sampled councils where interviews were conducted are amongst the less deprived based on the English indices of deprivation, even though they have pockets of deprivation. However, the per capita level of local authority spending on ASC varied and was below average in one and above average in the other council (MHCLG, 2019; NHS Digital, 2017). As this research was based on a small sample, the strength of specific barriers may have been different in another sample, for example, the impact of financial austerity on prevention may have been more prominent in more deprived areas. A detailed analysis of the impact of financial austerity on prevention activity is of critical importance, and merits

Downloaded from https://academic.oup.com/bjsw/advance-article/doi/10.1093/bjsw/bcae010/7606671 by guest on 13 March 2024

separate research, which is beyond the scope of this article. The purpose of this article was not to record in exhaustive detail every barrier or facilitator but to identify overarching themes and assess their applicability to the RWA model as a tool for critical analysis and a potential guide for future research.

Conclusion

We found English local councils were experiencing continuing difficulties in the design and delivery of sustainable prevention strategies and interventions. Additions to their implementation toolkits might helpfully reinforce their capabilities to address those challenges. We used the RWA framework to expose both the range of implementation difficulties that councils were facing and to identify the features of individual challenges and inter-relationships between them, especially where they create specific bottlenecks to effective implementation. The framework's strength is in identifying and categorising facilitators, barriers and their interrelationships. Thus, RWA can provide a straightforward and parsimonious framework for identifying implementation difficulties singly and in combination. However, it is less helpful as a tool for constructing routes through the bottlenecks that it identifies. Success in implementing prevention may thus require a bigger toolkit, of which RWA may be just one element. For example, and like Tew *et al.* (2019), we would point to the potential utility of the theory of change approach and associated logic models, which enable implementors to map and help influence causal pathways, which may link specific contextual influences, selected mechanisms and desired outcomes to support the introduction and operation of prevention strategies.

In summary, therefore, RWA may provide a helpful mapping tool for gaining a high-level appreciation of current barriers and bottlenecks. As such, it might be adopted to support problem analysis and help to pinpoint areas where targeted improvement initiatives might be particularly beneficial. In an ASC context where we found opportunities and capabilities for analysis and reflection remarkably scarce, it may be shortsighted to ignore a relatively parsimonious approach that can help local actors begin to clarify and understand the dimensions of obstacles to and opportunities for progress with prevention. However, further studies, which explore the application of the model to social care settings, would help to establish both the feasibility of its adoption and the extent to which the limitations we have anticipated here might need to be met by other items in a well-stocked implementation toolbox.

Conflict of interest statement. None declared.

Downloaded from https://academic.oup.com/bjsw/advance-article/doi/10.1093/bjsw/bcae010/7606671 by guest on 13 March 2024

Funding

This study is funded by the National Institute for Health Research (NIHR) Policy Research programme, project title: "Developing a Local Prevention Evaluation Framework". The views expressed are those of the authors and not necessarily those of the NIHR or the Department of Health and Social Care.

Data availability

Access to data is restricted due to ethical concerns and to protect informants' anonymity and confidentiality.

References

Boyatzis, R. E. (1998) *Transforming Qualitative Information: thematic Analysis and Code Development*, Thousand Oaks, United States, Sage Publications.

Braun, V. and Clarke, V. (2006) 'Using thematic analysis in psychology', *Qualitative Research in Psychology*, **3**(2), pp. 77–101.

Bunzli, S., Nelson, E., Scott, A., French, S., Choong, P. and Dowsey, M. (2017) 'Barriers and facilitators to orthopaedic surgeons' uptake of decision aids for total knee arthroplasty: A qualitative study', *BMJ Open*, **7**(11), p. e018614.

Carers Trust. (2015) *Prevent, Reduce, Delay: Are Councils Meeting their New Duties to Support Unpaid Carers?* Essex, Carers Trust.

Coale, A. J. (1973) 'The demographic transition reconsidered', in *IUSSP—Proceedings of the International Population Conference*, Belgium.

Cylus, J., Figueras, J. and Normand, C. (2019) *Will Populating Ageing Spell the End of the Welfare State? A Review of Evidence and Policy Options*,Copenhagen, Denmark, European Observatory on Health Systems and Policies.

Damschroder, L., Aron, D., Keith, R., Kirsh, S., Alexander, J. and Lowery, J. (2009) 'Fostering implementation of health services research findings into practice: A consolidated framework for advancing implementation science', *Implementation Science*, **4**, 50.

Davies, B. and Knapp, M. (1981) *Old People's Homes and the Production of Welfare*, London, Routledge.

Dearing, J. and Cox, J. (2017) 'On the diffusion of people and practices: Prospects for health communication research', in Mao, Y. and Ahmed, R. (eds), *Culture, Migration, and Health Communication in a Global Context* (pp. 33–44). New York, Routledge.

Department of Health. (2014) *Care and Support Statutory Guidance Issued under the Care Act 2014*, London, Department of Health.

Department of Health and Social Care. (2018) *Care and Support Statutory Guidance: Updated 26 October 2018*, London, Department of Health and Social Care.

European Commission. (2021) '2021 Long-Term Care Report Trends, challenges and opportunities in an ageing society', Publications catalogue—Employment, Social Affairs & Inclusion—European Commission (europa.eu)

Downloaded from https://academic.oup.com/bjsw/advance-article/doi/10.1093/bjsw/bcae010/7606671 by guest on 13 March 2024

Field, O. (2017) 'Prevention in Action: How prevention and integration are being understood and prioritised locally in England' London, British Red Cross.

Flaspohler, P. D., Meehan, C., Maras, M. A. and Keller, K. E. (2012) 'Ready, willing, and able: developing a support system to promote implementation of school-based prevention programs', *American Journal of Community Psychology*, **50**(3–4), pp. 428–44.

Fullan, M. (2003) *Change Forces with a Vengeance*, London, Routledge. https://doi.org/10.4324/9780203165805.

Fuller, H. J. A., Arnold, T., Bagian, T. M. and Gunner, W. P. (2020) 'A human factors framework and heuristics for diffusion of innovations', in Kalra, J. and Lightner, N. (eds), *Advances in Human Factors and Ergonomics in Healthcare and Medical Devices. AHFE 2020. Advances in Intelligent Systems and Computing*, Cham, Springer.

Glasby, J. (2012) *Commissioning for Health and Well-Being*, Bristol, The Policy Press.

Godfrey, M. (2001) 'Prevention: developing a framework for conceptualizing and evaluating outcomes of preventive services for older people', *Health & Social Care in the Community*, **9**(2), pp. 89–99.

Greenhalgh, T. and Papoutsi, C. (2019) 'Spreading and scaling up innovation and improvement', *British Medical Journal (Clinical Research ed.)*, **365**, p. l2068.

Greenhalgh, T., Robert, G., MacFarlane, F., Bate, P. and Kyriakidou, O. (2004) 'Diffusion of innovations in service organizations: Systematic review and recommendations', *Milbank Quarterly*, **82**(4), pp. 581–629.

Greenhalgh, T., Robert, G., MacFarlane, F., Bate, O. and Kyriakidou, F. (2005) *Diffusion of Innovations in Health Service Organisations: A Systematic Literature Review*, Massachusetts /Oxford/Carlton, Blackwell Publishing Ltd.

Ham, C., Alderwick, H., Dunn, P. and McKenna, H. (2017) 'Delivering Sustainability and Transformation Plans: From ambitious proposals to credible plans', London, King's Fund.

Hartley, J. (2005) 'Innovation in governance and public services: Past and present', *Public Money and Management*, **25**(1), pp. 27–34.

Hastings, A., Bailey, N., Bramley, G., Gannon, M. and Watkins, D. (2015) 'The cost of the cuts: The impact on local government and poorer communities', available online at: https://www.jrf.org.uk/report/cost-cuts-impact-local-government-and-poorer-communities (accessed May 20, 2022).

HM Government. (2014) *Care Act 2014*, London, HM Government.

Knapp, M. (1984) *The Economics of Social Care*, London, Macmillan.

Lesthaeghe, R. and Vanderhoeft, C. (2001) 'Ready, willing, and able: A conceptualization of transitions to new behavioral forms', in Casterline, J. B. (ed.), *Diffusion Processes and Fertility Transition: Selected Perspectives*, Washington, D.C., National Research Council (US) Committee on Population.

Llewellyn, M., Verity, F., Wallace, S., Calder, G., Garthwaite, T., Lyttleton-Smith, J. and Read, S. (2023) 'From act to impact? Final report of the Evaluation of the Social Services and Well-being (Wales) Act 2014', Cardiff, Welsh Government, GSR report number 36/2023.

Lincoln, Y. S. and Denzin, N. K. (2000) *Handbook of Qualitative Research*, 2nd edn, Thousand Oaks/London, Sage.

Lombard, D. (2013) Preventing need and maximising independence: Literature review. Dartington, Research in Practice for Adults.

Downloaded from https://academic.oup.com/bjsw/advance-article/doi/10.1093/bjsw/bcae010/7606671 by guest on 13 March 2024

Marczak, J., Wittenberg, R., Frisina Doetter, L., Casanova, G., Golinowska, S., Guillen, M., Rothgang, H. and Doetter, F. (2019a) 'Preventing loneliness and social isolation among older people', *Eurohealth Observer*, **25**(4), pp. 3–5.

Marczak, J., Wistow, G. and Fernandez, J. L. (2019b) 'Evaluating social care prevention in England: Challenges and opportunities', *Journal of Long-Term Care*, **2019**, pp. 206–17. Available online at: https://journal.ilpnetwork.org/articles/10.31389/jltc.32 (accessed August 12, 2022).

Marczak, J., Fernandez, J. L. and Wittenberg, R. (2017) 'Quality and cost-effectiveness in long-term care and dependency prevention: English policy landscape', CEQUA report. Available online at: e1a359_d837fe802373413f9b7-ba11615dcab92.pdf (filesusr.com) (accessed August 14, 2022).

Marmot, M., Atkinson, T., Bell, J., Black, C., Broadfoot, P., Cumberlege, J., Diamond, I., Gilmore, I., Ham, C., Meacher, M., Mulgan, G. (2010) 'Fair society, healthy lives: The Marmot review', Strategic Review of Health Inequalities in England Post-2010.

Meijer, E., Schout, G., de Jong, G. and Abma, T. (2017) 'Regaining ownership and restoring belongingness: Impact of family group conferences in coercive psychiatry', *Journal of Advanced Nursing*, **73**(8), pp. 1862–72.

Miller, R. (2014) 'Is integration or fragmentation the starting point to improve prevention?'University of Birmingham, Health Services Management Centre.

MHCLG (2019) English indices of deprivation. London: Ministry of Housing, Communities and Local Government. Available online at: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019 (accessed October 5, 2023).

NAO. (2015) 'Care Act first-phase reforms', available online at: https://www.nao.org.uk/report/care-act-first-phase-reforms/, (accessed August 20, 2022).

NHS Digital. (2017) 'Adult Social Care Activity and Finance Report, England 2016–17', available online at: , https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report (accessed August 20, 2023).

OECD. (2017) 'How much do OECD countries spend on prevention?', OECD Health Working Papers No.101.

Orton, L., Lloyd-Williams, F., Taylor-Robinson, D., O'Flaherty, M. and Capewell, S. (2011) 'The use of research evidence in public health decision making processes: Systematic review', *PLoS One*, **6**(7), p. e21704.

Osborne, S. and Brown, L. (2011) 'Innovation, public policy and public services delivery in the UK: The word that would be king?', *Public Administration*, **89**(4), pp. 1335–50.

Patton, M. Q. (2002) *Qualitative Research and Evaluation Methods*, 3rd edn, London/Thousand Oaks/New Delhi, Sage.

QSR International Pty Ltd. (2015) *Nvivo Version 11*.

Read, S., Verity, F., Llewellyn, M., Tetlow, S. and Richards, J. (2023) 'Problematising "fused principles" in discourses of preventative social care: Interpreting the implementation of National Social Services Legislation in Wales, UK', *British Journal of Social Work*, **53**(4), pp. 2331–51.

Ritchie, J. and Lewis, J. (2003) *Qualitative Research Practice: A Guide for Social Science Students and Researchers*, London/Thousand Oaks/New Delhi, Sage.

Ritchie, J. and Spencer, L. (1994) 'Qualitative data analysis for applied policy research', in Bryman, A. and Burgess, R. G. (eds), *Analyzing Qualitative Data* (pp. 173–94). London, Routledge.

Downloaded from https://academic.oup.com/bjsw/advance-article/doi/10.1093/bjsw/bcae010/7606671 by guest on 13 March 2024

Rogers, E. M. (1995) *Diffusion of Innovations*, 5th edn, Free Press. Available at: https://www.perlego.com/book/780731/diffusion-of-innovations-5th-edition-pdf (accessed August 14, 2023).

Rostgaard, T., Parsons, J. and Tuntland, H. (2023) *Reablement in Long-Term Care for Older People: International Perspectives and Future Directions*, Bristol, Policy Press.

Shultz, C. G. and Jimbo, M. (2015) 'Decision aid use in primary care: An overview and theory-based framework', *Journal of Family Medicine*, **47**(9), pp. 679–92.

Starfield, B., Hyde, J., Gervas, J. and Heath, I. (2008) 'The concept of prevention: A good idea gone astray?', *Journal of Epidemiology and Community Health*, **62**(7), pp. 580–83.

Tew, J., Duggal, S., Carr, S., Ercolani, M., Glasby, J., Kinghorn, P., Miller, R., Newbigging, K., Tanner, D., Afentou, N. (2019) 'Building social resources to prevent, reduce or delay needs for care and support in adult social care in England', Implementing the Care Act 2014 (birmingham.ac.uk).

Tew, J., Duggal, S. and Carr, S. (2023) 'How has the idea of prevention been conceptualised and progressed in adult social care in England?', *Journal of Social Policy*. Published online 2023, pp. 1–19. https://doi.org/10.1017/S0047279423000132.

Verity, F., Richards, J., Read, S. and Wallace, S. (2020) 'Towards a contemporary social care 'prevention narrative' of principled complexity: An integrative literature review', *Health & Social Care in the Community*, **30**(1), pp. e51–e66.

Wistow, G. and Lewis, H. (1997) 'Preventative services for older people: Current approaches and future opportunities'. Kidlington, Oxon, Anchor Trust

Wye, L., Brangan, E., Cameron, A., Gabbay, J., Klein, J. H. and Pope, C. (2015) 'Evidence based policy making and the "art" of commissioning—how English healthcare commissioners access and use information and academic research in "real life" decision-making: An empirical qualitative study', *BMC Health Services Research*, **15**(1), p. 430.

Downloaded from https://academic.oup.com/bjsw/advance-article/doi/10.1093/bjsw/bcae010/7606671 by guest on 13 March 2024