Short to Medium Term Operational and Cost Pressures Affecting Social Care in Wales

Final Report to the Welsh Government

LE Wales

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Executive Summary

In this report we present projections of net current expenditure by local authorities on social care services in Wales for the period 2018/19 to 2022/23. The projections cover social care services for different age groups (children, working age adults and older people), consider net expenditure (i.e. excluding income from clients and other sources) and are all expressed in nominal (or cash) terms. The modelling and projections are based on data available at 31 August 2019.

There is significant uncertainty about future expenditure needs for social care services in Wales and so we present a number of different scenarios for expenditure:

- **'Baseline scenario'**: assumes that net current expenditure for each age group will be driven only by demographic trends (projected growth in each age group) and inflation;
- **'Scenario 1'**: assumes that net current expenditure will continue to grow at the same rate experienced in recent years (from 2011/12 to 2017/18);
- **'Central cost' scenario**: takes the Baseline scenario and adjusts it for various factors linked to social care spend, including: wage cost pressures; additional future demand; impact of preventative and integrative services; and new technologies;
- **'Low cost' scenario**: adjusts the assumptions of the central cost scenario to provide a lower cost estimate;
- **'High cost' scenario**: adjusts the assumptions of the central cost scenario to provide a higher cost estimate;

The expenditure projections for each scenario are shown in Table 1. In the Baseline scenario total net expenditure is projected to increase from £1,812M in 2017/18 to £2,094 by 2022/23 (a cumulative increase of 15.6% over five financial years). Scenario 1 and the 'Central cost' scenario show slightly higher cumulative increases over the same period (at 17.5% and 19.5% respectively).

Table 1 Projected Net Current Expenditure on social care services between 2020/21 and 2022/23 – different scenarios

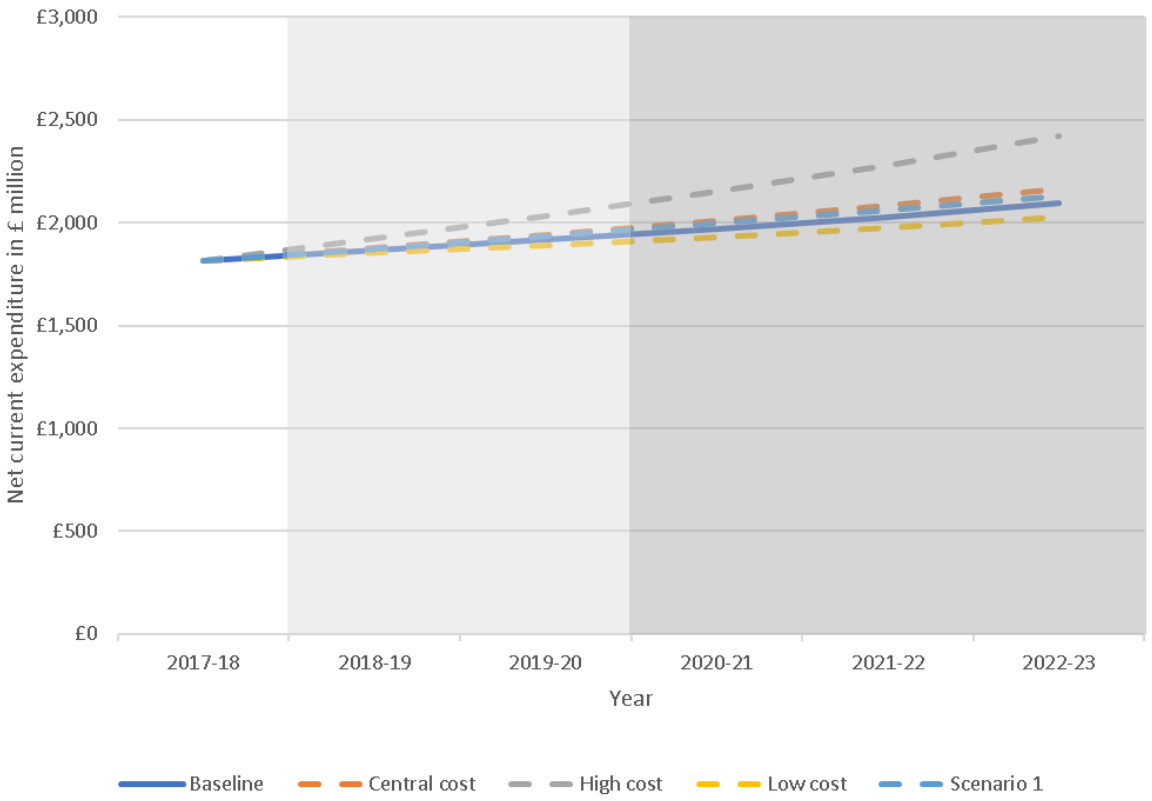
	Actual	Projection	Projection	Projection	Projection	Projection	Difference with baseline in 2022/23	Change 2017/18 to 2022/23	Avg. annual growth rate 17/18 to 22/23
	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23			
	£M	*£M*	*£M*	*£M*	*£M*	*£M*	*£M*	%	%
Baseline scenario	£1,812M	£1,867M	£1,917M	£1,970M	£2,028M	£2,094M	-	15.6%	2.9%
Scenario 1	£1,812M	£1,871M	£1,932M	£1,995M	£2,061M	£2,129M	£35M	17.5%	3.3%
'Central cost' scenario	£1,812M	£1,879M	£1,941M	£2,008M	£2,081M	£2,165M	£71M	19.5%	3.6%
'High cost' scenario	£1,812M	£1,923M	£2,034M	£2,151M	£2,278M	£2,421M	£327M	33.6%	6.0%
'Low cost' scenario	£1,812M	£1,854M	£1,891M	£1,930M	£1,973M	£2,024M	-£70M	11.7%	2.2%

Note: Cells shaded in grey represent projections; unshaded cells represent actual figures. The Baseline Scenario use current number of care recipients, population projections and CPI forecasts to project Net Current Expenditure (Gross expenditure minus Total Income). The Central/High/Low cost scenarios reflect the baseline scenario and the parameters presented in Table 7. Scenario 1 is based on past trends. All nominal (cash) values.

Source: LE Wales' calculations based on StatsWales, ONS and BoE data.

These projections are illustrated in Figure 1, which also shows the spread between the 'High cost' and 'Low cost' scenarios, both of which show cost increases. The 'High cost' scenario suggests the possibility of very significant increases in expenditure: 33% compared to 2017/18 by 2022/23.

Figure 1 Projected Net Current Expenditure under different scenarios (£ million)



Note: The darker grey shaded area indicates the three financial years of the projections of the modelling exercise (2020/21 to 2022/23), while the lighter grey shaded area represents the financial years 2018/19 and 2019/20 (which had to be projected as actual data is not yet available). The Baseline Scenario use current number of care recipients, population projections and CPI forecasts to project Net Current Expenditure (Gross expenditure minus Total Income). The Central/High/Low cost scenarios reflect the baseline scenario and the parameters presented in Table 7. Scenario 1 is based on past trends. All nominal (cash) values.

Source: LE Wales' calculations based on StatsWales, ONS and BoE data.

The 'Baseline' scenario and 'Scenario 1' are both relatively straightforward, with the 'Baseline' scenario being based only on future changes in the size and structure of the population and on future inflation, whilst 'Scenario 1' is based on previous trends in social care expenditure continuing into the future. Details of how these scenarios are produced are provided in Chapters 1 and 2, and in Annex 1.

The 'central cost', 'high cost' and 'low cost' scenarios are more complex in that they take the Baseline scenario as their starting point and then incorporate additional assumptions about how other factors might affect social care expenditure in future. In order to inform

the evidence base for these assumptions we have undertaken short reviews of the available evidence using a mix of sources including publicly available data, previous research and a short qualitative survey of Welsh local authorities. In general, the evidence base suggests a range of factors that may influence social care expenditure in future, with some factors having the potential to increase expenditure and some having the potential to reduce expenditure. The evidence however does not provide a strong steer on the size of these impacts nor on how quickly impacts may happen. The factors we assessed were:

- Unit cost pressures (e.g. wages increasing at a faster rate than inflation);
- Additional demand (i.e. current or future service provision is not able to meet demand, or needs, in full and new demand is likely to arise in the future);
- Preventative and integrative care services (e.g. leading to less need for care services);
- New technologies (reducing the cost of service provision).

Chapter 3 summarises how these factors could affect future social care expenditure and sets out the assumptions we have used to model the 'central cost', 'high cost' and 'low cost' scenarios. Further supporting evidence relating to these factors is provided in Annex 2.

1 Modelling the baseline scenario

Baseline projections assume that growth in future net expenditure (up to 2022/23) will reflect demographic trends in each age group (under 18, 18-64 and 65+)[1] and inflation expected for the period. All the assumptions and definitions used in the baseline scenario are presented in Annex 1 and are based on data available at 31 August 2019.

Results from the baseline scenario are presented in Table 2, Figure 2 and Figure 3, along with the latest data available on actual net expenditure (2017/18).

Total net current expenditure on social care services (included children and adults) is projected to increase from **£1.812** million in 2017/18 to **£1.970** million in 2020/21, **£2,028** million in 2021/22 and **£2,094** million in 2022/23

Taking each age group, net current expenditure on social care services is projected to increase:

- from **£613M** in 2017/18 to **£695M** in 2022/23 for the group aged **under 18;**
- from **£613M** in 2017/18 to **£676M** in 2022/23 for the group aged **18-64;** and
- from **£586M** in 2017/18 to **£723M** in 2022/23 for the group of older people aged **65+**.

Table 2 Projected Net Current Expenditure on social care services: 2020/21 to 2022/23 - Baseline Scenario

	Actual	Projection	Projection	Projection	Projection	Projection
Client group	**2017/18**	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**2022/23**
	£M	*£M*	*£M*	*£M*	*£M*	*£M*
Under 18 (Children and Families)	£613M	£629M	£643M	£659M	£677M	£695M
18-64 (Working Age Adults)	£613M	£628M	£639M	£651M	£664M	£676M
65+ (Older People)	£586M	£611M	£635M	£659M	£687M	£723M
Total	£1,812 M	£1,867M	£1,917M	£1,970M	£2,028M	£2,094M

Note: Cells shaded in grey represent projections; unshaded cells represent actual figures. The Baseline Scenario use current number of care recipients, population projections and CPI forecasts to project Net Current Expenditure (Gross expenditure minus Total Income).

Source: LE Wales' calculations based on StatsWales, ONS and BoE data.

[1] The 65+ age group was also divided into three sub groups to improve the accuracy of the estimates.

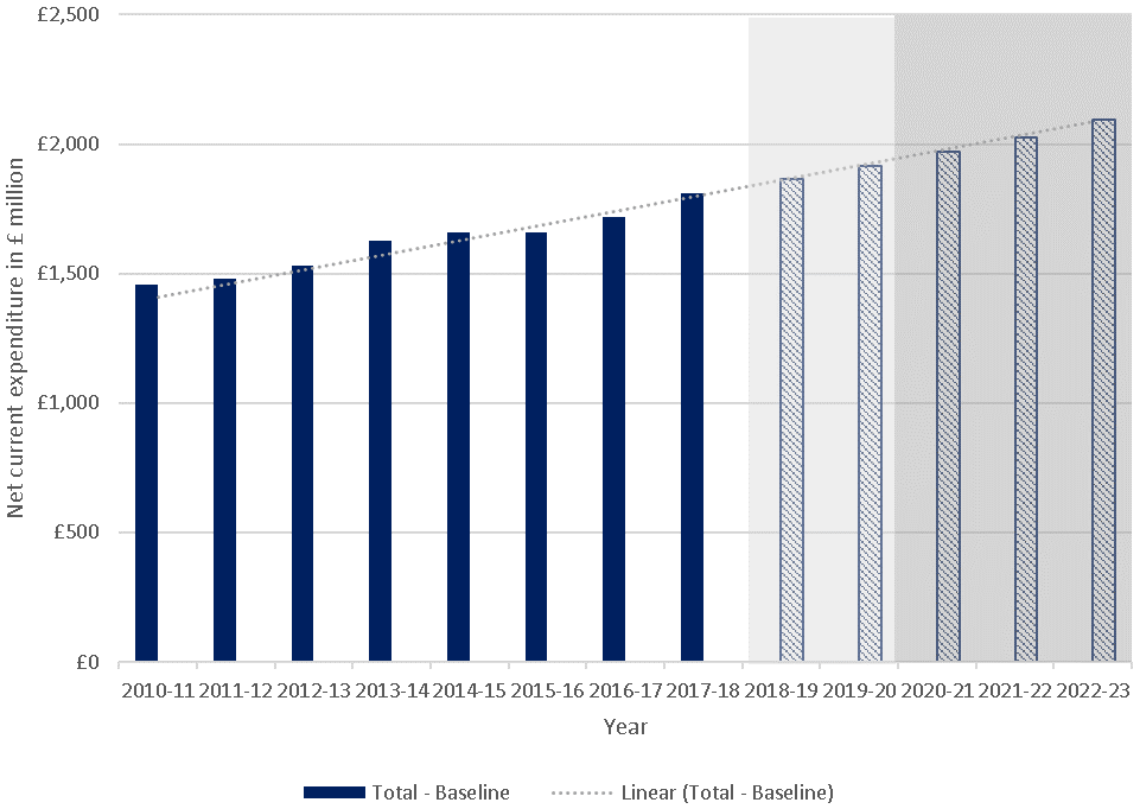
Table 3 Growth rates in net expenditure on social care services between 2018/19 and 2022/23 in the baseline scenario

Client group	2018/19	2019/20	2020/21	2021/22	2022/23
Under 18 (Children and Families)	2.5%	2.3%	2.5%	2.7%	2.7%
18-64 (Working Age Adults)	2.4%	1.9%	1.8%	2.0%	1.9%
65+ (Older People)	4.2%	3.9%	3.9%	4.2%	5.2%
Total	3.0%	2.7%	2.7%	2.9%	3.3%

Note: these growth rates are generated by the baseline scenario which accounts for demographic changes and inflation.

Source: LE Wales' calculations based on StatsWales, ONS and BoE data.

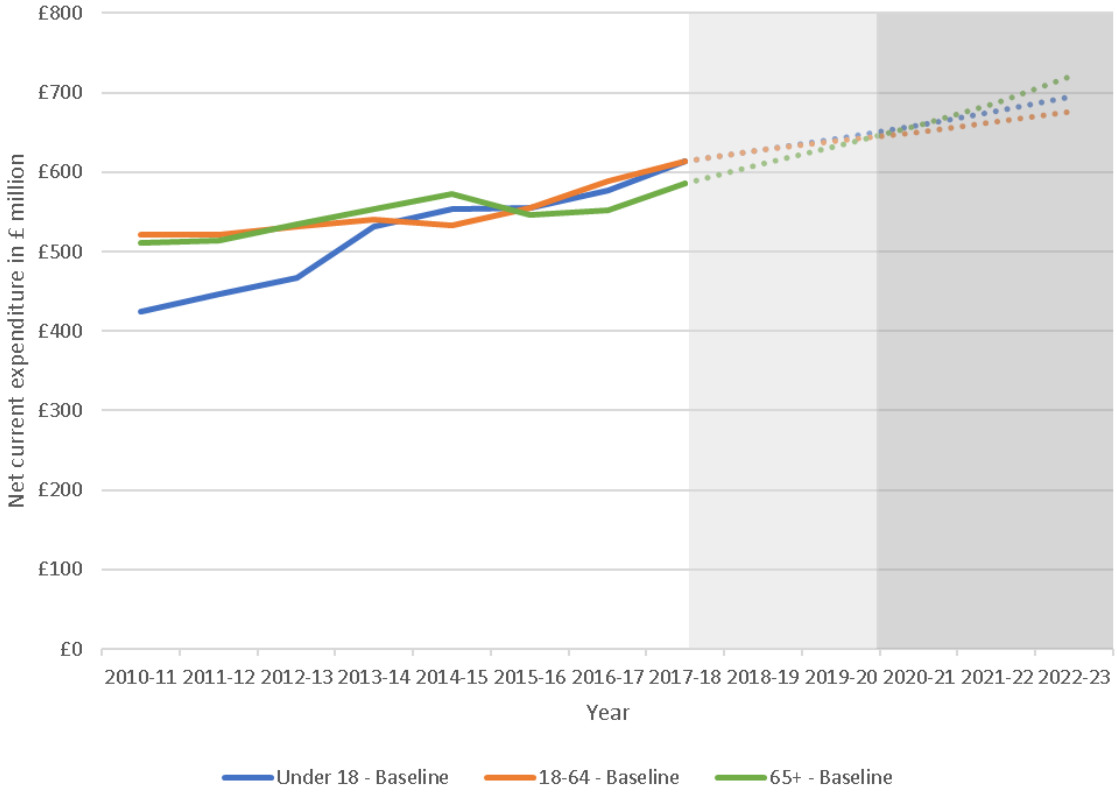
Figure 2 Total projected Net Current Expenditure (£ million) – Baseline Scenario



Note: The darker grey shaded area indicates the three financial years of the projections of the modelling exercise (2020/21 to 2022/23), while the lighter grey shaded area represents the financial years 2018/19 and 2019/20 (which had to be projected as actual data is not yet available). Dark blue columns represent actual expenditure, while columns filled with blue diagonal stripes represent projections. Linear trend line added in grey dots.

Source: LE Wales' calculations based on StatsWales, ONS and BoE data.

Figure 3 Projected Net Current Expenditure by client group (£ million) – Baseline Scenario



Note: The grey shaded area indicates the three financial years of the projections (2020/21 to 2022/23). The solid lines represent actual net current expenditure, while the dotted lines represent projected net current expenditure

Source: LE Wales' calculations based on StatsWales, ONS and BoE data.

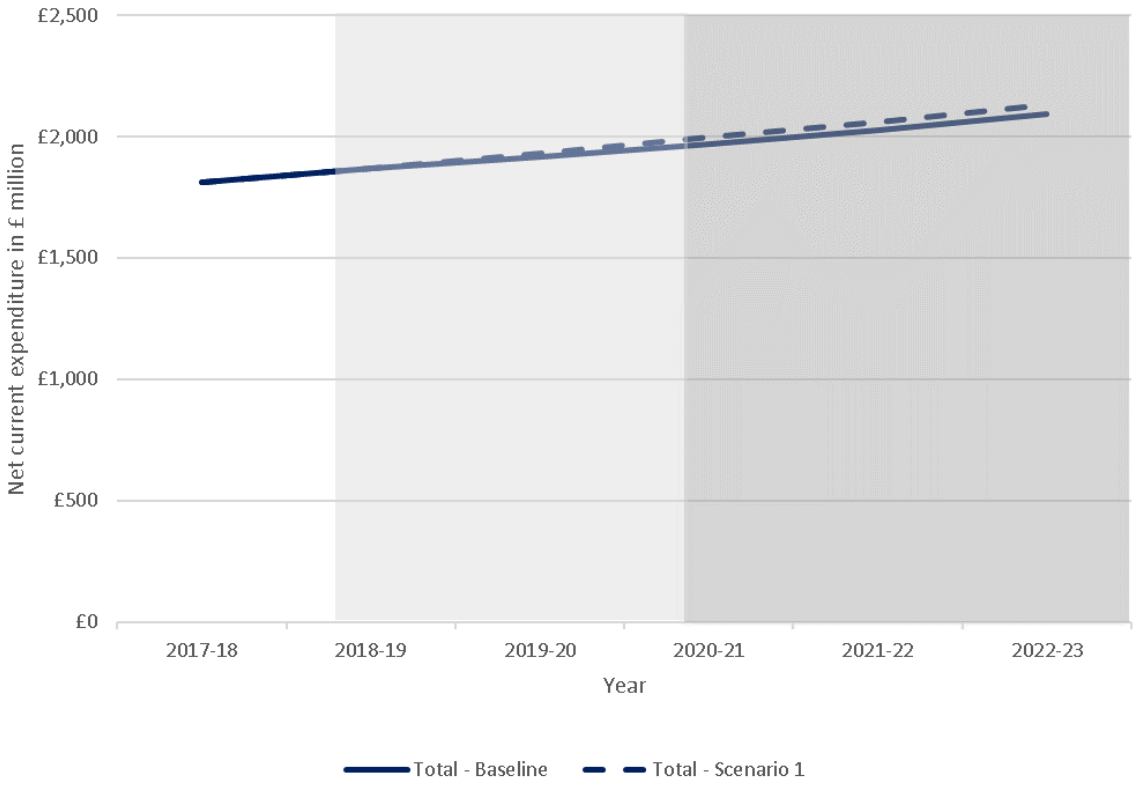
2 Scenario based on recent trends ('Scenario 1')

We have also generated projections using an alternative scenario ('**Scenario 1**') where we assume that **net current expenditure will continue to grow at the same rate experienced in recent years**. In order to compute the growth rate we used the annual changes observed in the last seven years (from 2011/12 to 2017/18) excluding, for each client group, the maximum and minimum value observed in the period. In other words, in this scenario we assume that the change in net expenditure will continue to evolve following recent trends in net expenditure, regardless of demographic trends.

In Figure 4 we compare the projections for total net expenditure using the Baseline Scenario and Scenario 1. The average annual changes used in this scenario are also presented in Table 4 and amount to 4.9%, 2.4% and 2.5% for the groups aged 'under 18', '18-64' and '65+' respectively.

When we compare the Scenario 1 projections with the Baseline projections, we can see that for the group of 'working age adults' the projections are quite similar under both scenarios, while for 'children' the projections under Scenario 1 are higher compared to the Baseline (as expenditure on this group has experienced a relatively fast growth in recent years); on the other hand, the group of 'older people' is projected to increase in size over the next three financial years, leading to higher estimates in the Baseline Scenario compared to Scenario 1. Overall net current expenditure is projected to increase to almost £2,000 million in 2020/21 and £2,129 million by 2022/23, compared with £1,970 and £2,094 for the Baseline scenario in the same years.

Figure 4 Projected Net Current Expenditure (£ million) – Baseline Scenario and Scenario 1



Note: The grey shaded area indicates the financial years of the projections. The Baseline Scenario use current number of care recipients, population projections and CPI forecasts to project Net Current Expenditure. Scenario 1 use annual changes in expenditure observed between 2011/12 and 2017/18 to project Net Current Expenditure.

Source: LE Wales' calculations based on StatsWales, ONS and BoE data.

Table 4 Projected Net Current Expenditure on social care services between 2020/21 and 2022/23 - Scenario 1

	% change*	Actual	Projection	Projection	Projection	Projection	Projection
Client group	**2011/12 to 2017/18**	**2017/18**	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**2022/23**
		£M	*£M*	*£M*	*£M*	*£M*	*£M*
Under 18 (Children and Families)	4.9%	£613M	£643M	£674M	£707M	£742M	£778M
18-64 (Working Age Adults)	2.4%	£613M	£628M	£642M	£658M	£673M	£689M
65+ (Older People	2.5%	£586M	£600M	£615M	£631M	£646M	£662M
Total		£1,812M	£1,871M	£1,932M	£1,995M	£2,061M	£2,129M

Note: *Average of annual changes between 2011/12 and 2017/18 excluding the minimum and maximum values observed for each client group. Cells shaded in grey represent projections; unshaded cells represent actual figures. Scenario 1 use annual changes in expenditure observed between 2011/12 and 2017/18 to project Net Current Expenditure (Gross expenditure minus Total Income).

Source: LE Wales' calculations based on StatsWales and ONS data.

3 Modelling additional cost drivers

We now go beyond the baseline scenario projections and explore the various additional factors that may affect expenditure on social care services in the short to medium term. All these factors are modelled on the baseline scenario and affect cost estimates in each year.

The factors considered in the model are based mainly on evidence gathered in a short review of the evidence, including a qualitative survey undertaken with the assistance of the Welsh Local Government Association. Additional insights were provided through interactions with the Welsh Government and the Welsh Local Government Association. For each factor we present a 'central' estimate. However, as explained below in full detail, there is generally no clear evidence to support any one specific assumption about the impact of these factors on future social care expenditure. The accompanying spreadsheet, which generates the projections, allows user to customise the parameters used in the model.

These additional parameters were modelled differently for adults and children for a variety of reasons:

- The type of service provided is considerably different across children and adults;
- Trends in demand and supply of services are also likely to be significantly different;
- Relevant literature has typically focused on older people so the equivalent impact for children is not known (if applicable at all);
- Expenditure on services for Children and Families as defined on the StatsWales website cover highly heterogeneous categories[2], from Children's Centres to Children looked after (which itself covers Fostering care, Residential care etc.) to Youth Justice services etc.
- Although the trend for working age adults is likely to differ from trends for older people, categories of services are consistent and, due to the lack of specific evidence for the category, we decided to apply the same assumptions to all adult services (with the exception of additional demand, which is set to zero for working age adults);

Below we describe in detail which areas we considered in the model and refer back to the relevant literature when possible:

3.1 Brief description of the model

The modelling of future operational cost pressures and savings is applied on the baseline model. In other words, cost and efficiency drivers considered are designed to affect net expenditure over and above demographic trends and inflation. Parameters are designed to affect projections from 2018-2019 (as actual data is available up until 2017/18) to 2022-

[2] See https://statswales.gov.wales/Catalogue/Local-Government/Finance/Revenue/Social-Services/social-services-socialservicesrevenueexpenditure-by-clientgroup

2023. In the text we refer in detail to the three financial years of the anticipated expenditure review (2020/21 to 2022/23).

We have allowed for the effect of each factor to take some time to fully affect expenditure (or to be fully implemented). When we refer to 'number of years' we assume that changes take place starting from 2018/19, so that the period of five years cover up until the end of 2022/23 financial year (last year covered by the projections). If the value is set to one year, the change has full effect in year 1 and the trend is driven by demographics and inflation thereafter (i.e. the baseline projection is upscaled by the same factor in each year). If the value is set to more than 5 years, the effect is not fully implemented by the end of 2022/23.

As mentioned, the effect of the different factors is to scale up or down the baseline projections for net expenditure in each year. When the effect takes place over multiple years (e.g. 5% in 5 years), the annual effect on the baseline costs is increased by an equal amount year after year (e.g. 1% in year 1, 2% in year 2, up to 5% in year 5).

3.2 Description of the factors affecting costs of service provision

In this section we shortly describe the various factors likely to affect the cost of service provision in the short to medium. A more systematic review of existing evidence is presented in Annex 2. While we have identified factors affecting social care services for adults (assuming a similar effect on working age adults and older people, due to the lack of specific evidence for working age adults), expenditure categories for children identify vastly heterogeneous services and have been modelled via a generic parameter identifying cost pressures or cost savings.

It should be acknowledged that there is a wide degree of uncertainty on how these factors impact on costs and the magnitude of each effect. Users are free to customise these assumptions when using the model.

Additional demand (older people only)

The concept of 'additional demand' used here identifies further pressure on costs in the short to medium term deriving from a variety of factors:

- Pressure on local authorities to satisfy existing additional demand for social care services, i.e. individuals who want to receive care services (but are currently not receiving any) or individuals who are receiving some form of care services but may want to receive further or different services. Although all these individuals may not be immediately eligible for a care and support plan, available evidence shows that:
  - For older people, the volume of services provided declined by around 17% between 2010/11 and 2017/18. Expressed as a ratio of the relevant population that represents a decline of almost 20%. A similar trend was not observed for working age adults;

- A decline of similar magnitude (-20%) was observed for real net current expenditure per individual aged 65 and over between the pre-crisis level (2007/08) and 2017/18;
- The National Survey for Wales reported that around 11% of respondents received social care services (NSW 2018/19) but a further 4% reported that they 'have needed help from social care services but not had it'. Both proportions are higher for the group of older people;
- Information gathered from Welsh local authorities indicated that factors such as capacity issues amongst providers, staffing levels, overall constrained financial resources may lead to delays to assessments and agreed packages of care for lower needs groups;
- Individuals can ask for a re-assessment if the initial assessment has not led to a care plan and feel they should receive care services; data for StatsWales that the number of requests for repeat assessment (and the number of repeat assessment undertaken) grew by more than 25% between 2016/17 and 2017/18;
- Expectations: local authorities also cited that increases in charges for services and in Council tax are raising expectations of public service provision at a time when in fact, the service is taking longer to arrange and may also be reduced for lower needs group;

- In the medium to longer term, further pressures on social care services are likely to arise:
  - The rising demand from those people who do not have dependents, or those people who are currently relying on older carers that may not be able to care in the future;
  - An increasing number of carers needing care in their own right as they get older;
  - Local authorities cited 'increasingly complex' needs, potentially implying that the packages of care currently received may need to be reviewed in the future. LAs also referred to higher expectations and more emphasis on maintaining independence, again leading to higher costs in future.

There is no clear evidence to support any one specific assumption about the future combined expenditure impact of all of these factors. It does however seem likely that there will be a future increase of expenditure at some level. For our central estimate, we used a 20% increase in spend (based on the decline in spend over the last ten years, as noted above), applied to older people only[3]. We assume that this increase takes place over ten years, so by the end of our five year modelling period only half of this amount is added to spend. For the purposes of the modelling we assumed that no 'additional demand' of this type for working age adults (as there is no specific supporting evidence) and children (as

[3] The estimate is also in line with a previous estimate for Wales, see Holtham (2018), "Paying for Social Care".

children services cover a variety of services with different drivers, from childcare to foster care services to youth justice services etc).

Increasing commissioning costs for residential care (adults only)

This assumption reflects pressure on fees paid by local authorities to care homes, generally considered to be too low for long-term financial sustainability of care home providers. In Wales, the Competition and Markets Authority reported that 24% of care home residents are self-funded, and they pay on average 36% more than their LA-funded counterparts for relatively similar levels of services provision (corresponding to around £200)[4]. These data suggest that care homes engage in cross-subsidisation to remain financially viable.

The central estimate we use in the model (8.64%)[5] is built assuming that in future both types of client pay the same rate (as they receive a similar service), meaning that rates for self-funders and LA supported clients converge over time to a level which maintains unchanged revenues for care providers (so income for care homes stays the same, but all clients pay the same rate).

In the central estimate we assumed that this change will take place in full over five years. It should be noted that this central estimate does not reflect further cost pressure that care providers may face.

Increasing local authorities' fees paid for non-residential care (adults only)

The UK Homecare Association (2018)[6], recently calculated that, the average rate for an hour of home care paid by Welsh local authorities is equal to £16.78. However, the association recommends a minimum rate of at least £18.01 to comply with National Minimum Wage Regulations (including care workers' travel) and to cover the costs of running the service in a sustainable way. The corresponding estimate for 2019 is £18.93.

Using these figures, the volume of hours of home care provided and the volume of services, we calculate that following the above recommended rate would lead to a 5.94% increase in costs as a percentage of 2017-2018 total net expenditure. We used this figure as the central estimate in our model and applied this percentage increase to home care services but also to day care services (assuming that a similar differential applies). The change is assumed to take place over five years in the central estimate. We have also used estimates from the UKHCA that assume that homecare cost will rise in the projection period (up to 2022/23) at the same rate observed between 2016 and 2019 for the UKHCA minimum rate (3.8%),

[4] "Care homes market study". Competition & Markets Authority (2017).

[5] The corresponding decline in self-funders rate is around 25.2%

[6] UK Home Care Association report on home care, "The Homecare Deficit 2018", UK Home Care Association (2018).

putting further pressure on costs[7]. This results in additional expenditure of 7.64% (compared to baseline cost) and was incorporated in our 'high cost' estimate.

The UK Homecare Association data' only concerns individuals aged 65 and over, though the authors note that services for adults aged 18-64 often have higher fee rates. However, due to the absence of specific research for working age adults, we have assumed a similar effect for all adults.

Potential savings due to preventative and integrative care services (adults only)

Available evidence on preventative services seems to indicate a potential to reduce social care costs, although the extent of these effects seems limited and mostly confined to specific cases. Interesting applications include preventing fall hazards, installing home adaptions[8], signposting and navigation of services[9]. In response to our short survey some, but not all, Welsh local authorities thought that new models of working, including a shift away from traditional approaches to a more preventative, holistic and outcome-focussed approach as well as better commissioning could lead to cost savings.

Hence, the evidence collected suggests that preventative services can reduce operating costs, at least in some circumstances. However, the evidence is linked to specific programmes in a range of different countries (including Wales), and is not sufficient to support any specific estimate of future reduction in costs in Wales.

The rate used in the central assumption in the model corresponds approximately to a reduction in costs, relative to the baseline, of 1% per annum (5% over 5 years) due to the implementation of preventative care services. We have conducted some sensitivity analysis and the impact of setting the parameter to zero (i.e. assuming that there is no effect of preventative services but leaving everything else unchanged) resulted in an extra £70M of expenditure by 2022/23 (or an additional 3.2% on total net expenditure, see Table 5). In the 'high cost' estimate the impact of preventative care services is always set to zero.

[7] Inflation forecast for the period is 2.1%, meaning that expenditure will also need to cover an extra 1.7%.

[8] For Welsh evidence on preventative services, see Tudor et al. (2018), "Living well for longer: The economic argument for investing in the health and wellbeing of older people in Wales". For a study on falls prevention programmes based on physical exercise, see Carande-Kulis et al. (2015), "A Cost-Benefit Analysis of Three Older Adult Fall Prevention Interventions". For a systematic review of RCTs and other experiments on the effectiveness of home adaptations, see Powell et al. (2017), "The role of home adaptations in improving later life".

[9] For evidence on the effectiveness of signposting/navigation of services, see McDaid et al. (2017), "Making the economic case for investing in actions to prevent and/or tackle loneliness: a systematic review".

This figure is applied to the net costs of provision, over and above any additional cost linked to the provision of these services.

Table 5 Sensitivity analysis – impact of preventive care services or adoption of new technologies on costs

	Actual	Projection	Projection	Projection	Projection	Projection
Estimate	**2017/18**	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**2022/23**
Central estimate	£1,812M	£1,879M	£1,941M	£2,008M	£2,081M	£2,165M
Central estimate with effect of preventative services or new technologies set to 0 (only adults aged 18+)	£1,812M	£1,891M	£1,967M	£2,047M	£2,135M	£2,235M
Difference in £ millions	-	£12M	£26M	£39M	£54M	£70M
Difference in %	-	0.64%	1.34%	1.94%	2.59%	3.23%

Note: Sensitivity analysis on central estimate, by setting the effect to preventative services or new technologies to zero (the two have the same annual effect in the central estimate) and leaving everything else unchanged.
Source: LE Wales' calculations based on StatsWales and ONS data.

Efficiencies related to the adoption of new technologies (adults only)

Overall, new technologies principally affect the provision of social care services for adults by assisting them at home and increasing telecare's possibilities[10]. For the social care sector as a whole, new technologies allow different agencies to collaborate more effectively and to reduce the strain on the social care system. Additionally, robotics and AI could potentially lead to the automation of multiple administrative tasks and thus free up considerable time for care workers.

Although there is available literature covering a range of different interventions (in Wales and elsewhere), we have only found one system-wide estimate of the impact of introducing new technologies in the care sector: the IPPR (2018)[11] calculated that the adoption of new technologies could lead to £6 billion in annual efficiency savings for the UK social care sector, corresponding to 18.83% of total 2017-2018 social care costs for the UK. The figure corresponds to the maximum savings achievable after overcoming potential barriers to adoption, but there is no indication of how long it might take to achieve this level of savings. For the purposes of this analysis, we think it is useful to think of this figure as an upper

[10] For a comprehensive review of new technologies' use cases in health and social care, see Blackwood (2018), "The promise of healthtech", and "Transforming social care through the use of information and technology", Local Government Association (2016).

[11] Lord Darzi (2018), "Better health and care for all", IPPR.

bound on the maximal savings which may be realised as a consequence of new technologies.

In the model our central case assumption was set at a reduction in costs of 10% over 10 years (compared to the baseline scenario). If the parameter is set to zero (leaving everything else unchanged), this would result in higher costs of £70M in 2022/23 (see Table 5, preventative care services and new technologies have the same impact on costs after 5 years in the central estimate).

In the 'high cost scenario', we assumed that there are no savings available from investment in technology measures over the period of our projections, while in the 'low cost' scenario we assumed that 15% savings are available over ten years.[12]

Other cost pressures/savings on adult social care (adults only)

This parameter allows the user to account for potential cost pressures and/or efficiency savings for adults not controlled by other parameters. Examples of additional cost pressures include pension and wage increases, increasing commission costs for other areas of costs or different care services (beyond residential and non-residential care), while possible savings may encompass higher administrative efficiency. The value of this parameter is currently set to zero in the model, reflecting an assumption that these other cost pressures will rise in line with general inflation.

Cost pressures/savings on children social care (children only)

All the previous factors are applied to adult care services only in the model. The different expenditure items included in children's social care cover a wide range of services, from 'Children's centres', to 'Youth Justice' services and services for 'Children looked after'. Even these categories may cover a variety of services: for example the category 'Children looked after' covers both 'Fostering care' services and 'Residential Care' services.

We present available evidence for the factors that could affect future expenditure on children services in section A2.6. A range of factors have been associated with differences in spending on looked after children across Welsh local authorities, including levels of deprivation, local authority policies and practices, and rates of domestic abuse, parental substance misuse and parental mental ill health. The range of services, and the array of factors that potentially influence the level of need for services, make it difficult to predict the impact on future expenditure and there is no clear evidence to support any one specific assumption about the future combined expenditure impact.

[12] The 15% assumption for the low cost scenario is broadly based on the 18.8% savings estimated from the IPPR (2018) report quoted earlier in this section. It is rounded down slightly to reflect the uncertainty around the feasible time period for achieving the reductions estimated in the IPPR report.

As a result, we have only included one parameter reflecting potential increase/reduction in total costs for children services. The central estimate for this parameter is set at 2% per year (over and above inflation and demographic trends) based on the real growth rates observed for expenditure on children services between 2010-2011 and 2017-2018 (2.33% per annum).

3.3 Additional scenarios

In addition to the **'central-cost'** scenario we have also generated projections for two further scenarios: a **'high-cost'** scenario, assuming further pressures on costs and a **'low-cost'** scenario, assuming further efficiency savings and lower pressures on costs. High/low cost scenarios assume that costs will grow at a higher/lower rates compared to the central cost estimate and provide sensitivity analysis. Users of the model are free to customise the assumptions used.[13]

The full list of parameters and the number of years needed for a full implementation is presented in Table 7 for each scenario, while Table 6 details the growth rates implied by the baseline scenario over and above which the modelling assumptions in Table 7 are applied.

Table 6 Growth rates in social care expenditure between 2018/19 and 2022/23 implied by the baseline scenario

Client group	2018/19	2019/20	2020/21	2021/22	2022/23
Under 18 (Children and Families)	2.5%	2.3%	2.5%	2.7%	2.7%
18-64 (Working Age Adults)	2.4%	1.9%	1.8%	2.0%	1.9%
65+ (Older People)	4.2%	3.9%	3.9%	4.2%	5.2%
Total	3.0%	2.7%	2.7%	2.9%	3.3%

Note: these growth rates are generated by the baseline scenario which accounts for demographic changes and inflation.
Source: LE Wales' calculations based on StatsWales, ONS and BoE data.

[13] Note that in the high and low cost scenarios, not all factors are necessarily adjusted with respect to the central-cost scenario. It is the overall scenario which is high cost or low cost, rather than every one of the individual factors.

Table 7 Summary of the modelling assumptions employed – Central, high and low cost scenarios

Factor	Impact on costs	Central cost estimate	High cost estimate	Low cost estimate
Additional demand (older people only)	+	2% (annual) *(20% in 10 years)*	2% (annual) *(20% in 10 years)*	1% (annual) *(10% in 10 years)*
Increasing commissioning costs for residential care	+	1.7% (annual) *(8.6% in 5 years)*	1.7% (annual) *(8.6% in 5 years)*	0.9% (annual) *(8.6% in 10 years)*
Increasing local authorities' fees paid for non-residential care	+	1.2% (annual) *(5.9% in 5 years)*	1.5% (annual) *(7.6% in 5 years)*	0.6% (annual) *(5.9% in 10 years)*
Preventative and integrative care services	-	1% (annual) *(5% in 5 years)*	0% (annual)	1% (annual) *(5% in 5 years)*
New technologies	-	1% (annual) *(10% in 10 years)*	0% (annual)	1.5% (annual) *(15% in 10 years)*
Other cost pressures/savings on adult social care	+/-	0% (annual)	1% (annual)	0% (annual)
Other cost pressures/savings on children social care	+/-	2% (annual)	3% (annual)	1% (annual)

Note: Changes are additional to factors reflected in the baseline scenario, i.e. demographic changes and inflation. Thus a 0% change in the table above means that costs increase at the same rate as inflation. The annual change reported indicates the additional impact on costs in each year, e.g. 1% annual over 5 years (total of 5%) means that the factor will increase baseline cost by 1% in year 1, 2% in year 2, etc. Figures rounded to the nearest 0.1

Source: LE Wales' analysis.

4 Cost projections

4.1 Current expenditure projections

In this section we present the results of the projections based on the baseline scenario, the 'central-cost', 'high-cost' and 'low-cost; scenarios. Figure 5 shows total projected expenditure for the period 2017/18 (last year for which actual data are available[14]) to 2022/23 (last relevant year for the modelling exercise) under the different scenarios, while Table 8 shows the different projections, the monetary difference for each scenario compared with the baseline scenario, the cumulative percentage increase from 2017/18 to 2022/23 and the average annual growth rates for the period 2020/21-2022/23 under the different scenarios. All values are nominal (or cash) values.

Under the 'central cost' scenario, total net expenditure on social care services is projected to be £71M higher in 2022/23 compared to the baseline scenario; corresponding differences for the 'high cost' and 'low cost' scenarios are £327M and -£70M (i.e. lower net expenditure compared with the baseline scenario) respectively.

The cumulative percentage growth in net expenditure between 2017/18 and 2022/23 is projected to be around 16% in the baseline scenario, 19% in the 'central cost' scenario, almost 33% in the 'high cost' scenario and slightly less than12% in the 'low cost' scenario. Finally, average annual growth rates for the period 2020/21-2022/23 in the different scenarios are projected to be about 3%, 3.6%, 6% and 2.2% (in the baseline, 'central', 'high' and 'low' cost scenarios respectively).

All these projections depend on the assumptions used and are provided to illustrate potential further pressures on costs (or additional efficiency savings) compared to a situation where costs are driven solely by demographics and inflation trends (as in the baseline scenario).

[14] The modelling and projections are based on data available at 31 August 2019.

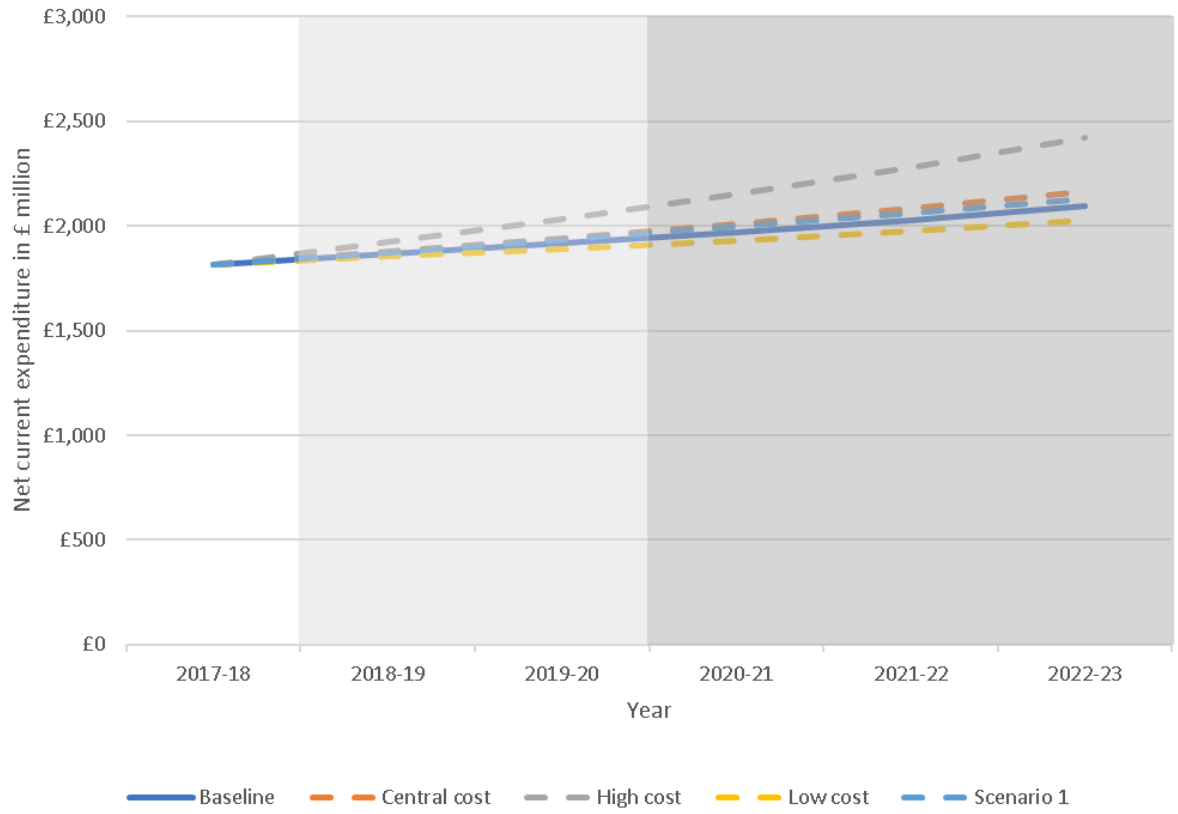
Table 8 Projected Net Current Expenditure on social care services between 2020/21 and 2022/23 – different scenarios

	Actual	Projection	Projection	Projection	Projection	Projection			
	2017/18	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**2022/23**	Difference with baseline in 2022/23	Change 2017/18 to 2022/23	Avg. annual growth rate 17/18 to 22/23
	£M	*£M*	*£M*	*£M*	*£M*	*£M*	*£M*	%	%
Baseline scenario	£1,812M	£1,867M	£1,917M	£1,970M	£2,028M	£2,094M	-	15.6%	2.9%
Scenario 1	£1,812M	£1,871M	£1,932M	£1,995M	£2,061M	£2,129M	£35M	17.5%	3.3%
'Central cost' scenario	£1,812M	£1,879M	£1,941M	£2,008M	£2,081M	£2,165M	£71M	19.5%	3.6%
'High cost' scenario	£1,812M	£1,923M	£2,034M	£2,151M	£2,278M	£2,421M	£327M	33.6%	6.0%
'Low cost' scenario	£1,812M	£1,854M	£1,891M	£1,930M	£1,973M	£2,024M	-£70M	11.7%	2.2%

Note: Cells shaded in grey represent projections; unshaded cells represent actual figures. The Baseline Scenario use current number of care recipients, population projections and CPI forecasts to project Net Current Expenditure (Gross expenditure minus Total Income). The Central/High/Low cost scenarios reflect the baseline scenario and the parameters presented in Table 7. Scenario 1 is based on past trends. All nominal (cash) values.

Source: LE Wales' calculations based on StatsWales, ONS and BoE data.

Figure 5 Projected Net Current Expenditure under different scenarios (£ million)



Note: The darker grey shaded area indicates the three financial years of the projections of the modelling exercise (2020/21 to 2022/23), while the lighter grey shaded area represents the financial years 2018/19 and 2019/20 (which had to be projected as actual data is not yet available). The Baseline Scenario use current number of care recipients, population projections and CPI forecasts to project Net Current Expenditure (Gross expenditure minus Total Income). The Central/High/Low cost scenarios reflect the baseline scenario and the parameters presented in Table 7. Scenario 1 is based on past trends. All nominal (cash) values.
Source: LE Wales' calculations based on StatsWales, ONS and BoE data.

4.2 Capital expenditure projections

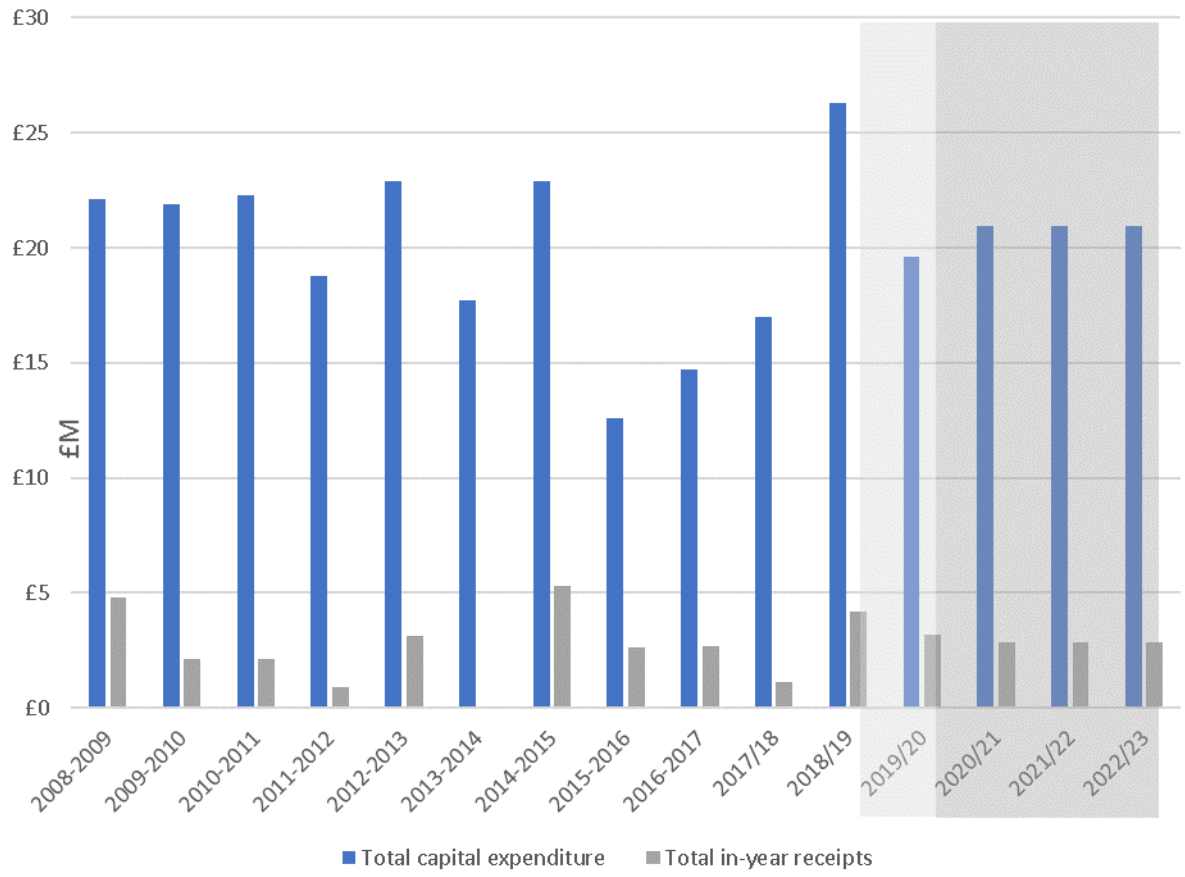
Finally, we looked at recent data on capital expenditure and receipts in social services. It should be noted that the definition of social services covered by capital outturn expenditure and receipts does not match the definition used in the current expenditure series (Revenue Outturn series).

The data cover actual capital expenditure and receipts for 2018/19, Welsh Government forecasts for 2019/20 published on StatsWales, and projections for the period 2020/21-2022/23 generated under the simple assumption that expenditure and receipts in those three years will be equal to the average between 2017/18-2019/20. Given the typically high volatility of estimates for the capital expenditure and receipt series (shown in Figure 6 for the

period 2008/09-2018/19) we have not tried to project the evolution of future trends, but taken a conservative approach.

Using this approach, the projected figure for capital expenditure in the period 2021/22-2022/23 is £21M per annum, while the projected figure for capital receipts is around £2.8M per annum (see Figure 6).

Figure 6 Projected Capital Expenditure and Receipts (£ million)



Note: £ million. Actual values up to 2018/19 from https://statswales.gov.wales/Catalogue/Local-Government/Finance/Capital/Outturn . Forecasts for 2019/20 are taken from StatsWales https://statswales.gov.wales/Catalogue/Local-Government/Finance/Capital/Forecast . Projections for the period 2020/21 to 2022/23 were computed as the average of the values for the period 2017/18 to 2019/20. The definition of social services covered by Capital outturn expenditure and receipts does not match the definition used in the Revenue Outturn series (current expenditure).

Source: LE Wales' calculations based on StatsWales

Index of Tables, Figures and Boxes

Tables

Figures

Annex 1 Methodology used in the Baseline Scenario

The inputs and assumptions used in the baseline scenario are listed below:

A1.1 Definitions and assumptions

- All projections are undertaken for net current expenditure, which is defined as Gross Expenditure minus Total Income and reported in the Revenue Outturn series on StatsWales;
- The projections are modelled separately for expenditure on social care services for the groups of children (up to the age of 18), working age adults (18-64) and older people (65+);
- For children services, the series on expenditure and services are not directly linkable for all items – we linked expenditure and number of care recipients for 'Children looked after' and for the 'Flying Start' programme and assumed the same rate of growth for the other data items. Under the current baseline scenario, all changes are driven by population trends and inflation;
- The projections were made at the Welsh level using aggregate numbers;
- One local authority (The Vale of Glamorgan) did not return any data on adult care services volumes or recipients for 2017/18, so we decided to use the 2016/17 data instead. Two other local authorities (Caerphilly and Newport) returned incomplete data for adult care services provided in 2017/18[15] and we grossed up the figure to estimate an equivalent annual total (based on the number of days covered/remaining until 31st March);
- The projections were made for net current expenditure, assuming that the proportion of gross expenditure covered by total income remains constant over the next three financial years (i.e. gross expenditure and total income are assumed to follow the same trends);
- We have assumed that the proportion of care recipients receiving services stays constant as a percentage of the population in each age band in the next three financial years;
- The demographic trends were taken by the 2016-based ONS' population projections;
- The inflation forecasts were taken by the Bank of England latest Inflation Report (May 2019);
- All figures are expressed in current (nominal) monetary terms and are based on data available at 31 August 2019;
- The category 'service strategy – adult services' was not included in the net current expenditure figure;

[15] The data returned covered up until 13th February 2018 for Caerphilly and 6th March 2018 for Newport

A1.2 Steps

- For each client group we calculated the ratio of net current expenditure divided by volume of services provided during the year using the latest information available on StatsWales (2017/18) generating net current expenditure per service provided. For the under 18 group only the number of children supported at 31st March is available and we used that series;
- We then expressed the number of recipients as a proportion of the overall population in each age band. To improve the accuracy of the estimates, the group of older people was divided in three sub-groups (65-74, 75-84 and 85+);
- These ratios were combined with demographic trends to generate an estimate of the volume of services provided up to 2022/23, assuming that the volume of service stays constant as a proportion of the overall population in each age band and that the number and mix of services provided per care recipient also stays constant over time;
- The monetary figures were inflated using CPI forecasts to generate the projections in the baseline scenario.

Annex 2 Additional cost pressures: supporting evidence

Our baseline projections take account of the potential effects of demographic changes and general inflation on social care costs in Wales over the period to 2022-23.

In this Annex, evidence relating to potential additional pressures (positive and negative) on social care costs in Wales is reviewed.

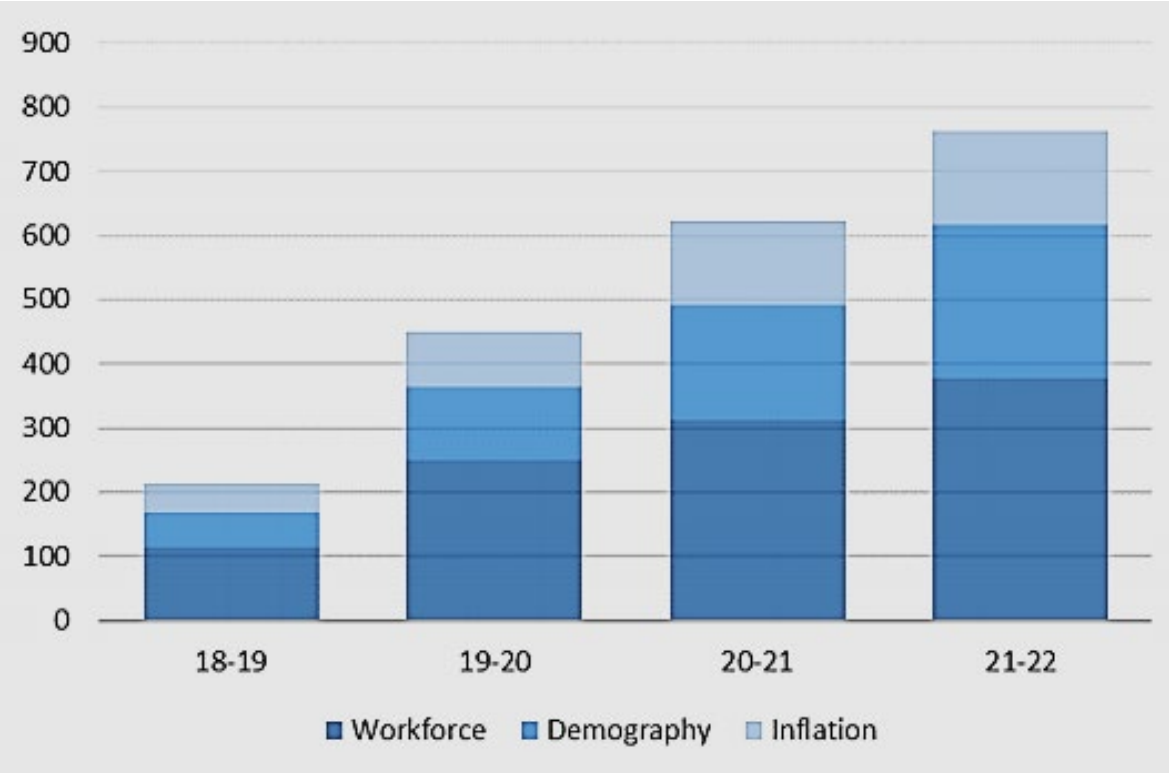
- First, we outline previous estimates on overall social care cost pressures in Wales and recent policy changes taking place in Wales.
- Second, we consider whether there is existing unmet demand for social care services in Wales and, if so, how significant this may be.
- Third, we review evidence relating to unit cost pressures, such as workforce costs.
- Fourth, we review evidence relating to whether preventative measures, and increasing use of technology, could contribute to reducing cost pressures.

A2.1 Social care funding pressures in Wales: previous estimates

In December 2018, the Welsh Local Government Association[16] estimated that, compared to 2017-2018, Welsh local authorities will face an additional £762 million in cumulative expenditure pressures by 2020-2021. Of these, £378 million are due to additional workforce costs resulting from increases in pensions and wages, while £239 million and £145 million are respectively the result of demographic and inflationary pressures. A visual breakdown is provided in Figure 7.

[16] Document available here: http://www.wlga.wales/SharedFiles/Download.aspx?pageid=62&mid=665&fileid=1432

Figure 7 Cumulative cost pressures faced by the Welsh local authorities in £ million



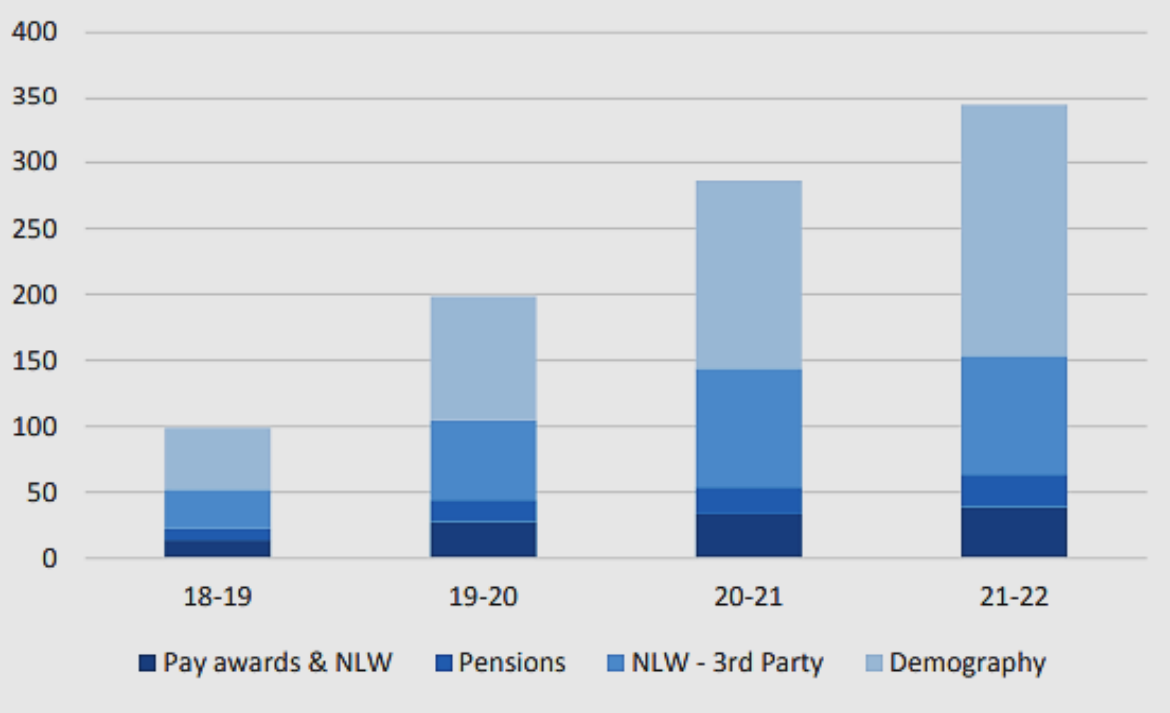
Note: the x-axis indicates years and the y-axis denotes £ in million.

Source: WLGA and ADSS (2018), Evidence to the finance committee on the inquiry into the cost of caring for an ageing population.

The WLGA (2018)[17] notes that, by 2021-2022, 45% of the cost pressures faced by local governments, or £344 million, are related to the provision of social services. Slightly more than half of these are due to demographic trends, while increases in wages (e.g. the national living wage) and pensions account for the remainder; see Figure 8.

[17] Ibid.

Figure 8 Cumulative cost pressures for social services faced by the Welsh local authorities in £ million



Note: the x-axis indicates years and the y-axis denotes £ in million.

Source: WLGA and ADSS (2018), Evidence to the finance committee on the inquiry into the cost of caring for an ageing population.

Although there is no Welsh equivalent to the English Longitudinal Study of Ageing (ELSA), an issue noted by the Finance Committee of the National Assembly for Wales (2018)[18], the Health Foundation (2016)[19] uses the ELSA to estimate future demand pressures for social care in Wales. In particular, they assume that the relative growth in required spending per capita in the age groups 16-64 and 65+ in Wales are similar to their English counterparts

[18] Ibid.

[19] Document available here: https://www.health.org.uk/sites/default/files/PathToSustainability_0.pdf

and use the same model[20] as Hancock et al. (2013)[21]. They estimate that social care cost pressures will increase by 4.1% per year in real terms between 2015 and 2030-2031 as a result of demographic trends, chronic conditions and rising costs, and thus reach £2.3 billion in 2030-2031.

A2.1.1 Recent changes in charging policy in Wales

Two major changes have recently taken place in Wales in social care funding and charges:

- The capital limit for residential care increased from £24,000 to £30,000 in 2017 and then further increased to £40,000 (2018) and £50,000 (2019). The Welsh Government provided a total of £18.5m a year to support implementation of this policy[22];
- The maximum weekly charge for non-residential care services, originally introduced in 2011 (and set at £50) was uplifted annually by £10 between 2016 and £2019 and now stands at £90 and is set to go up to £100 in April 2020;

The combined effect of these policy changes on net expenditure is unclear. Also, although gross expenditure is likely to go up due to the increase in the capital limit, the proportion of gross expenditure covered by income from charges will depend on personal income. Looking at historical data and the ratio net/gross expenditure, there is not much difference between the proportion of gross expenditure covered by clients in the period 15/16-17/18 (when the capital limit was increased to £30,000) – the ratio net/gross expenditure is consistently around 74% for older people and around 84% overall.

[20] The model in question was elaborated by Wittenberg and Hu (2011) (full description available here: http://eprints.lse.ac.uk/40720/1/2811-2.pdf). The model is a cell-based macro-simulation with 5 different parts. The first one estimates the number of older people with disabilities by different groups of socio-economic variables. The second attaches a probability of receiving a health or social care service to each specific group: for residential services, historic data was employed, and proportions assumed to remain constant over time; for non-residential services, a logit model was employed to calculate the relevant probability as a function of socio-economic variables and results were scaled up to account for the intensity of service receipt. The third part projects total expenditure on the formal services demanded by employing the unit costs of formal care and the probabilities calculated before, the fourth allocates the various sources or funding and the final one relates to the social care workforce.

[21] Document available here: http://www.lse.ac.uk/LSEHealthAndSocialCare/PDF/DP2857.pdf

[22] https://gov.wales/written-statement-raising-capital-limit-ps50000#targetText=Wales%20has%20the%20highest%20capital,at%20or%20below%20%C2%A350%2C000.

A2.2 Additional demand

In this section we consider evidence about whether there is likely to be additional demand for social care services in future that is not reflected in the current system. If there is additional demand, then this will contribute to pressures for rising social care costs in future.

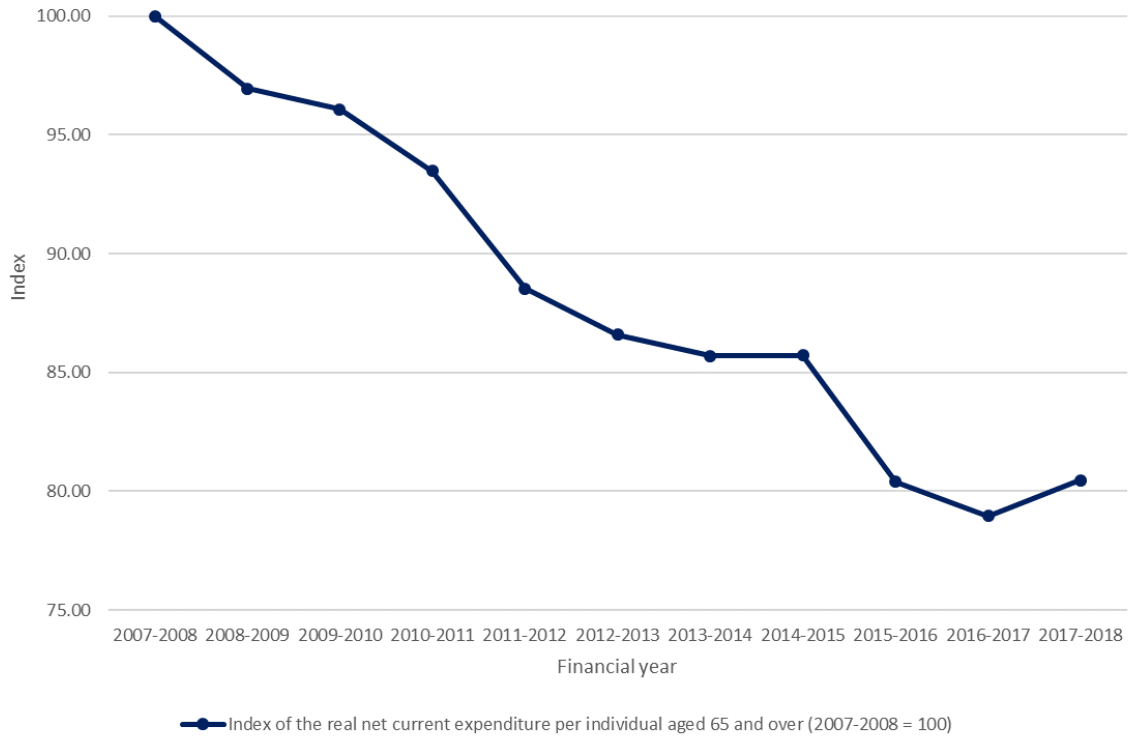
A2.2.1 Evidence for Wales

Figure 9 shows that for the group of people aged 65 and above in Wales, net current social care expenditure per capita declined by approximately 20% between 2007-2008 and 2017-2018 in real terms (i.e. adjusted for inflation).

Expressed in 2017-2018 prices, real annual spending per older adult was equal to £1,132 in 2007-2008 and £911 in 2017-2018. The Finance Committee of the National Assembly for Wales (2018)[23] reports concerns by Social Care Wales that some older people may not be receiving the same amount of support as they used to a few years earlier because of these decreases.

[23] Document available here: http://www.assembly.wales/laid%20documents/cr-ld11773/cr-ld11773-e.pdf

Figure 9 Evolution of the real net current expenditure per individual aged 65 over in Wales



Note: (i) population estimates by local authority and year and (ii) social services revenue outturn expenditure by client group; for inflation data the relevant series is the CPI index.
Source: LE Wales analysis based on population and expenditure data from StatsWales and inflation data from the ONS.

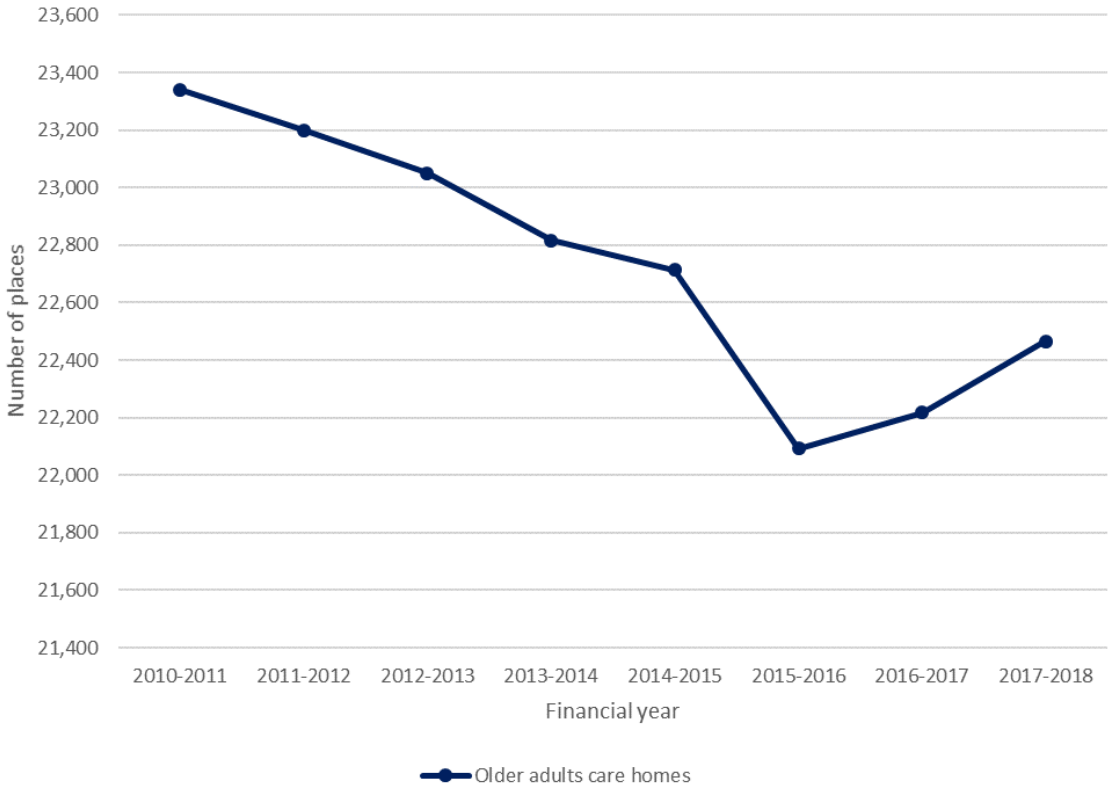
The effects of the documented decrease in real spending per capita on older adults' care is clearly visible in Figure 10. Although the number of places in care homes for older adults rose between 2016-2017 and 2017-2018, it is still considerably lower than in 2010-2011 (by almost one thousand with approximately 22,400 places in 2017-2018 compared to 23,400 in 2010-2011).[24]

In addition, the fall in places over the entire period occurred at a time when the number of individuals aged 65 and over continually increased. It is possible that the reductions in expenditure and in the numbers of places were a consequence of increased efficiency and the impacts of preventative measures, but we know that there were also increased spending pressures over this period.

[24] See Figure 10. Data available from Stats Wales: 'CIW Services and Places by Setting Type and Year'.

Holtham (2018)[25] estimates that satisfying "unmet demand" could require local authorities to increase per capita social care spending by approximately 20%, though the author admits that further investigation is required to precisely estimate the extent of "excess demand". More specifically, this figure is obtained by noting that (i) per capita real expenditure has decreased by approximately 20% between 2007-2008 (pre-crisis levels) and 2017-2018 and (ii) assuming that rising costs associated with higher wages (e.g. the NLW) are compensated by efficiencies in care provision and better targeting of the population's needs.

Figure 10 Number of places in care homes for older adults



Note: places are not registered for domiciliary care, nurses' agencies, adult placement schemes and other settings which the CCSIW does not register.
Source: StatsWales: 'CIW Services and Places by Setting Type and Year'.

The National Survey for Wales[26] provides some evidence on the views of respondents about care services in Wales. In particular, some editions asked participants to answer whether they agreed or not (on a scale ranging from "Strongly disagree" to "Strongly agree") with the following statement: "Good social care services are available in my local area". At the

[25] Holtham (2018) Paying for Social Care, Report for Welsh Government. See : https://gov.wales/written-statement-paying-social-care-independent-report-professor-gerald-holtham

[26] The results mentioned thereafter were also described in the interim report are based on the National Survey for Wales 2014-2015, 2016-2017 and 2017-2018.

Welsh level, data suggests that dissatisfaction with social care services has increased over time, from 15.2% in 2014-2015 to 18.6% in 2016-2017 and 21.6% in 2018-2019. On the other hand, the proportion of individuals reporting satisfaction increased from 51% in 2014-2015 to 57% in 2016-2017 before reverting to 51% in 2017-2018.

The National Survey for Wales 2018-2019 also indicates that 11% of the respondents received help from social care services, but 4% mentioned they needed support from social care services and did not receive it (both figures are higher for older people).

A2.2.2 Evidence for the UK and England

For context, some data for England are provided here, though eligibility criteria in England are different and so the data are not directly comparable with the data for Wales. Across England, nearly 1 in 7 older people are estimated by AgeUK[27] to have unmet needs, or 1,400,000 individuals[28]. Of these, over 300,000 require assistance with three or more essential everyday tasks. 160,000 do not receive any informal or formal help. According to the LGA (Local Government Association, 2018)[29], it would require an additional £2.4 billion a year to meet the demands of the latter, and £1.2 billion a year to meet the demand of care recipients with unmet needs. The LGA figures are based on AgeUK estimates and should be considered as indicative[30], but they imply that satisfying unmet demand would require an increase in social care funding of approximately 23%[31], a percentage close to the

[27] Document available here: https://www.ageuk.org.uk/latest-news/articles/2018/july/1.4-million-older-people-arent-getting-the-care-and-support-they-need--a-staggering-increase-of-almost-20-in-just-two-years/

[28] Estimates are based on the English Longitudinal Study of Ageing for which there is no Welsh equivalent.

[29] Document available here: https://futureofadultsocialcare.co.uk/wp-content/uploads/2018/07/The-lives-we-want-to-lead-LGA-Green-Paper-July-2018.pdf

[30] To obtain these figures, they employ AgeUK's results and assume support for people with unmet needs mirrors the existing support's profile of older people in terms of domiciliary and residential care. Then, unit costs are applied as follows: 1 hour per day for domiciliary care and the cost associated with one year in a care home for residential care.

[31] Based on net current expenditure for adult social care in England of £15,330,129,000 for 2017-2018; see the following document for further information: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/787836/RS_2017-18_data_by_LA_-_revised.xlsx

estimate for Wales provided by Holtham (2018)[32]. AgeUK[33] also estimates that delayed discharges from hospitals due to insufficient social care cost the NHS £500 a minute, or approximately £263 million a year.

A2.3 Unit cost pressures

In addition to general price inflation, the unit costs of social care provision may also be affected by a number of factors including:

- Changes in workforce costs (e.g. wages, pensions etc).
- Increases in commissioning costs – the fees paid to providers of non-residential care services, residential and nursing care homes, family centres, etc. Commissioning costs may be driven by rising wage costs for providers as well as increases in other costs.

A2.3.1 Changes in workforce costs

Evidence for Wales

Over the last few years, the national living wage in the United Kingdom (NLW, equivalent to the National Minimum Wage for the group aged 25+ from 1st April 2016) has increased at a higher rate than inflation (CPI). The NLW is a good indicator of changes in the costs associated with social care staff as many workers in the social care sector are typically paid the NLW. For instance, a UK-wide study by LaingBuisson[34] reports that the evolution of carers' wages in for-profit care homes closely mirrors the trends observed for the NLW in the UK.

In Wales, a report by the Association of Directors of Social Services Cymru and the National Provider Forum (2016)[35] highlights the difficulties associated with increases in the NLW. In particular, they note that staffing corresponds to approximately two thirds of all costs in

[32] Document available here: https://gweddill.gov.wales/docs/caecd/publications/180628-paying-for-social-care-en.pdf

[33] See here: https://www.ageuk.org.uk/latest-news/articles/2018/july/1.4-million-older-people-arent-getting-the-care-and-support-they-need--a-staggering-increase-of-almost-20-in-just-two-years/

[34] Document available here: https://www.laingbuissonevents.com/wp-content/uploads/2017/05/William-COP.pdf

[35] The National Provider Forum includes Care Forum Wales, United Kingdom Homecare Association, Cymorth Cymru, Carers Trust Wales, Learning Disability Wales and Age Cymru. The document is available here: https://www.cymorthcymru.org.uk/files/2114/5250/3787/Report_-_The_impact_of_the_National_Living_Wage_on_the_care_sector_in_Wales.pdf

social care, and that the need to maintain wage differentials will require providers to reflect NLW uprates for senior care workers as well.

The report also states that, unless local authorities receive additional funding, NLW increases are likely to have several adverse consequences for the social care market. The first consequence relates to the financial fragility of providers; for instance, learning disability providers reported that they could face £60,000-£1,054,000 additional costs in 2016-2017 as a result of the NLW hikes. The Welsh Government has recognised the pressures faced by the social care sector and has pledged to dedicate £10 million a year to support local authorities with the extra costs associated with the NLW[36]. However, estimates provided by the WLGA (2018)[37] show that workforce-related cost pressures were approximately equal to £50 million in 2018-2019 and could triple to £150 million by 2021-2022.

Another factor which may put upward pressures on care workers' wages relates to skills shortages and difficulties in retaining talent. For instance, a report from Workforce Intelligence[38] estimates that the turnover rate in the adult independent social care industry for England is around 30.7%, thus implying that approximately 390,000 people left their jobs in 2017-2018. Additionally, they report that turnover rates have steadily increased over recent years, rising by 7.6 percentage points from 2012-2013 (23.1%) to 2017-2018 (30.7%), and it is particularly high among younger individuals and low-paid workers.

Furthermore, Workforce Intelligence also estimates that, in 2017-2018, 8% of adult independent social care positions were vacant in England,[39] or 110,000 jobs, a rate 2.5 percentage points higher than in 2012-2013 (when it stood at 5.5%). The authors of the report conclude that given the growing demographic pressures and the rising demand for social care services, the independent care sector may struggle to meet future demand. They also note that Brexit is expected to take place over the next few months and this could potentially constrain even more the availability of EU workers in the care sector depending on the outcome of the UK-EU negotiations.

Qualitative research in Wales[40] noted that "*All service providers expressed concern about the current unit prices and the implications of NLW, arguing many independent sector*

[36] The associated press release is available here: https://gov.wales/ps10m-year-more-social-care-0

[37] Document available here: http://www.wlga.wales/SharedFiles/Download.aspx?pageid=62&mid=665&fileid=1432

[38] Ibid.

[39] As far as we are aware, similar data are not available for Wales.

[40] Atkinson et al (2016) Factors that affect the recruitment and retention of domiciliary care workers and the extent to which these factors impact upon the quality of domiciliary care,

providers risked ceasing to trade and that this would create substantial capacity difficulties in the domiciliary care market". In response to our survey, Welsh local authorities also highlighted potential problems with workforce capacity and skills shortages in Wales and the consequences for upward pressure on wage rates.

A2.3.2 Commissioning costs: residential care

For care homes, there are considerable variations in cost between state- and privately-funded care residents. LaingBuisson[41] suggest that the market for state-funded care is plagued by uncertainty as financially constrained local authorities (LA) try to achieve value for money by limiting what they pay to providers, whilst the market for privately-funded care is relatively healthy.

An important issue relates to the gap between payments for LA-funded and self-funded residents. Since local authorities are the dominant buyer in the care home market, they may have wielded their influence to contain the rise in fees paid. In fact, using data on care homes fees in England from 2008 to 2010, Allan et al. (2017)[42] estimate the size of this effect at £40 per week (i.e. local authorities pay £40 a week less than privately-funded residents thanks to their market power) and the effect is generally weaker when there is less competition in the care home market.

Table 9 summarises a UK-wide analysis by LaingBuisson[43] and shows that, for similar levels of service quality, self-funded residents pay considerably more than LA-funded ones. Accordingly, they also report that, across the UK, care homes with higher rates of privately-funded residents are generally more profitable than the ones with more LA-funded individuals.

Available at: https://gweddill.gov.wales/docs/caecd/research/2016/160317-factors-affect-recruitment-retention-domiciliary-care-workers-final-en.pdf

[41] See comments by LaingBuisson available here: https://www.laingbuissonevents.com/wp-content/uploads/2017/05/William-COP.pdf

[42] Document available here: https://www.pssru.ac.uk/pub/4559.pdf

[43] Document available here: https://www.laingbuissonevents.com/wp-content/uploads/2017/05/William-COP.pdf

Table 9 Differentials in fees between LA-funded and self-funded residents

Care home category	Number of unique room settings	Weighted average ratio of self-funded to LA-funded fees within unique room settings	% of occurrences with higher self-funded fees than LA-funded ones for similar services
Nursing homes	147	1.41	94.6%
Residential homes	304	1.46	96.7%
All homes in sample	451	1.43	96%

Note: comparison between LA-funded and self-funded residents was only made for residents receiving similar services.

Source: LaingBuisson, Care homes for Older People market analysis and projections.

Both Allan et al. (2017)[44] and LaingBuisson[45] note that LA-funded fees also depend on the market power of care homes, which in turn is a decreasing function of the gap between demand and capacity: if demand continues to increase due to demographic trends and capacity falls, then market power will shift from local authorities to care homes and LA-funded fees will be corrected upwards. On the other hand, if local authorities succeed in maintaining their market power, then the care home's margins will continue to erode due to increases in the NLW.

The Competition & Markets Authority (CMA, 2017)[46] has a similar view and notes that current fees paid by LAs are unsustainable for the industry supplying LA-funded residents, and the current model will require additional public funding. In particular, they estimate that the average weekly cost for a self-funder in 2016 was equal to £846 across the UK but LAs only paid £621. With a quarter of care homes having at least 75% of LA-funded residents, these are the most at risk of exiting the market due to funding shortfall. In Wales, the CMA (2017)[47] documents that the fee differential between self- and LA-funded residents (for nursing and residential care homes) stands at 36%[48].

[44] Document available here: https://www.pssru.ac.uk/pub/4559.pdf

[45] Ibid.

[46] Document available here: https://assets.publishing.service.gov.uk/media/5a1fdf30e5274a750b82533a/care-homes-market-study-final-report.pdf

[47] Ibid.

[48] The price differential is calculated as follows: Price differential = ((Self-funded fees – LA-funded fees)/LA-funded fees))

A2.3.3 Commissioning costs: non-residential care

For non-residential care, the UK Home Care Association (UKHCA, 2018)[49] estimates that, in Wales, local authorities pay an average hourly rate of £16.78 to local authorities. This compares favourably against the UK average (£16.12) but falls short of the UKHCA's recommendation of £18.01 per hour.

The UKHCA also published the recommended minimum rate for an hour of home care in 2019 (£18.93)[50]: looking at recent trends, UKHCA data between 2016 and 2019 indicates that the recommended minimum price grew at an annual rate of 3.8% in that period (faster than inflation). On the other hand, the average hourly fee paid by Welsh local authorities increased at an annual rate of 5.8% between 2016 and 2018 (latest available information), suggesting that Welsh LAs are closing the gap. In 2018, three local authorities (Carmarthenshire, Pembrokeshire and Bridgend) paid on or above the recommended rate of £18.01 an hour.

Using data on the volume of hours of home care as provided in the UKHCA's report (2018)[51], the volume of services for older people and the associated expenditure, we calculate that meeting the UKHCA's recommended rate would require a 5.94% increase in 2017-2018 total net expenditure.

Some local authorities did not provide the number of weekly hours (Denbighshire, Flintshire and the Vale of Glamorgan), the average price paid (Denbighshire and Torfaen) or had incomplete/missing data on StatsWales (Caerphilly, Newport and the Vale of Glamorgan). To control for this, we calculated the total number of hours provided by the local authorities for which data was complete and then multiplied that number by a corresponding scale-up factor[52].

Underfunding of home care providers may have adverse consequences on the supply of these services. For instance, the WLGA (2018)[53] notes that in Wales, 13 out of 22 local authorities reported that domiciliary care contracts were handed over back to them.

Lower fees also limit the capacity of service providers to offer adequate training, better contractual terms and higher wages, factors which may negatively affect the supply of

[49] Document available here: https://www.ukhca.co.uk/downloads.aspx?ID=589

[50] 'Minimum Price for Homecare - Version 6.0' available at https://www.ukhca.co.uk/downloads.aspx?ID=434#bk1

[51] Ibid.

[52] More precisely, the total number of individuals aged 65+ receiving home care was 24,710 in 2017-2018. The number of such individuals in the local authorities which submitted complete data was 17,680, and thus the upscale factor simply is 24,710/17,680 = 1.38.

[53] Document available here: http://www.wlga.wales/SharedFiles/Download.aspx?pageid=62&mid=665&fileid=1432

domiciliary care workers. For example, a report by Atkinson et al. (2016)[54] for the Welsh Government notes that care workers were dissatisfied with their salaries and believed it did not reflect the level of responsibility of their roles. While service providers acknowledge this issue, they claim that commissioning rates prevent them from offering better conditions. Workers in the independent sector also complained about the insecurity associated with zero-hour contracts, the long working hours, the lack of recognition for the skill and responsible nature of care work and the fact that travel time is not properly compensated.

A survey by UNISON (2018)[55] reveals that, in Wales, only 40% of councils stipulated that travel time must be paid to domiciliary care workers. The UKHCA (2019)[56] estimates that, on average, domiciliary care workers travel almost 12 minutes for each hour of contact time they deliver.

A2.4 Preventative services

A2.4.1 Welsh Government's objectives and strategies

Definition of prevention

Firstly, we report the definition of the preventative approach as set out in the Social Services and Well-being (Wales) Act 2014:

A preventative approach means building a stronger community infrastructure in neighbourhoods or localities and providing accessible public services for vulnerable adults to reduce, delay or prevent them from becoming socially excluded and needing more intensive, costly support. Its primary focus is not personal care for those with substantial and complex needs and it is not a simple re-labelling of existing traditional low-level services, e.g. laundry services or meals-on-wheels.

More broadly, the Act mentions that preventative services include activities enhancing and extending quality of life.

Welsh Government's objectives

Through the Social Services and Well-being (Wales) Act 2014, the Welsh Government has committed local authorities to increase the provision of preventative services. The Act

[54] Atkinson et al. (2016), *Factors that affect the recruitment and retention of domiciliary care workers and the extent to which these factors impact upon the quality of domiciliary care,* available here: https://gweddill.gov.wales/docs/caecd/research/2016/160317-factors-affect-recruitment-retention-domiciliary-care-workers-final-en.pdf

[55] Document available here: https://www.unison.org.uk/content/uploads/2019/01/Pressed-for-time-and-out-of-pocket-.docx

[56] Document available here: https://www.ukhca.co.uk/downloads.aspx?ID=434

emphasises the importance of early intervention and the aforesaid services to maintain people's independence and provide help before the situation becomes critical. Regarding prevention, the policy objectives are the following:

- Prevent or delay the development of needs for care and support.
- Reduce the demand for care and support amongst individuals receiving such services.
- Promote the upbringing of children within their families.

Note also that as part of the bill's enactment and the efforts for increased prevention, local authorities will also deploy the online platform Dewis Cymru[57] originally developed for the northern areas of Wales. The site provides both narrative contents to help people identify their own needs and a resource directory.

Integrated Care Fund

In 2014-2015, the Welsh Government set up the Integrated Care Fund to enable integrated working between social services, health, housing, the third sector and independent providers[58]. The fund is financed through both a capital and a revenue allocation, and funding is distributed across the seven Regional Partnership Boards (RPBs). Capital is used to purchase and improve assets, while the revenue allocation covers administrative and staffing expenses. In 2018-2019, the total fund allocation was equal to £80 million and it was raised to £115 million for 2019-2020[59].

The Welsh Government's aim is that the fund will support new local projects or extensions of existing ones, with successful ones being deployed at the national level. Some examples[60] of funded projects are provided below:

- Stay well @ Home – Cwm Taf RPB, a range of services helping people to remain independent at home and preventing hospital admissions.
- Multi Agency Placement Support Service – Western Bay RPB, helps looked after children, or children at risk of mental illness, emotional or behavioural difficulties by providing specialist placement support.
- Supporting life alongside caring – Greater Gwent RPB, supports carers in their caring roles.

[57] Link to the platform: https://www.dewis.wales/home

[58] A description of the fund, its funding, its performance and the projects funded is available here: https://www.audit.wales/system/files/publications/integrated-care-fund-report-eng.pdf

[59] Ibid.

[60] Ibid.

When evaluating the fund, the Auditor General for Wales (2019)[61] estimates that it has been successful in bringing together social care and health services. However, the authors also mention that the main objective of the fund – upscaling projects at the national level – has not been achieved yet, and instead projects are generally rolled forward every year. Moreover, they report that it is unclear whether the fund has led to better outcomes for service users and that there is little evidence on projects becoming mainstream and funded as part of the public bodies' core services.

A2.4.2 Research evidence on the effectiveness of preventative services

As outlined above, the Act formulates high expectations in the effectiveness of prevention. We review below some studies on the subject. Preventative services for older adults are structured under three main headers: preventative services for falls and to promote independent living, loneliness prevention and other forms of prevention support and care. At the end of this section, we also briefly consider the effectiveness of preventative services for children.

Preventative services for falls and to promote independent living for older adults

A report by Tudor et al. (2018)[62] details large and positive returns on investments for preventative services aimed at older people in Wales. In particular, the Welsh Government spends approximately £50 million per year on housing and independent living to adapt the homes of older people to frailty conditions. The authors estimated that for every £1 invested in Care & Repair Cymru, the taxpayer may expect to save £7.50: in fact, adapting the homes of older people generally delays their entry in residential care homes and postponing entry by one year may result in savings exceeding £30,000 per person. In a survey of Care & Repair Cymru's recipients, 14% mentioned they would not have been able to remain in their homes without the service[63].

Preventing falls could also lead to large financial savings for the government, as they estimate that these cost the NHS over £2.3 billion per year. For instance, preventative physiotherapy and other actions could reduce older people's falls in Wales by 9,396 every year, thus potentially leading to £15.87 million per year in savings for the NHS. As a result, investment in physiotherapy for falls prevention is associated with benefits exceeding £4 for each £1 invested.

[61] Ibid.

[62] Document available here: https://www.housinglin.org.uk/_assets/Resources/Housing/OtherOrganisation/livingwell2018.pdf

[63] Ibid.

A report from Care & Repair England (2018)[64] estimates similar results with every £1 spent on the Preston Care & Repair handyperson service[65] reducing health and care costs by £4.28 when solely considering the reduction in falls risk. Notably, the latter was reduced by 37% for older people who requested help from this service.

The study also highlights that 90% of older handyperson service users reported improved well-being. Additionally, 96% of these reported that the service made them less worried about their home, while 77% said they would not have had the job done if the service was unavailable due to difficulties in finding a trustworthy builder.

In a study carried out in the US, Carande-Kulis et al. (2015)[66] estimate the returns for various physical training prevention programmes. For every £1 invested, Otago's return on investment was equal to 36p for adults aged 65 and over and £1.27 for adults aged 80 and older. Similarly, the returns for Tai chi: Moving for Better Balance and Stepping One were respectively equal to £4.91 and 59p for every £1 invested[67].

Furthermore, in a systematic review of 60 RCTs and other experiments[68] on the impact of home adaptations, Powell et al. (2017)[69] conclude that there is strong evidence that minor home adaptations can be cost-effective measures to reduce the risk of falls, improve the performance in everyday activities and mental health. In particular, the effectiveness of such adaptations is greatest when combined with other repairs or home improvements (e.g. improving lighting, removing fall hazards, etc.).

The authors also estimate that preventive work to mitigate hazards associated with falls on stairs in households with an adult older than 65 was associated with a positive ROI (return on investment) of £62p for every 1£ invested. However, they also highlight the scarce research evidence on the cost-effectiveness of home adaptions, and their results on the benefits associated with preventing falls are more conservative than other estimates mentioned above.

[64] Document available here: http://careandrepair-england.org.uk/wp-content/uploads/2018/07/Small-but-Significant-Handyperson-Evaluation-CRE-2018.pdf

[65] The service provides help with home repairs, adaptations and improvements. It is provided to those requesting it themselves or through referrals.

[66] Document available here: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6604798/

[67] Otago, Tai chi: Moving for Better Balance and Stepping One are various falls prevention programme for older adults.

[68] Studies were carried out in various countries, including the UK, Australia, New Zealand, Canada, the USA, Taiwan, Japan, Korea and several European countries.

[69] Document available here: https://www.ageing-better.org.uk/sites/default/files/2017-12/The%20role%20of%20home%20adaptations%20in%20improving%20later%20life.pdf

Another systematic review of 31 economic evaluation studies for adults aged 60 and over in the USA by Olij et al. (2018)[70] strengthens the case for preventing falls. The majority of studies analysed found that such prevention programmes were cost-effective, with 2 thirds reporting ICERs (incremental cost-effectiveness ratio, in this study the additional cost per unit of quality-adjusted life years for the intervention over usual care) below USD 50,000, a widely used willingness-to-pay threshold in the USA.

In particular, home assessment programmes (ICERs < USD 40,000 on average) were the most cost-effective for community-dwelling older people, and studies for older people (aged over 75) reported lower ICERs than the ones estimated for the population aged 65 and above. On the other hand, medication adjustment programs[71] (ICERs < $13,000) were the most cost-effective for individuals placed in residential care homes.

However, it should be noted that the literature reviewed does not unanimously agree on the effectiveness of these preventative services. For instance, a systematic review of 46 RCTs and other studies[72] in preventative integrative[73] care for community-dwelling frail older people by Mijntje et al. (2019)[74] shows that such services do not lead to better outcomes compared to standard care. In particular, the analysis highlights the limited evidence concerning the effectiveness and cost-effectiveness of such services. Additionally, healthcare utilisation is not significantly reduced for recipients of these integrative care services, and effects on the outcomes regarding informal and professional caregivers (e.g. caregiver's satisfaction with care, caregiver's subjective/objective burden, etc.) are generally negligible.

The authors also report that integrative care seems more successful with subjective outcomes such as well-being and life satisfaction, but the effects of the interventions analysed were less likely to be significant when considering health outcome measures such as ADL/IADL ((instrumental) activities of daily living).

[70] Document available here: https://www.researchgate.net/publication/328320159_Economic_Evaluations_of_Falls_Prevention_Programs_for_Older_Adults_A_Systematic_Review

[71] These include taking vitamins D supplements, the withdrawal of certain medicines increasing the risk of fall (in particular those aimed at improving sleep, reducing anxiety and treating depression) and other therapies.

[72] These were principally undertaken in Canada, the USA, and the Netherlands, but also in Sweden, Australia, Finland, France, Hong Kong, Japan and New Zealand.

[73] Integrative care aims to tackle the causes of illness and determinants of health through the collaboration of various agencies, generally the NHS, local authorities and the third sector.

[74] Document available here: https://onlinelibrary.wiley.com/doi/full/10.1111/hsc.12571

You et al. (2012)[75] corroborate some of these findings in a systematic review of 15 RCTs and comparative observational studies carried out in the USA and other developed countries[76]. The evidence they analyse shows that case management (a form of integrative care) in community aged care interventions may lead to improvements in psychological health, well-being and unmet service needs. On the other hand, the interventions did not lead to better health outcomes such as client mortality, functional status, medical conditions and behavioural problems. Furthermore, satisfaction with care services and carer outcomes were not significantly impacted either.

These results are also supported by Stokes et al. (2015)[77]. The authors systematically reviewed 36 studies focussing on the case management of "at-risk" primary care patients, the majority of which are RCTs, conducted in the USA and other developed countries[78]. Beyond small improvements in patient satisfaction, the evidence reviewed does not suggest that the intervention led to better health outcomes, reduced the use of secondary care or total costs.

Overall, academic research seems mixed on the effects of these interventions. For instance, in a systematic review of 9 RCTs carried out in Canada, Italy and the USA, Eklund & Wilhelmson (2009)[79] provide some evidence that integrated and coordinated care decreases healthcare utilisation and thus total costs. Nonetheless, they highlight the scarcity of the available evidence and caution that their findings should be interpreted carefully.

In summary, the comparison of studies is restricted because of the considerable variations in interventions, outcome variables and populations, as well as a lack of evidence for particular outcomes. Nonetheless, the literature seems to indicate that preventing falls and promoting independent living are relatively cost-effective measures, though their impact may vary depending on the setting. On the other hand, evidence on the effects of integrative preventative services is more mixed.

[75] Document available here: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3508812/

[76] These include England, Hong Kong, Finland, Italy and Israel.

[77] Document available here: https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0132340

[78] These include the UK, Australia, Canada, France, Hong Kong, Italy, the Netherlands, New Zealand, Spain and Switzerland.

[79] Document available here: https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1365-2524.2009.00844.x

Loneliness prevention for older adults

Various studies also document the substantial social and economic benefits of preventing loneliness and social isolation. For instance, Tudor et al. (2018)[80] state that lonely older people are 3.5 times more likely to enter a residential care home, 3.4 more likely to suffer from depression, 1.8 times more likely to visit their GP, 1.6 times more likely to visit A&E and 1.3 times more likely to enter emergency admissions. Additionally, these individuals also tend to be more prone to certain diseases, such as heart coronary diseases (14%), strokes (8%) and diabetes (7%).

Although we note that unobserved covariates may be driving both the likelihood of being lonely and the outcomes considered, with 17% of individuals aged 75-79 and 63% of people older than 80 reporting to be lonely in the UK (WRVS, 2012)[81], there seem to be considerable scope to improve well-being among these individuals.

Potential solutions advanced by Tudor et al. (2018)[82] to tackle loneliness include better community transports (£3 return for every £1 invested) and arts/craft-based programmes (£8.27-£10 return for every £1 invested), as well as initiatives bringing together generations (e.g. children and older adults) or new technologies (e.g. better use of social media or video calling). Moreover, community-based interventions (e.g. in Wales the University of the 3rd age, Men's Shed, Denbigh Welsh Society, etc.) can also offer positive returns of £1.11-£4 for every £1 invested, not to mention that the solutions described above are generally linked with well-being improvements and wider social benefits.

A systematic review of more than 50 studies (half of which in the UK) by McDaid et al. (2017)[83] presents more mixed evidence. The effectiveness of befriending initiatives and participation in social activities varied substantially across studies and it is unclear whether they generate economic benefits or not. On the other hand, signposting/navigation of services seem to generate higher ROI ranging from £2 to £3 per £1 invested, though these estimates rely on a smaller subset of recent studies.

[80] Document available here: https://www.housinglin.org.uk/_assets/Resources/Housing/OtherOrganisation/livingwell2018.pdf

[81] Document available here: https://www.royalvoluntaryservice.org.uk/Uploads/Documents/How_we_help/loneliness-amongst-older-people-and-the-impact-of-family-connections.pdf

[82] Document available here: https://www.housinglin.org.uk/_assets/Resources/Housing/OtherOrganisation/livingwell2018.pdf

[83] Document available here: https://campaigntoendloneliness-rspmbr9ezvmofjn.netdna-ssl.com/wp-content/uploads/CTEL-summary-doc-final-15.9.17.docx

In general, it seems that preventing loneliness may be a cost-effective measure, but the literature also suggests that the nature of the intervention may lead to substantial variations in outcomes.

Other forms of prevention support and care for older adults

Preventative services for old carers can also deliver non-negligible benefits. In particular, Tudor et al. (2018)[84] note that the use of health services among carers generally increases as the caregiving load rises, and Wales has the highest percentage of unpaid older carers in the UK with 1 in 3 people over 50 being unpaid carers. For instance, they report that peer support for people with dementia and carers offers positive returns on investment ranging from £1.17 to £5.18 for every £1 invested.

Preventative services for children

A study by the King's Fund and the LGA (Local Government Association, 2014)[85] which defends the case for public health interventions in England documents several benefits associated with preventative services for children. For instance, every £1 spent on preventing teenage pregnancy could save £11 in care costs. Moreover, smoking prevention programmes in schools can return up to £15 for every £1 invested, while parenting programmes designed to prevent conduct disorder can return £8 over 6 years for every £1 invested.

A2.4.3 Conclusions

Overall, the evidence on preventative services seems to indicate that these can potentially reduce social care costs, though the extent of these effects seems limited and mostly confined to specific use-cases, such as preventing falls hazards. Nevertheless, preventative and integrative care services were generally associated with higher levels of satisfaction and well-being among care recipients, a positive outcome if the cost of providing such services is similar to the one for usual care.

[84] Document available here: https://www.housinglin.org.uk/_assets/Resources/Housing/OtherOrganisation/livingwell2018.pdf

[85] Document available here: https://www.kingsfund.org.uk/sites/default/files/media/making-case-public-health-interventions-sep-2014.pdf

A2.5 New technologies

A2.5.1 Welsh Government's strategy and objectives

The Welsh Government[86] has expressed its desire to harness new technologies and approaches to support the provision of social care services. To that end, it set up the £100 million Transformation Fund in 2018 to develop and implement new models of seamless health and social care with the potential to scale at the national level and meet national priorities. The fund's objectives are largely aligned with the ones of the Integrated Care Fund, with a strong emphasis put on promoting well-being and preventative services, and investment in new technologies is clearly defined as key enabler for change.

More specifically, its strategy regarding the latter entails the following actions:

- Accelerate the progress towards a fully integrated national digital infrastructure.
- Invest in the future skills required within the health and social care workforce to accelerate digital change.
- Develop an "open platform" approach to digital innovation by publishing national standards on software and the ways external partners can interact with national digital resources.
- Increase investment in digital infrastructure.
- Establish a national data resource to allow information to be shared securely.

In the rest of the section we review the available evidence on the use of new technologies in social care; the classification of the innovations broadly follows the one given by the Institute of Public Care at Oxford Brookes University (thereafter IPC, 2016)[87].

A2.5.2 Research evidence on the use of new technologies in social care

Integrating services and information

The IPC (2016)[88] notes that to provide personalised care services it is important that professionals involved in the care of an individual have access to all the relevant information and not just the one pertaining to their specific organisation or task. For instance, they mention the Leeds Care Record, implemented by the Leeds local government, as an example of successful information sharing which saves time and improve health outcomes. They also refer to Cumbria which implemented electronic referrals through Strata to

[86] Document available here: https://www.basw.co.uk/system/files/resources/180608healthier-wales-mainen.pdf

[87] Document available here: https://ipc.brookes.ac.uk/publications/Transforming%20social%20care%20through%20the%20use%20of%20information%20and%20technology%20November%202016.pdf

[88] Ibid.

support effective transfers of care, and the system is believed to have delivered annual efficiency savings of £400,000.

As mentioned by Blackwood (2018)[89], Coordinate My Care, a London NHS scheme, is another example of services integration. The web-based IT platform allows to plan multidisciplinary end of life care. Users benefit from higher compliance rates with their stated preference for the location of death (17% of them pass away in hospitals against 47% at the national level). Additionally, the system saves the NHS up to £2,100 per patient.

In Wales, the Welsh Community Care Information System allows the safe sharing of information across health and social care agencies[90]. Moreover, Master Patient Index[91] enables patients to be uniquely identified such that they may be cross-referenced with records stored in other databases, while the Welsh Demographic Service[92] holds people's demographics details.

Interacting with care services through digital channels

The IPC (2016)[93] reports that local authorities are starting to offer new opportunities for online self-assessment and self-service of goods and services. This can lead to reduction in back-office costs for the local authorities as well as greater satisfaction among users. Additionally, it facilitates the process through which citizens access their own information.

For example, Harrow council[94] developed a "community e-purse" approach enabling citizens to access their services via an online website, and it is estimated that the scheme could deliver £8 million in savings in back-office and purchasing costs from its launch in 2014 to 2020-2021.

Blackwood (2018)[95] also mentions Cera, a technology-enabled homecare provider which delivers door-to-door healthcare (e.g. prescriptions) and auxiliary (e.g. food or taxi) services.

[89] Document available here: http://www.public.io/wp-content/uploads/2018/04/PUBLIC-The-Promise-of-HealthTech.pdf

[90] See here: https://www.basw.co.uk/system/files/resources/180608healthier-wales-mainen.pdf

[91] See here: https://gweddill.gov.wales/docs/dhss/publications/151215reporten.pdf

[92] See here: https://gweddill.gov.wales/docs/dhss/publications/151215reporten.pdf

[93] Document available here: https://ipc.brookes.ac.uk/publications/Transforming%20social%20care%20through%20the%20use%20of%20information%20and%20technology%20November%202016.pdf

[94] Ibid.

[95] Document available here: http://www.public.io/wp-content/uploads/2018/04/PUBLIC-The-Promise-of-HealthTech.pdf

The platform is supported by a dashboard accessible to caregivers and family members to monitor in real-time the status of care deliveries.

In Wales, My Health Online[96] allows users to book GP appointments online and repeat prescriptions. Patients Know Best[97] allow Welsh citizens to access their medical records online and up-to-date information on treatments, medications, and allergies. They can also access messages from clinicians and test results.

Promoting independence and well-being through digital services

The IPC (2016)[98] also reports that technologies could reduce the need for home care and help monitor instances of carer burnout. For children, they note that new technologies could provide higher levels of confidence and reduce absence from school, while digital services could also reduce feelings of social isolation and loneliness. Recently, the focus has been put on proactive alert monitoring rather than personal alarms. This can potentially reduce the need to provide "sleep-in" support as well as increase the sense of independence among recipients.

A successful example of assistive technologies (e.g. alarms, fall detectors, GPS tracking technology for people with dementia, medication reminders, sensors, etc.) implementation notably includes the Hampshire council[99]. The latter developed a "technology agnostic" approach, i.e. the aim was on the barriers social care needs to address rather than on a specific technology to be deployed. In 2015-2016, 2,931 older people were using this new service and it is estimated that it led to net savings of £1.9 million through lessened reliance on non-personal domiciliary care, delayed admissions in care homes and lower carer burnout.

Another interesting example detailed by Blackwood (2018)[100] concerns Big White Wall, a digital health service supporting people suffering from anxiety, depression and other related conditions. The platform allows users to anonymously share their griefs with other members, and it has also developed programmes to reduce alcohol consumption and stop smoking. Blackwood (2018)[101] reports that 67% of the users enjoyed higher levels of well-

[96] See here: https://gweddill.gov.wales/docs/dhss/publications/151215reporten.pdf

[97] See here: https://www.digitalcommunities.gov.wales/wp-content/uploads/2018/11/Digital-Inclusion-in-Health-and-Care-in-Wales-Eng.pdf

[98] Document available here: https://ipc.brookes.ac.uk/publications/Transforming%20social%20care%20through%20the%20use%20of%20information%20and%20technology%20November%202016.pdf

[99] Ibid.

[100] Document available here: http://www.public.io/wp-content/uploads/2018/04/PUBLIC-The-Promise-of-HealthTech.pdf

[101] Ibid.

being thanks to the website, and 1 in 2 members share an issue for the first time on the platform.

The author also mentions the service Echo which delivers medicines at home and provides patients with instructions and reminders for their medicines' intake, along with notifications when a repeat for a prescription is required. The app links patients with NHS GP practices[102] and only functions with fully accredited UK-based NHS pharmacies. The author reports that the service is associated with reductions in last minute GP/A&E appointments related to prescription administration and less prescription frauds.

In Wales, Social Care Wales provides various online training resources related to assistive technologies in social care to promote independent living[103].

Integrating commissioning through better data analytics

The IPC (2016)[104] notes that commissioning social care services requires predicting patterns of activity and forecast future use costs. To improve this process, a number of English local authorities (e.g. Kent, Leicestershire, Leicester City)[105] have been using anonymised linked health and care microdata. This enables public authorities to take a more predictive and proactive approach with respect to commissioning care services. For instance, the West London Alliance has saved £10 million a year[106] by using CarePlace, a market management tool for social care enabling efficiency savings in residential and nursing care placements by identifying differences in price paid.

Blackwood (2018)[107] documents several services aimed at healthcare with potential applications in the provision of social care. For example, the author mentions the online text-based service DrDoctor which allows patients to digitally manage their bookings, thereby helping hospitals to handle patient volume according to their capacity. Moreover, it can target long waiting lists and fill empty slots; overall, the author reports that it reduced time to first contact by eight days, cut waiting lists by 10-15% and led to average savings of £1.5 million for each acute trust.

[102] The service is only available through GP nurseries part of the NHS Electronic Prescription Service.

[103] See here: https://socialcare.wales/learning-and-development/assistive-technology

[104] Document available here: https://ipc.brookes.ac.uk/publications/Transforming%20social%20care%20through%20the%20use%20of%20information%20and%20technology%20November%202016.pdf

[105] Ibid.

[106] Ibid.

[107] Document available here: http://www.public.io/wp-content/uploads/2018/04/PUBLIC-The-Promise-of-HealthTech.pdf

In Wales, the Welsh Patient Administration System[108], a platform used by 6 out of 7 health boards in 2015[109], helps agencies to manage patient scheduling.

Enabling care professionals to work from anywhere at anytime

As reported by the IPC (2016)[110], the emergence of multidisciplinary and multiagency teams strengthens the case for enabling carers to work from multiple locations without having to use different login credentials, email addresses, etc. The authors note that this can be achieved through simple collaboration tools such as shared email directories, calendars, service directories and instant messaging. Several local governments (e.g. Kent, Leeds, London, etc.)[111] have already adopted these tools.

Blackwood (2018)[112] provides some interesting examples of telecare. For instance, Kraydel has developed a TV-enabled video software to allow relatives and care workers to provide remote care for elderly patients receiving home care. This includes video chat, medication, event-reminders and data-driven automated alerts for caregivers. Similarly, Rally Round allows friends and relatives to provide joint care through an online platform which allows the creation of private networks and collaboration tools (e.g. to-do lists, group noticeboards, etc.).

In Wales, patients over 85 in the Betsi Cadwaladr Health Board area consult their doctors remotely[113]. The project's outcomes are encouraging with 83% of recipients stating that they would recommend telecare to relatives and friends, and each patient saved on average 64 minutes of travel time to and from the clinics[114].

[108] See here: https://gweddill.gov.wales/docs/dhss/publications/151215reporten.pdf

[109] See link above.

[110] Document available here: https://ipc.brookes.ac.uk/publications/Transforming%20social%20care%20through%20the%20use%20of%20information%20and%20technology%20November%202016.pdf

[111] Ibid.

[112] Document available here: http://www.public.io/wp-content/uploads/2018/04/PUBLIC-The-Promise-of-HealthTech.pdf

[113] See here: https://www.digitalcommunities.gov.wales/wp-content/uploads/2018/11/Digital-Inclusion-in-Health-and-Care-in-Wales-Eng.pdf

[114] See link above.

Automation of services

The IPPR (Institute for Public Policy Research)[115] outlined that automation and AI could potentially lead to economic gains of £12.5 billion in healthcare and £5.9 billion in the social care sector across the UK. Notably, these new technologies will complement and support caregivers by reducing the burden associated with administrative tasks (e.g. communicating medical notes, booking appointments, processing prescriptions, etc.) rather than displace jobs. Table 10 provides UK estimates of potential time freed up and expected savings for social care workers as a result of automation.

An example of service automation provided by Blackwood (2018)[116] concerns ArtemusICS, a data-driven population health intelligence. ArtemusICS offers a wide range of tools to caregivers, such as resource planning by CCG (clinical commissioning group) or GP, identification of patients by different metrics, tracking the effectiveness of an intervention, long-term conditions dashboards, identification of patients who require end of life care, poly-pharmacy and medication management, re-admission analysis, modelling tools and others.

As such, ArtemusICS supports community teams by helping to identify patients susceptible to require hospitalisation in the future and thus offers opportunities for early intervention. Along with Docobo, the Sussex Community Trust carried out a telehealth pilot with 92 patients in care homes, and results were very encouraging with hospital admissions among these care home residents declining by up to 75%.

[115] Document available here: https://www.ippr.org/files/2018-06/better-health-and-care-for-all-june2018.pdf

[116] Document available here: http://www.public.io/wp-content/uploads/2018/04/PUBLIC-The-Promise-of-HealthTech.pdf

Table 10 Potential time and monetary resources freed up by automation for social workers

Job role	Potential time freed up for care and value-added activities (%)	Expected savings (£ million)
Care worker	24	3,425
Managerial	36	1,322
Registered nurse	29	397
Senior care worker	24	377
Support and outreach	24	252
Other direct care	24	96
Social worker	11	62
Occupational therapist	25	21
Other regulated profession	21	13
Total	N/A	5,969

Source: IPPR, Better health and care for all.

A report by the Houses of Parliament[117] also underlines that robotics is currently underused in the social care sector. Crucially, the report states that robotics could generate savings by enabling older people to live in their homes for longer and preventing hospitalisations due to falls and illnesses. A few notable examples cited in their report include Robear, a robotic device to help lifting patients, and Hector, a robot monitoring patients in case of falls and which is integrated with emergency calls and remote monitoring services.

However, the report also reminds the reader that the use of robotics in social care raises several ethical, legal and regulatory issues. A few examples notably include privacy concerns, security risks (e.g. robots' malfunctions, hacking), biases inherent to AI systems, uncertainty over the legal personality of robots and their legal liability.

A2.5.3 Conclusions

Overall, research on new technologies principally relates to the provision of social care services for adults, influencing care provision through the following two channels: (i) assisting individuals at home through reminders, robots, smart alerts and other devices (ii) and increasing telecare's possibilities thanks to collaborative tools, private social networks, video messaging and other digital channels.

For the social care sector as a whole, new technologies allow different agencies to collaborate more effectively and to reduce the strain on the social care system thanks to

[117] Document available here: https://researchbriefings.parliament.uk/ResearchBriefing/Summary/POST-PN-0591#fullreport

shared databases and better data on user demand. Additionally, robotics and AI could potentially lead to the automation of multiple administrative tasks and thus free up considerable time for social care workers.

Using IPPR's calculations, we calculate that total savings in social care costs from automation, AI and digital technologies could amount to 18.83%[118] of the total 2017-2018 social care costs for the UK. Note that these correspond to the maximal savings achievable after overcoming potential barriers to adoption. As such, this figure should be considered as an upper bound on the potentially feasible savings which may be realised thanks to new technologies.

A2.6 Children services

A2.6.1 Introduction

This section presents historical trends and discusses potential future cost pressures affecting social care services for children. Evidence from Welsh Local Authorities was collected in a survey prepared by LE Wales and administered in July/August 2019.

A2.6.2 Historical trends

Data on the number of children receiving social care services are available from StatsWales. The categories identifying service recipients are only available on StatsWales for 'children looked after', while data on expenditure also covers a variety of other services (e.g. childcare, youth justice services etc.).

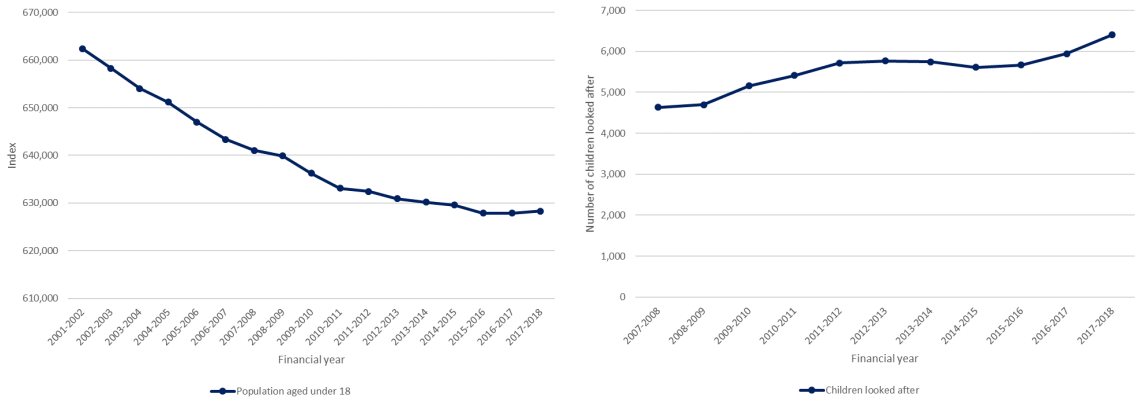
Figure 11 shows that the number of 'children looked after' has grown from 4,635 in 2007-2008 to 6,405 in 2017-2018. The overall population aged 18 and under in Wales decreased from 640,000 to less than 630,000 in the same period. As a result of these diverging trends, the corresponding share of the overall population aged 18 and under who were looked after increased from 0.72% in 2007-2008 to 1.02% in 2017-2018.

Over the decade spanning 2007-2008 to 2017-2018, the real net current expenditure per child looked after has increased by 11% (corresponding annual average growth rate of 1.08%), as seen in Figure 12.

Figure 12 reveals a similar trend for the real net current expenditure per child (i.e. the overall population aged under 18). Between 2007-2008 and 2017-2018, this has increased by almost 35% (corresponding annual average growth rate of 3.05%).

[118] For the social care costs across the UK (£31.7 billion in 2017-2018), see the following document:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/818399/CCS001_CCS0719570952-001_PESA_ACCESSIBLE.pdf

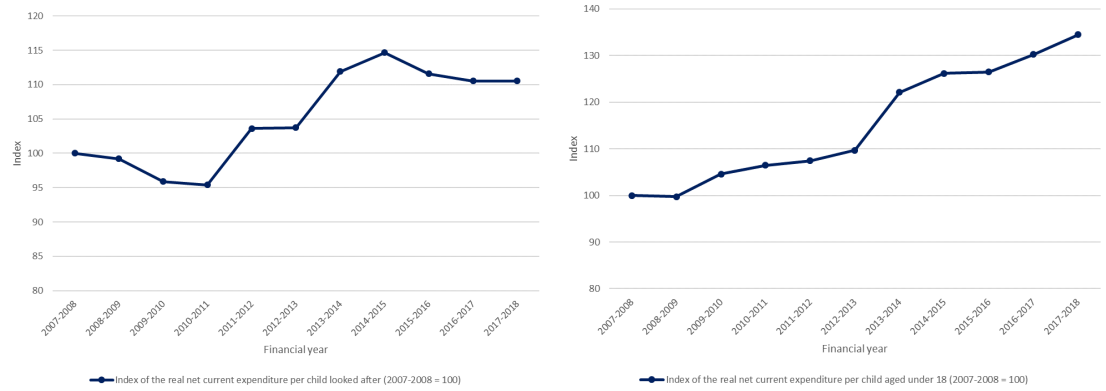
Figure 11 Trends in population aged under 18 of the number of children looked after in Wales



Source: StatsWales;

Note: Left hand panel: population aged under 18. Right hand panel: children looked after at 31st March

Figure 12 Real net current expenditure per child looked after and per child (under 18)



3

Source: LE Wales analysis based on population and expenditure data from StatsWales and inflation data from the ONS.

Note: Left hand panel: (i) children looked after at 31 March by local authority and placement type and (ii) social services revenue outturn expenditure by client group; for inflation data the relevant series is the CPI index

Right hand panel: (i) population estimates by local authority and year and (ii) social services revenue outturn expenditure by client group; for inflation data the relevant series is the CPI index

A2.6.3 Factors driving demand for children services

In an assessment of the factors driving the relatively high rates of looked after children in Wales, the Wales Centre for Public Policy[119] concluded that there is a strong positive relationship (though not necessarily causal) between levels of deprivation and both the numbers of looked after children and expenditure on looked after children, when comparing the position in different local authority areas across Wales. They also noted that other factors that influence relative rates of looked after children include: differences in policies and practices for children's social care services across local authorities; and different rates of domestic abuse, parental substance misuse and parental mental ill health. They also note that decisions of the family court can also influence the numbers of looked after children, noting that applications for care orders occur at a higher rate in Wales than in England. The conversion rate into resulting care orders is also higher in Wales.

In response to our short survey, Welsh local authorities suggested that the increases in looked after children may be due to several socio-economic factors, including deprivation.

Research in England reaches similar conclusions. For example, a report from the Association of North East Councils[120] notes that variations in the number of children looked after within a local authority are highly correlated with deprivation. A report by Newton Europe (2018)[121] and commissioned by the Local Government Association also supports this idea. Notably, they identify five factors accounting for slightly over half of the variations in children's social care spending across English local authorities[122]: deprivation (accounts for 31% of the variations alone), the size of the population aged under 25 (negative correlation), disposable household income, unemployment and criminality levels. Research for England by ADCS (2018)[123] estimates that 69% of children looked after had experienced domestic abuse at home.

[119] WCPP (2019) Analysis of the Factors Contributing to the High Rates of Care in Wales - Briefing Paper (Revised). Available here: https://www.wcpp.org.uk/wp-content/uploads/2019/05/190715-Analysis-of-Factors-Contributing-to-High-Rates-of-Care-REVISED.pdf

[120] Document available here: https://www.local.gov.uk/sites/default/files/documents/Children%E2%80%99s%20Social%20Care%20Needs%20and%20Cost%20Drivers.docx

[121] Document available here: https://newton-cdn.ams3.cdn.digitaloceanspaces.com/pdfs/hybrid/spend_on_services.pdf

[122] These variables were identified using forward selection and the criteria to optimise was the associated R^2 of the model.

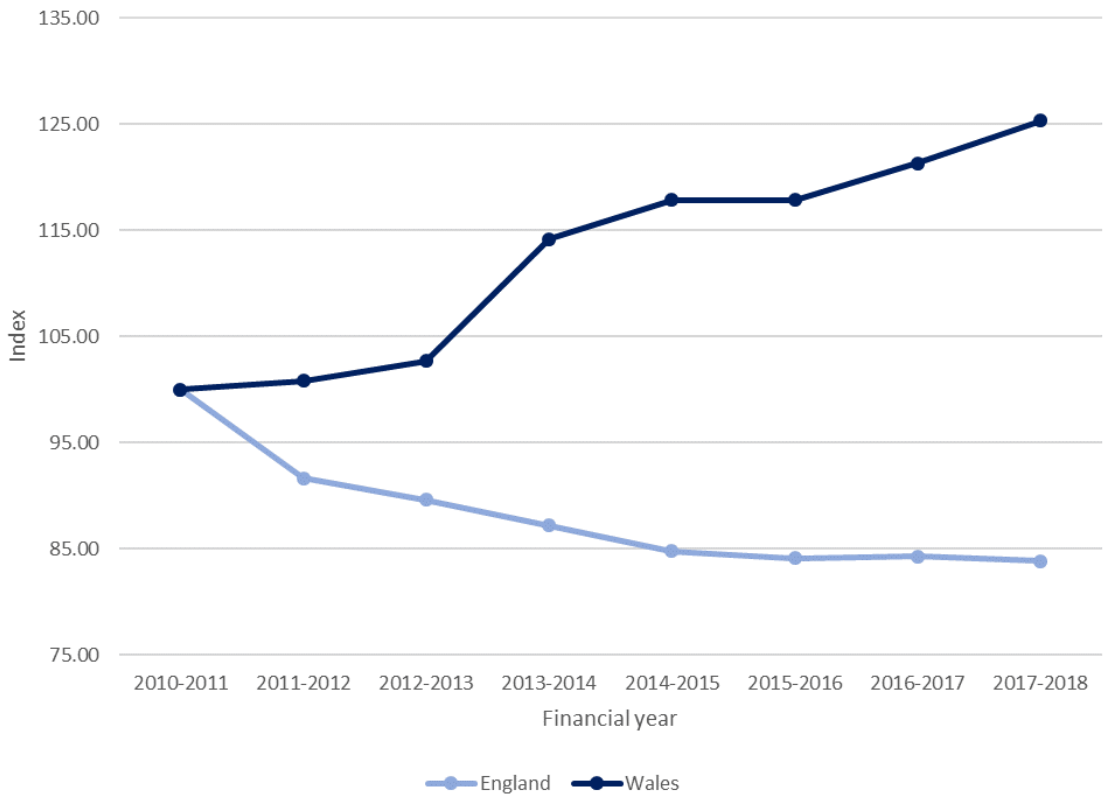
[123] Document available here: https://adcs.org.uk/assets/documentation/ADCS_SAFEGUARDING_PRESSURES_PHASE_6_EXECUTIVE_SUMMARY_FINAL.pdf

A2.6.4 Future cost pressures

Generally, predicting patterns of demand for children's social care services is a relatively complex task. In England, a report by Aldaba and the Early Intervention Foundation (2016)[124] highlights that most local authorities generally do not attempt to do that or resort to basic forecasting techniques (e.g. extrapolation based on the average growth rate prevailing the previous years). The report mentions that demand for these services tends to be driven by socio-demographic trends which are difficult to predict, such as court rulings and public awareness of issues affecting children (e.g. criminality, mental health, etc.).

Total real net current expenditure on children's social care in Wales has followed an upward trend between 2010-2011 and 2017-2018, increasing by approximately 25% over that period. As seen in Figure 13, this sharply contrasts with the declines observed in England.

Figure 13 Evolution of spending in children's social care (constant 2017-2018 prices)



Source: for Wales: LE Wales analysis based on population and expenditure data from StatsWales and inflation data from the ONS. From StatsWales we used (i) population

[124] Document available here: https://www.google.com/search?q=pauperisation&rlz=1C1CHBF_enGB832GB832&oq=pauperisation&aqs=chrome..69i57j0l5.3007j0j7&sourceid=chrome&ie=UTF-8#dobs=impoverishment

estimates by local authority and year and (ii) social services revenue outturn expenditure by client group; for inflation data the relevant series is the CPI index. For England: data originates from the joint analysis "Children and young people's services: Funding and spending 2010/11 to 2017/18" realised by Action for Children, the National Children's Bureau, NSPCC, the Children's Society and Barnardo. The data show indices for total expenditure rather than expenditure per child.

In response to our survey, Welsh local authorities reported rising pressures on social care for children looked after as their numbers and the complexity of their needs have increased over time.

Beyond rising demand and needs, local authorities also highlighted the lack of investment in preventative services for children which they blamed on shrinking budgets. They argue that the decline in funding have forced them to focus on statutory services, and these are mostly associated with immediate needs rather than early intervention. Several respondents believed this could have adverse consequences in the long run. Additionally, some local authorities also underlined the shortage of residential placements available to them and reported that market capacity saturation forced them to place children in residences where they receive services over and above their needs.

A joint statement issued in August 2018 by the Association of Directors of Social Service in Wales (ADSS Cymru) and the Welsh Local Government Association (WLGA)[125] reported that in the decade ending in 2018, real expenditure on children looked after services increased by 30% while real core grant funding for local councils fell by 22%. The statement identifies four principal areas where children social care faces significant pressures:

- **External demands and complexities**, mainly in relation to higher public awareness (e.g. of Child Sexual Exploitation or Adverse Childhood Experiences) and impoverishment;
- **Placements,** with more children entering into care, increasingly complex needs, an ageing foster care population and rising residential care costs;
- **Legislation and work with the Courts,** due to higher numbers of children being subject to care proceedings and increasing expectations from legal judgements;
- **Workforce,** as the sector is plagued by high vacancy and turnover rates.

The continued effort of Welsh local authorities to protect children's social care is also highlighted by the Family Rights Group (2018)[126], which note Wales' expansion of certain services (e.g. Families First and Flying Start).

[125] The statement is available here: https://www.adss.cymru/en/blog/view/childrens-services/fileAttachment

[126] *Care Crisis Review: options for change* (2018) London: Family Rights Group. Document available here: https://www.frg.org.uk/images/Care_Crisis/CCR-FINAL.pdf

Welsh Government policy will also affect future expenditure on children's social care services in Wales. The Welsh Government has committed to reduce rates of looked after children in line with the First Minister's manifesto proposals based on:

- *prevention* (prevent the need for children to be taken away from their families);
- *systems-wide*: children who end up in the care system may receive treatment from a different service, such as mental health or youth justice;
- for each local authority, targets linked to reducing the number of children placed outside Wales/placed outside their own county/removed from the care of their family/ taken away from families because parents have a learning disability.

Whilst it is possible that future reductions in the numbers of looked after children may reduce some costs it is likely that expenditure will also need to be incurred in order to achieve reductions in numbers of looked after children.

Annex 3 Evidence from a survey of Welsh local authorities

A3.1 Introduction

In this Annex we summarise the qualitative answers provided by Welsh local authorities to a short qualitative survey conducted by LE Wales with the kind assistance of the Welsh Local Government Association. The survey was sent by e-mail from the WLGA to all Welsh local authorities during Summer 2019. Responses were returned to the WLGA, who passed them on to us. The survey asked questions about future operational cost pressures affecting social care services. The organisation of the headings below reflects the structure of the questionnaire. Overall, we received responses from a total of 14 of the 22 Welsh local authorities.

A3.2 Unit cost pressures

Over the next five years, the principal unit cost pressures which local governments reported relate to wages, regulations, increasing needs and higher costs due to capacity shortages.

A high proportion of frontline care staff is paid the NLW or slightly above, and thus the UK's government pledge to increase the NLW above £9 an hour will place considerable pressure on local governments. Additionally, respondents suggest that NLW increases often translate into uplifts for the entire staff in order to maintain pay differentials across different levels of seniority.

Local authorities also highlighted difficulties in recruiting and retaining staff, in particular when other sectors (e.g. retail) offer better conditions and salaries. They also worry that Brexit may add further pressure to recruitment. Recent changes in legislation, e.g. the Regulation and Inspection of Social Care (Wales) Act 2016, will also increase the costs associated with staff training and registration.

For rural local authorities, rising transport costs are also problematic since social care staff in these areas generally travel a lot. Local authorities also report that the population's needs are becoming increasingly more complex, thus increasing the cost of delivering certain services (e.g. domiciliary care). Furthermore, a lack of capacity in certain areas, for example in placements for children with high needs, sometimes force local authorities to place individuals in more expensive accommodation.

A3.3 Factors reducing unit costs

Some local authorities expressed doubts regarding the existence of factors which may lessen unit cost pressures in the short-term.

Nonetheless, several respondents cited new technologies, such as assistive technologies, telecare and telehealth, has having the potential to reduce future costs. New models of working, including a shift away from traditional methods to a more preventative, holistic and outcome-focussed approach were also mentioned repeatedly. Notably, local

authorities believe that new technologies and models of social care services could reduce hospital admissions and the need for providing residential care, the latter being substituted by extra care services.

Other factors cited include better commissioning approaches, in particular by fostering collaboration among agencies, regions and with the private sector, as well as increasing capacity in the types and quantity of accommodation available. Finally, several respondents also mentioned bringing services in-house and better clarity regarding overnight wage rates as potential factors which may reduce future unit costs.

A3.4 Impact of recent legislative changes

Generally, local authorities expect that the Wellbeing of Future Generation (Wales) and Social Services and Wellbeing (Wales) Acts will lead to increased costs due to higher obligations. Increased demand due to changing eligibility criteria, as well as higher public expectations, will also put additional pressures on unit costs in the next years.

Whilst respondents believe that the Acts' emphasis on long-term planning and preventative services may increase costs in the short-run, they also welcome this paradigm change and believe in its cost-effectiveness over longer time horizons.

A3.5 Capacity of the social care sector to meet demand

There was some variation in the answers provided by local authorities on whether social care services met the population's needs. Some respondents reported that needs were fully met, while others cited difficulties in several areas and recognised that demand was not always met. The main factors mentioned by respondents covered:

- capacity issues amongst providers, especially for domiciliary care;
- staffing levels (recruitment and retention);
- overall constrained financial resources;

These factors hindered their capacity to provide some services, in particular for individuals with lower needs, or resulted in delays to the assessments.

Respondents highlighted the difficulty of reconciling shrinking budgets with higher public expectations (also due to increase in charges and Council Tax paid) and increasingly complex needs. Some respondents also related their answers to the introduction of the Wellbeing of Future Generation (Wales) and Social Services and Wellbeing (Wales) Acts and welcomed the higher emphasis on preventative services and well-being as potentially reducing future levels of demand.

A3.6 Factors affecting the future volume of services demanded

Overall, local authorities identified two principal sources of increase in future levels of service volumes required to meet local demand. Firstly, respondents cited that the emphasis on maintaining people's independence, along with recent medical advances, has

led to the creation of increasingly more complex care packages. Secondly, they report that the number of children looked after, people with learning disabilities and individuals suffering from dementia (and other mental health issues) has increased; together with higher life expectancy, the latter trend may result in significantly higher volume of services required to meet the population's needs.

Some respondents also deplored the lack of investment in preventative services which they consider vital to reduce future levels of demand. Additionally, they highlight that higher financial thresholds (e.g. higher capital requirements) imply that more individuals satisfy the eligibility criteria to receive LA-funded social care. Access to proper accommodation was also reported to be problematic in some areas, thus leading individuals to receive care services over and above their needs.

Finally, other socio-economic trends may add further strain on the social care system in the upcoming years. These include: higher levels of poverty among citizens which lead to greater demand for social care services; higher levels of loneliness among elderly individuals; alcohol/drug related issues; and the activities of criminal gangs.

A3.7 Other operational cost pressures

Many local authorities reiterated their concerns regarding workforce recruitment and retention, thereby highlighting the importance of this issue to them, and worried about the impact of Brexit on these matters. Another recurring operational pressure related to the lack of funding and the recent budget cuts; local authorities believe this hinders their ability to implement alternative models of services delivery (e.g. focussing on prevention and well-being) and limits their capability to plan strategically and for longer time horizons.

Local authorities also reported that market capacity saturation may impose additional operational pressures. Other factors cited by the respondents include: additional legislative/regulatory requirements (e.g. with respect to continuing health care assessments); a focus on reducing delayed transfers of care shifting burdens away from the NHS to the social care sector; and increasing funding pressures on services for individuals with learning disabilities.

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