Llywodraeth Cymru
Welsh Government

Evaluation of the Social Services and Well-being (Wales) Act 2014

Financial and Economic Evaluation

Attributable costs and the implementation of the Social Services and Well-being (Wales) Act 2014

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The Final Report to which this document relates can be found here: https://www.gov.wales/final-report-evaluation-social-services-and-well-being-wales-act-2014.

Views expressed in this report are those of the researchers and not necessarily those of the Welsh Government. For further information please contact:

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1. Introduction and Context

1.1 The Welsh Government commissioned a partnership of academics across four universities in Wales and expert advisers to deliver the evaluation of the *Social Services and Well-being (Wales) Act 2014* (hereafter referred to as 'the Act').

1.2 The independent national evaluation – the IMPACT study[1] – has been running since November 2018 and is led by Professor Mark Llewellyn, Director of the Welsh Institute for Health and Social Care (WIHSC) at the University of South Wales (USW) alongside Professor Fiona Verity, Professor of Social Work and Social Care, Swansea University.

1.3 The partnership also includes other colleagues from USW, Swansea, Cardiff Metropolitan and Bangor Universities and PRIME Centre Wales, and it is supported by the Study Expert Reference Group (SERG)[2] with its three citizen co-chairs.

1.4 The Act sets out the Welsh Government vision to produce 'transformative changes' in social service policy, regulation and delivery arrangements across Wales. It has 11 parts and is informed by five principles and aligned to it are structures, processes and a series of Codes of Practice.

Table 1.1: Five principles of the Act, and the five domains of the study[3]

Principles	Domains
Well-being	Citizens
Voice and control	Families and Carers
Co-production	Communities
Multi-agency working	Workforce
Prevention and early intervention	Organisations

[1] A bilingual introductory film explaining the structure of the study can be found here: Ffilm gwerthuso'r Ddeddf / Act evaluation film – WIHSC - YouTube

[2] For more on the SERG, see: Study Expert Reference Group | University of South Wales

[3] Definitions for these principles are provided by Social Care Wales (https://socialcare.wales/resources-guidance/information-and-learning-hub/sswbact/overview) and are included in the Glossary of this document.

Context

1.5 This section aims to place this evaluation in the context of the Act. It does this through considering the thinking behind the Act's costs and benefits, and the associated publicly available data on social services.

Arriving at the costs and benefits associated with the Act

1.6 The implementation of an Act as significant as the SSWBA inevitably involves the commitment of a substantial range of public service resources in relation to these five main themes, which warrant careful consideration within the context of prudent healthcare. The Regulatory Impact Assessment (RIA)[4] that accompanied the Act indicated an intention to phase its implementation over three to five years starting in 2015/16. As a result, it was acknowledged that there was a large measure of uncertainty about many of the costs and benefits provided in the RIA.

1.7 Estimates of some of the costs and benefits likely to be incurred through adoption of the preferred options was included in the RIA and determined a net present value of £2.1 billion. The RIA suggested that the additional benefits of implementing the Act would outweigh the additional costs of implementation, and thereby represent a return on investment in the context of value-based care. However, there was no indication as to how this figure of £2.1 billion was arrived at, the completeness of the costs and benefits included and the degree of confidence that could be placed on these early estimates.

1.8 It was also acknowledged that further costing work was needed on the identification of costs and benefits when the detail of regulations that would follow under the Act became clearer. The RIA had identified areas where additional costs and benefits were likely to occur as a result of implementation, but also indicated that there were some aspects of implementation that would be likely to incur costs, but these would not be evident until the schemes were operational, with the major additional costs falling on local authorities as a result of training and the time needed to undertake such training.

Social services data

[4] The RIA is part of the Explanatory Memorandum published in January 2014: pri-ld9181-em-r-e.pdf (senedd.wales)

1.9 Data on national social services spending is published by the Welsh Government on an annual basis, broken down by budgetary sub-areas and local authority. These are included in the revenue outturn (RO) returns and monitor trends in expenditure to assess the effects of Welsh Government policy.

1.10 Table 1.2 data shows that social services expenditure across Wales has increased since the introduction of SSWBA. Total social services expenditure increased from £3.9 billion in 2014-15 to £4.8 billion in 2020-21, an increase of 23.53%. The largest proportion of social services expenditure relates to people aged 65 and over, followed by expenditure on services for children and families. These two budgetary areas had an increase in spending over this period of 19.2% and 30.3% respectively.

Table 1.2: Social Care Expenditure (£ millions)[5]

Category	2014-15	2015-16	2016-17	2018-19	2019-20	2020-21
Children and families' services	1,147	1,150	1,198	1,272	1,368	1,495
Older people services	1,503	1,470	1,506	1,578	1,674	1,791
Adults aged under 65 with a physical disability	241	243	245	262	260	252
Adults aged under 65 with learning disabilities	764	797	837	870	908	956
Adults aged under 65 with mental health needs	185	187	200	209	212	208
Other adult services	54	80	93	95	105	130
Total Social Services	**3,923**	**3,949**	**4,100**	**4,305**	**4,539**	**4,846**
Annual Increase		0.66%	3.84%	5.00%	5.43%	6.75%

1.11 The largest annual increase in social services spending was observed for 2020-21 following the COVID-19 pandemic. However there was a significant rate of growth at which social services spending increased over the 2014-15 to 2020-21 period.

[5] Social services (gov.wales). Data on social services activity for the period of the Act's life can be found summarised in the Final Report available from https://www.gov.wales/final-report-evaluation-social-services-and-well-being-wales-act-2014

1.12 Table 1.3 shows the total registered social care workforce in Wales over the lifetime of the Act. The data shows that numbers of registrants (which is not the same as numbers in the actual workforce) increased by 17.5% over the first 5 years of the Act with notable increases in registrant domiciliary care managers (58.1%), residential child care managers (59.9%) and residential child care workers (39.5%). Increases in social workers and adult care home managers were also observed but of a smaller magnitude. There were no notable changes in 2020 or 2021 detected in these datasets in light of the COVID-19 outbreak, with the general continuation of trends observed in previous years.

Table 1.3: Registered social care workforce in Wales[6]

Category of worker	2016	2017	2018	2019	2020	2021
Social workers	6,063	5,965	6,133	6,263	6,293	6,470
Adult care home managers	1,263	1,218	1,213	1,304	1,294	1,314
Domiciliary care managers	618	633	642	773	913	977
Residential childcare managers	187	195	205	231	256	299
Residential childcare workers	2,269	2,482	2,666	2,894	2,975	3,165
Total registered social care workforce	**10,400**	**10,493**	**10,859**	**11,465**	**11,731**	**12,225**
Domiciliary care workers	-	-	-	-	19,637	22,131

Report structure

1.13 This report considers the financial and economic implications of the implementation of the Act, through considering costs attributable to that process of implementation. It does this through a series of chapters as follows:

- Aims and Design of the Evaluation
- Results and limitations – Costs, and Outcomes/Benefits
- Conclusions and Recommendations

[6] National Social Care Data Portal for Wales. Domiciliary care workers have only been required to be registered since 2020 so are not included in the total registered workforce.

2. Aims and Design of the Evaluation

2.1 At the outset of the project, this evaluation aimed to do the following:

- to undertake a cost-benefit analysis to provide a 'more accurate' estimate of the costs and benefits to derive an indicator of the return on investment;
- to determine which organisations incurred the additional costs and which would be in receipt of benefits accruing; and
- to explore the extent of differences between the original estimates and 'more accurate' estimates of additional expenditure that have emerged following the implementation of the Act and its component areas.

Overview of approaches

2.2 Following the literature review undertaken by the team (Phillips et al., 2020), a series of key messages emerged regarding the methodological approaches that can be used in assessing costs and benefits for complex legislation programmes such as the Act.

2.3 Marsh et al (2012) proposed that in order to help capture all the costs and benefits relevant to the assessment of public health interventions, research need to consider a broader range of modelling techniques, facilitated by good data on behavioural outcomes. This needs to be assessed alongside the use of 'valuation paradigms' which include the capabilities approach and the subjective well-being approach.

2.4 Sanders et al (2017) recognised the challenges and complexities of using cost-effectiveness models in different social and health care contexts, especially when there is such a range of different tools and models to evaluate the economic health of specific services. They added that for modelling tools of interventions to be successful, they should be co-produced by designers of the intervention and the users themselves.

2.5 Teresi et al (2017) described the complexity of assessing the cost effectiveness of health and social care services in conjunction with quality of life indicators, which was also noted by Frick and Kunz (2008) who noted the difficulties of measuring improvements in well-being in an objective manner, and the difficulties of attributing

those improvements in well-being to the direct impact of the intervention, although they did recognise that a number of approaches are available.[7]

2.6 Further, Stein et al (2016) argued that little is known about measuring improvements in use of resources as a consequence of integrated care, partly due to the fact that adequate methods are lacking, partly due to a failure to include economic evaluation in the design, planning and implementation of integrated care.

2.7 However, it is evident is that there is no clear consensus as to which is the preferred method for measuring and valuing the costs and benefits resulting from public service interventions and programmes, and evaluators therefore need to be explicit regarding design and method employed and the limitations associated with the approach so that policy makers are fully informed of the cautions that should be applied to the findings produced.

2.8 Economic evaluation seeks to assess the extent to which a programme, project, intervention, scheme or, in this case, the implementation of the Act provides additional benefits relative to the additional costs incurred. A range of techniques are used for such a purpose, where the choice of technique is dependent on the nature of the benefits emerging. The term cost-effectiveness has become synonymous with economic evaluation and has been used (and misused) to depict the extent to which 'interventions' measure up to what can be considered to represent value for money. Cost-Effectiveness Analysis (CEA) has been defined by NICE, for example, as an economic study design in which consequences of different interventions are measured using a single outcome, usually in 'natural' units (for example, life-years gained, deaths avoided, heart attacks avoided, or cases detected), and the interventions are compared in terms of cost per unit of effectiveness. CEA was therefore not appropriate for our assessment of the SSWBA implementation due to the existence of two outcome measures in our design – improvements in the use of resources, and improvements in well-being, both of which are multi-faceted in nature.

2.9 Further, since the nature of the benefits likely to emerge from the implementation of SSWBA, it is not possible to use the technique, widely used in relation to health

[7] These issues are discussed in depth in the report of 'Well-being' (Lyttleton-Smith et al, 2022) produced within the study, which can be accessed from https://www.gov.wales/well-being-research-support-final-report-evaluation-social-services-and-well-being-wales-act-2014.

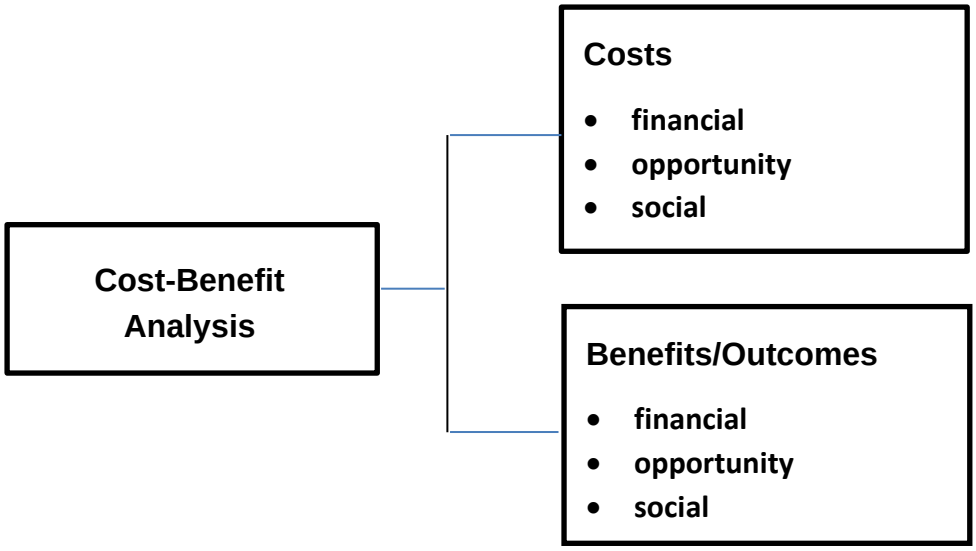
technology assessment – that of Cost Utility Analysis (CUA), which translates outputs and outcomes into a 'common currency' – the QALY, or Quality-Adjusted Life Year – and whereby the effectiveness of an intervention in one therapeutic area can be compared with the cost-effectiveness of an intervention in a different area. The challenge with employing CUA or CEA is that the economic evaluations will be dependent on the use of a single metric and will, in all probability, fail to capture all the effects resulting from the implementation of the Act. Such limitations have resulted in alternative approaches to be employed, where benefits are multiple and extend beyond sectoral boundaries, such as Cost Consequences Analysis (CCA) or Cost Benefit Analysis (CBA). However, these are not without their problems. While CCA provides a 'balance sheet' of outcomes that policy makers can weigh up against the costs of an intervention, the drawback is that it provides no guidance as to how the different outcomes included in the 'balance sheet' should be weighed against each other. This is especially problematic when outcomes move in different directions.

2.10 In CBA the costs and outcomes are expressed in monetary terms, so as well as being able to make comparisons across all areas of health care, comparisons can also be made with programmes and schemes in, for example, education, transport, the environment and in social care provision. As a result of the limitations of the other techniques, CBA is recommended by the HM Treasury's Green Book (HM Treasury, 2003) due to its ability to "to take account of the wider social costs and benefits" and provide outcome measures that are directly comparable with intervention costs.

Cost-benefit analysis

2.11 Following the literature as outlined above and the limitations attached to the other techniques associated with economic evaluation, the proposed design was to undertake a CBA – a utilitarian tool of economic analysis developed to aid in the overall evaluation of a wide range of activities. CBA has been widely used to evaluate large national infrastructure projects, smaller scale capital projects, public service programmes of activity and legislative / regulatory initiatives. The broad structure of a CBA is illustrated below in Figure 3.1 (overleaf).

Figure 3.1: Broad Structure of a CBA



2.12 The basis of a CBA is the identification of both the costs associated with undertaking activities, the outcomes that are generated by the activities and the benefits that derive from those outcomes. The magnitude of the costs would then be compared with the value of the outcomes/benefits, with suitable discounting to take account of the timing of the costs being incurred and benefits being realised.

2.13 For both costs and benefits, there are several stages to a CBA, which are illustrated in Table 3.1.

Table 3.1: Stages in a CBA

Stage	**1**	**2**	**3**	4
Title	***Identification***	***Expression***	***Quantification***	***Valuation***
Description	Identification of the various costs and benefits that might be involved	A qualitative description of the nature of the cost / benefit, its importance and likely impact	Numeric quantification of the various costs and benefits using some non-monetary scale	Expression of the various quantified costs and benefits in monetary terms

2.14 For each cost or benefit item identified, the aim is to 'travel' as far up this continuum as is practically possible given the time and resources available. There are

examples of where a CBA has achieved stage 4 for all, or most, of the costs and benefits, such as Heartbeat Wales, the Third London Airport, the Jubilee Line Underground and, more recently, the HS2 rail link where both the costs and the benefits associated with the project have been identified, expressed, quantified and valued. In most other projects, less progress along the continuum has been achieved and while some costs/benefits may be capable of valuation. Others might progress no further than the qualitative stage. However, to be meaningful, a CBA must have some level of quantitative data and it cannot be a purely qualitative exercise.

2.15 Further, in describing the CBA approach there are two other important matters that are pertinent and warrant consideration in the design of the evaluation:

- **Attribution effect** – this relates to the extent to which outcomes and costs can be 'directly' attributable to the implementation of the Act and not emerge or result from other activities.
- **Distribution effect** – this considers the way in which the overall costs and benefits are distributed across individuals and organisations. For example, it may be that all the benefits from a scheme would accrue to one individual/organisation, with zero benefits for others, which would mean that the scheme might be regarded as efficient but not equitable. This is basically the issue relating to the second aim of the evaluation – namely to determine which organisations incurred the additional costs and which would be in receipt of benefits accruing.

Framework of Outcomes/Benefits

2.16 The approach therefore was to employ the CBA framework to evaluate the economic impact of the implementation of the Act and attempt to verify or challenge the estimate highlighted in the RIA. We envisaged two key sets of outcomes and benefits that could be derived from the activities associated with the Act. Both of these types of outcomes and benefits are likely to be significant and possibly substantial.

Wellbeing

2.17 Improvements in well-being can accrue to both service users and service providers staff. There would be an expectation that improvements in wellbeing could accrue

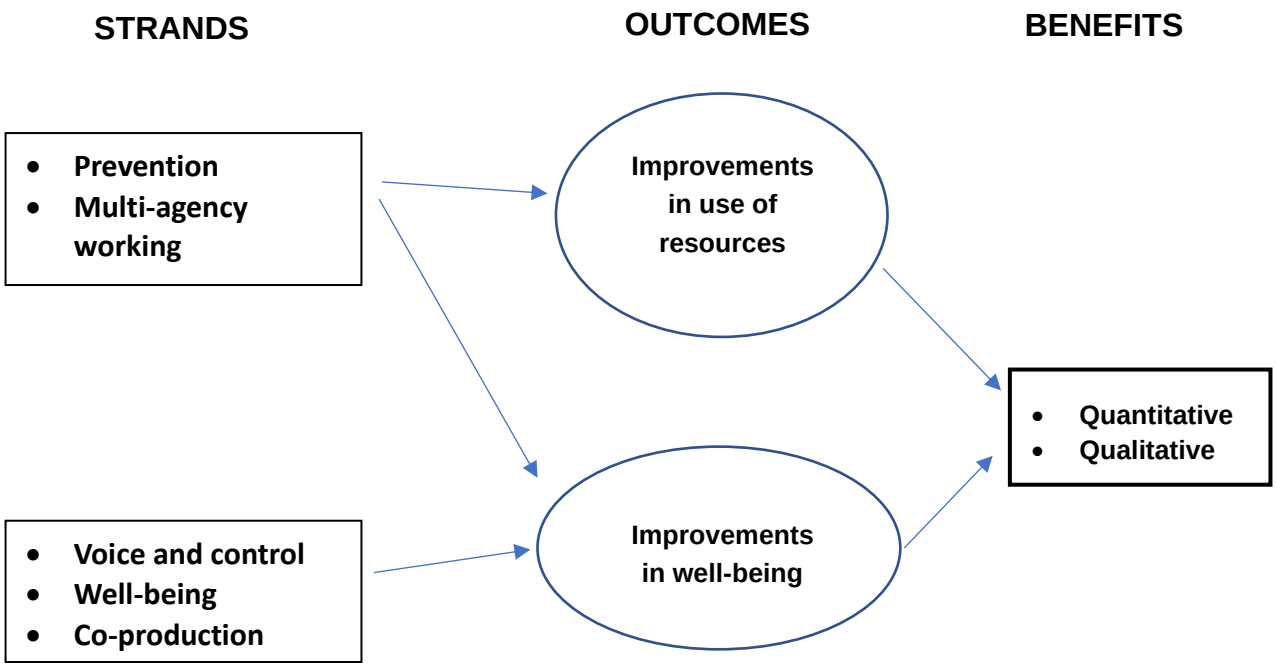
from activities being undertaken under each of the five themes being looked at and could come in the form of such things as improved emotional health, reduced loneliness and isolation, increased security etc.

Use of public resources

2.18 Undertaking activities under the umbrella of the SSWBA could lead to improvements in the use of public resources. This could mean such things as reduced costs, improved operational efficiency, avoidance of duplication etc. In particular we thought that this would be an outcome and benefit associated with activities falling under the umbrella of prevention and multi-agency working strands.

2.19 Figure 3.2 indicates the linkages between three factors: strands of activity, outcomes and benefits, which were intended to serve as the evaluation structure:

Figure 3.2: CBA Linkages



2.20 The expectation was that all five strands might generate outcomes in relation to improved well-being, while the strands of prevention and multi-agency working would also contribute to the outcomes emerging from improvements in the use of resources.

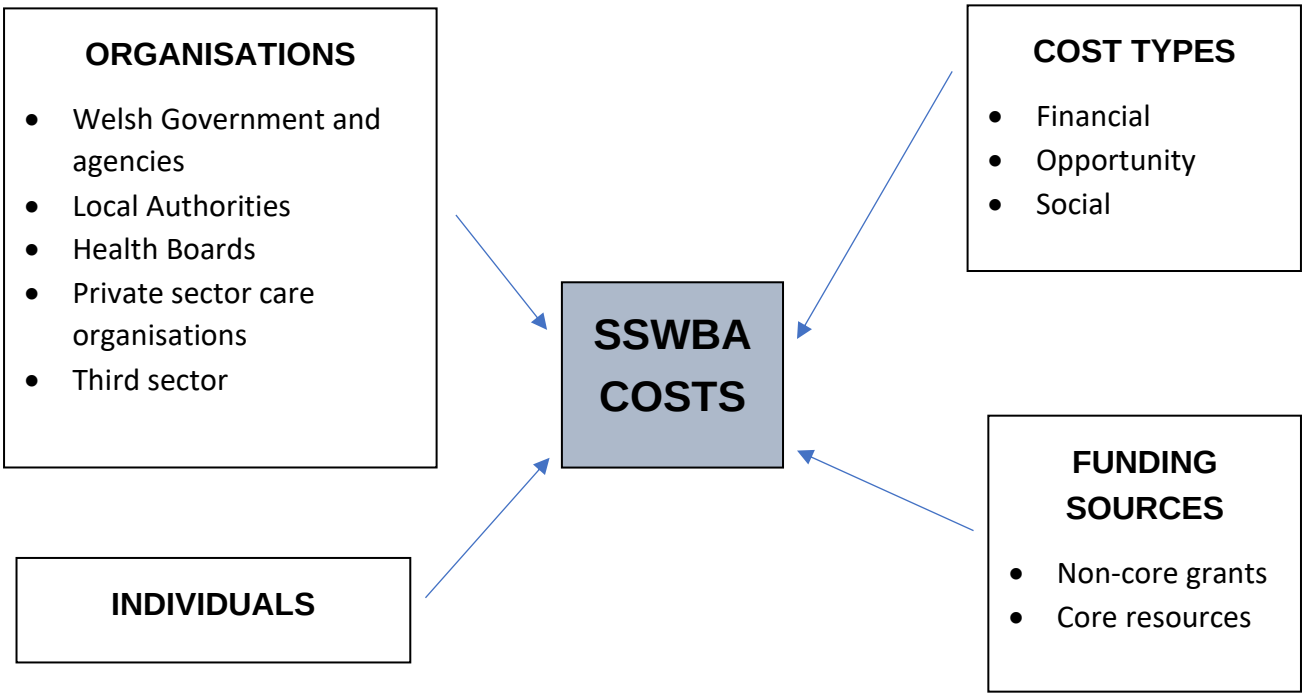
2.21 Each outcome would be quantified and converted into a monetary value, employing recognised conventional approaches and, as required by HM Treasury and other funding and assessment bodies, discounted at 3.5% per annum to reflect the time that the outcomes have emerged.

Framework of costs

2.22 The intention was two-fold in relation to costs and expenditure, namely:

1. to identify the types of costs incurred by organisations across the health and care system (and those incurred by individuals) in order to provide a 'more accurate estimate' of the costs and benefits emerging from the SSWBA implementation and
2. to explore the extent of differences between the original estimates and 'more accurate' estimates of additional expenditure that have emerged following the implementation of the Act and its component areas. The issue of costs relating to the SSWBA implementation is complex and needs to be considered in relation to four dimensions as shown in Figure 3.3 – the types of costs incurred, the organisations in Wales which incurred costs, costs incurred by individuals, and the source from which these costs have been funded:

Figure 3.3: Framework of costs



Types of cost

2.23 In seeking to establish the profile of costs associated with the implementation of SSWBA it is important to distinguish between different types of cost which can be considered three-fold:

1. **Financial costs** – these relate to incremental expenditure incurred to acquire resources (e.g. staff, consumables) to implement the requirements of the Act. It should be noted that such costs may be in the form of capital expenditure on fixed assets (e.g. buildings, vehicles) or running costs, such as staffing, consumables etc. In practice some such expenditure might be incurred for several purposes, including the implementation of the Act. In this case (as noted above) an attempt must be made to establish what proportion of that expenditure is attributable to the Act.
2. **Opportunity costs –** in some cases, existing resources (e.g. staff, buildings) might be diverted from existing activities and moved towards the implementation of the SSWBA. Although there would be no additional expenditure involved, it would be the case that there was an opportunity cost involved, because those resources would no longer be involved in delivering the 'original' services.
3. **Social costs –** this might be seen as the costs related to the activities of the organisation, but borne by communities, society and its individuals (e.g. provision of community facilities and activities supported by volunteers). Also, some activities may result in a cost (in terms of time or money) to be borne by, for example, service recipients or carers – and categorised as individual costs.

Organisations who incur costs

2.24 Figure 3.3 identified the main types of organisations in Wales who have incurred costs in order to implement the Act. Much of the funding involved will have been passed on to implementing agencies (e.g. local authorities, commissioned independent sector providers, health boards), but there will probably have been some direct expenditure incurred in support of the Act. In addition, there was bound to be a significant amount of staff time devoted by civil servants and others to the design and implementation of the Act.

Individual costs

2.25 There are likely to be costs to individuals in receipt of care packages consequent on the implementation of the Act, while there may be other individuals who are involved in the provision of care in conjunction with the statutory agencies and third sector organisations. In some cases, individuals might have incurred financial costs (e.g. travel costs), but there may also be situations where time costs have also been incurred (e.g. increased proportion of 'indirect care'). While the thrust of the SSWBA is about enhancing the well-being of the people of Wales, there may have been situations where well-being has declined for some consequent on the Act – and referred to as dis-benefits or social costs (see 2.16).

Funding sources

2.26 Expenditure requires funding. Particularly in relation to financial costs, it is important to recognise and differentiate the funding sources of the various financial costs. In simple terms these can be considered as

- ***Core funding*** – most public sector and third sector organisations in Wales have core funding to deliver their public services and is derived from Welsh Government funding allocations and, in some cases, self-generated revenues.
- ***Non-core funding*** this is expenditure provided for the delivery of specific public services rather than going into an overall pool. There are various non-core funding sources of relevance to the SSWBA, in particular the Integrated Care Fund (ICF) and the Transformation Grant (TG).

Issues experienced in the identification and collection of data

2.27 Our approach was predicated on the availability of extant data that would allow us to make assessments about the costs and benefits of the Act. What became apparent was that no such dataset had been collected form the time of the Act's implementation, meaning that data underpinning the Framework of Costs (see above) was lacking.

2.28 Despite numerous requests to a variety of sources and several enquiries over the course of the research, no data on either incurred costs or benefits in relation to the implementation of the Act emerged from any of the key stakeholders.

2.29 The lack of data and limited engagement were highly significant and problematic and resulted in a fundamental re-consideration of the design and methodologies. It also served to compromise any attempt to conduct a cost-benefit analysis,[8] and the focus therefore shifted to addressing two objectives:

1. To estimate the overall costs incurred in the implementation of the Act
2. To determine the incremental costs associated with implementing the Act

2.30 In order to address these objectives and meet the specification, a bespoke and pragmatic set of methods was developed.

Attributable expenditure and the implementation of the Act

2.31 As noted above, the challenge facing the study team was that no data had been collected which specifically asked about the costs (or benefits) associated with the Act. In order to mitigate for this, and with co-operation from a small number of local authorities, the team initiated an exercise to try and reconstruct the cost profile of the Act by asking local authorities to identify lines of expenditure in their accounting records which were, in some way, attributable to the Act's implementation.

2.32 Our aim was that data obtained from these pilot local authorities would then be used to extrapolate to an all-Wales figure for the costs of implementing the Act in Welsh local authorities. The process would have involved taking certain classes of expenditure and extrapolating these to a national total based on service expenditure and/or needs for service, based on the numbers (for each local authority) of elderly in the population, numbers of children in the population etc.

Cost and expenditure data collection methodologies

2.33 Building on this, detail is provided here outlining the specific approaches used to identify and analyse the costs involved.

Local authorities

2.34 Welsh local authorities were identified as the primary implementation agents of the Act and it was thought essential to obtain costs and benefits data from them. Given the lack of extant data described above, and with co-operation from a small number

[8] Data on service user and carer outcomes is collected in Wales, but it is neither sufficiently constant nor consistent for the purposes to which it was intended to be used for this evaluation

of local authorities, we initiated an exercise to try and reconstruct the cost profile of the Act's implementation costs from basic accounting records. ADSS Cymru was approached to help 'recruit' local authorities, we secured agreement from three local authorities which were prepared to try and identify:

1. Lines of expenditure in their accounting records which were, in some way, attributable to SSWBA implementation
2. The percentage of that expenditure line that could be attributable to the SSWBA.

2.35 In doing this we drew a distinction between expenditure funded by non-core funding sources (e.g. ICF) and from the local authority's core resources. We collaborated with senior social work managers and finance managers from each of the authorities to provide their best estimate of that attribution percentage. This was complicated because, as social care managers pointed out, over the period of the implementation of the Act, there were a number of other key drivers of social care expenditure, namely:

- ageing population;
- austerity;
- COVID-19 pandemic;
- Brexit process and its impact on the labour force; and
- other policy changes relevant to the Act.

2.36 This exercise was conducted in a structured manner to achieve consistency of practice across local authorities. In the absence of firm data, obtaining estimates of expenditure attributable to the implementation of the Act from senior managers involved with services was considered to be the optimal approach.

2.37 Our aim was that data obtained from these pilot local authorities would be used to extrapolate to an all-Wales figure for the costs of implementing the SSWBA in Welsh local authorities. The process would have involved taking certain classes of expenditure and extrapolating to a national total, based on service expenditure and/or needs for service, arising from the numbers (in each local authority) of elderly, children, etc. in the population.

Welsh Government and public bodies

2.38 In addition to the local authorities, we made a number of enquiries about the staff time of Welsh Government officials involved with the implementation of the Act. Conversations were held to try and identify relevant costs incurred. However, and as with local authorities, no specific dataset had been kept at the time of implementation, no one was available to offer any insights into time involved, and it was not therefore possible to estimate costs. Similarly, data from Welsh Government agencies (such as Care Inspectorate Wales) and other public bodies (such as Social Care Wales) had not been collected at the time, and it was not possible to retro-fit costs.

Health Boards

2.39 Using representatives from within the Study Expert Reference Group, we contacted all health boards in Wales, with a relatively positive response from one, and we tried undertaking a similar exercise to that done with local authorities. However, it was not possible for them to identify activities (outside of those funded by ICF/TG) which could be said to be attributable to the Act and which are likely to be of considerable magnitude. There was a suggestion from the limited engagement we had with one of the health boards that they might have funded some Act-related activities from its core funding, but it did not prove possible to identify what this might be.

Provider organisations – third sector and independent sector

2.40 Throughout Wales, a large number third sector organisations have implemented a range of non-core funded activities which are relevant to the implementation of the Act. These costs can be regarded as 100% attributable to the implementation of the Act – some of this high-level information is available within the ICF funding arrangements.

2.41 For independent sector agencies – typically commissioned by local authorities to provide care and support services – no direct approach was made, given the number and range of provider organisations, the difficulties in ascertaining costs from local authorities, and the knowledge that no extant data existed on the implementation costs.

Individuals and communities

2.42 As referred to earlier, this is the province of social costs. However, no relevant information was forthcoming from other components of the evaluation on which to base an estimate of these costs and outcomes.

3. Results and Limitations – Costs, Outcomes and Benefits

3.1 This section outlines the findings of the various costs associated with the SSWBA implementation.

Costs – Local Authority

3.2 As described in Chapter 2, data was obtained from three local authorities, but each of these had differed in the detailed approaches employed. As noted earlier, it was decided to structure our approach against two objectives: overall attributable costs and incremental costs.

Objective 1 – Overall attributions

3.3 This involved two of the local authorities and concerned the estimation of the overall level of costs that they felt was attributable in each financial year to the implementation of the SSWBA, expressed as a percentage of total expenditure across budget lines. This involved any additional new expenditure incurred in the implementation of the Act, plus the cost of any existing local authority resources which had been redirected and applied to the implementation. A wide range of activities (too numerous to list) were undertaken through this expenditure and just a few examples were: new social work posts, after care support, support to adopters, development of advocacy, regional adoption service etc

3.4 The results from Local Authority 1 are shown in Table 4.1 (below).

Table 4.1: Attributable Costs – Local Authority 1

Year	Attribution (% of total social services expenditure attributable to the implementation of the Act)
2014-15	57.0%
2015-16	55.8%
2016-17	76.2%
2017-18	49.6%
2018-19	24.1%
2019-20	25.0%
2020-21	30.4%
MEAN	**43.9%**

3.5 This authority saw social services expenditure had risen approximately 40% between 2014-15 and 2020-21. The proportion of expenditure that they felt was attributable to the implementation of the Act represents an approximate inverse U-shape trend with spending rising up to 2016-17 before generally falling up to 2019-20. An annual increase of over 10% of total social services expenditure observed for 2020-21 is likely to be associated with additional needs in response to Covid-19, with attributable expenditure estimated to increase between 25% and 59% during this period.

3.6 Annual expenditure data shows that spending on total social services increased 35% between 2014-15 and 2020-21 with an annual increase of 11.5% observed in 2020-21. Children's services increased 51.3% since 2014-15, whereas spending on services for older people and services for adults aged under 65 both increased by 28% over this time period.

3.7 The results from the second local authority are shown in Table 4.2.

Table 4.2: Attributable Costs – Local Authority 2

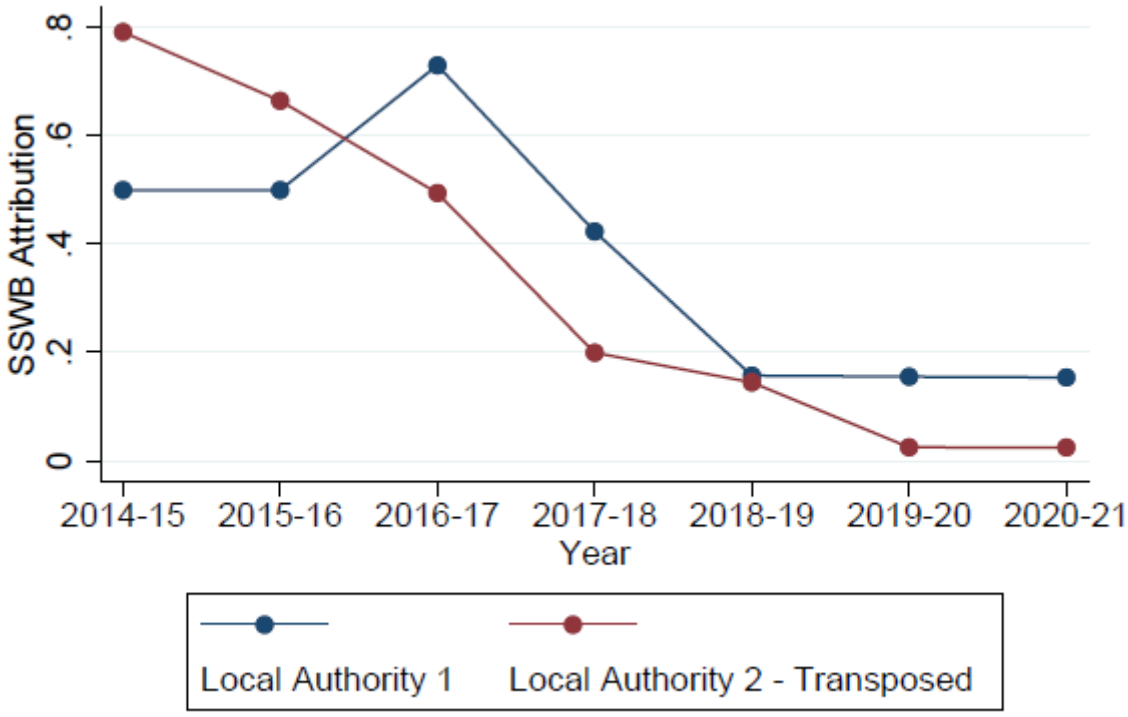
Year	Attribution factor (% of total social services expenditure attributable to the implementation of the Act)
2014-15	79.2%
2015-16	66.5%
2016-17	49.5%
2017-18	20.0%
2018-19	14.5%
2019-20	2.5%
2020-21	2.5%
MEAN	**30.5%**

3.8 Data from Local Authority 2 indicates that attributable expenditure for each category highest in 2014-15/2015-16 before reducing in later years, with attributable spending on older people and children accounting for the largest proportions of spend and values broadly similar for these two groups. As per local authority 1, there was a slight increase in attributable spending in 2020-21, potentially resulting

from Covid-19 expenditure. Annual expenditure data shows that spending on total social services increased 41% between 2014-15 and 2020-21. Over this time period, expenditure on children's services increased by 34%, services for older people by 69%, and services for adults aged under 65 by 20%. In 2020-21 total social services expenditure experienced a year-on-year increase of 14.2%.

3.9 Both scenarios demonstrate that attribution levels were relatively high for pre-Act and early post-Act years, due to costs associated with implementation, with later years having relatively lower attribution levels as local authorities moved towards a 'business as usual' model in accordance with the suppositions of the Act. This is illustrated in Figure 4.1.

Figure 4.1: Objective 1 – comparisons between Local Authority 1 and 2



Objective 2 – Incremental costs

3.10 This involved one local authority and concerned the incremental costs associated with implementing the Act. In relation to Objective 2, Local Authority 3 aimed to assess the incremental costs associated with the implementation of the Act. This was addressed by the LA providing specific changes in funding during the implementation of the Act, with attribution derived from extracting expenditure

specifically related to funding increases and funding reductions for each spending category (Table 4.3).

Table 4.3: Funding increases and decreases – Objective 2 (Local Authority 3)

Year	Funding Increase (% of total social services expenditure increased due to the implementation of the Act)	Funding Reduction (% of total social services expenditure reduced to the implementation of the Act)
2016-17	34.82%	0.00%
2017-18	37.07%	0.00%
2018-19	24.22%	3.77%
2019-20	38.13%	11.42%
2020-21	31.52%	15.83%
MEAN	**33.15%**	**6.20%**

3.11 No notable trend in funding increase/reductions were observed, which was due to the nature of data collection, where individual sources of funding was identified. For adult services, funding increases attributable to the Act were much higher in later post-Act periods; reductions in funding were also largest in later post-Act periods. The largest increase in attributable funding was for children in 2018-19 – while a similar attributable funding reduction in adult services was observed for same year. Annual expenditure data shows that spending on total social services increased by 35% between 2014-15 and 2020-21.

3.12 Over this time period, expenditure on children's services increased by 24%, services for older people by 35%, and services for adults aged under 65 by 51%. In 2020-21 total expenditure experienced a year-on-year increase of 34.7%.

All-Wales cost position – local authorities

3.13 Earlier in this chapter, we mentioned that attribution data obtained from these three local authorities would then be used to extrapolate to an all-Wales figure for the costs of implementing the SSWBA in Welsh local authorities. Given that we have only one data point in relation to Objective 2 and two data points in relation to Objective 1, the results are not sufficient and too variable to perform an extrapolation to the national picture.

3.14 In the event therefore, and in no small part due the complexity of the task, the lack of pre-existing data, and the capacity challenges experienced by social care managers in being unable to support this aspect of the work, we are unable to develop the all-Wales extrapolation of the costs associated with the Act. That having been said, and based on the data provided by the three local authorities who did contribute, it does appear that these attribution costs are likely to have been substantial.

Costs – Non-core funding sources

3.15 In addition to LA costs, there were non-core sources of funding which have been used to implement the Act. The largest of these concerns the Integrated Care Fund. The Integrated Care Fund (ICF) is a Welsh Government funded preventative programme, which aims to integrate and encourage collaborative working between social services, health, housing, and the third and independent sector to improve the lives of the most vulnerable people in Wales.[9]

3.16 ICF was delivered from 2014 to March 2022 when it was replaced by the Regional Integration Fund (RIF). The ICF included both annual capital and revenue allocations and was allocated to the seven Regional Partnerships Boards. The distribution of ICF funds across Wales is shown in Table 4.4 (overleaf).

3.17 Over its seven-year lifetime, around £500 million of these funds were allocated to the regions (via the health boards) to spend on projects and programmes across partners in health and social care, in effect helping to facilitate the partnership working envisaged by Part 9 of the Act.

3.18 In addition, there are other sources of non-core funding, such as the Transformation Fund (TF) which was a non-recurring grant of £100m made available to help public bodies implement *A Healthier Wales*,[10] which made a contribution to the implementation of the Act.

[9] For more on ICF, see Integrated Care Fund evaluation | GOV.WALES

[10] For more on the Transformation Fund and *A Healthier Wales*, see A healthier Wales: long term plan for health and social care | GOV.WALES and Health and social services transformation fund 2018 to 2021: evaluation | GOV.WALES

3.19 As noted previously however, no specific data was prospectively collected on the extent to which this total expenditure was attributable to the implementation of the Act and it is not possible to retrospectively undertake analysis to do this.

Table 4.4: ICF funding (£ millions)[11]

Region	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
Cardiff and Vale	5.547	5.547	6.372	6.273	6.273	11.402	11.602	13.406
Cwm Taf Morgannwg	4.377	4.377	5.056	5.015	5.015	12.756	12.42	14.850
Gwent	8.095	8.095	9.238	9.073	9.073	15.928	16.476	18.630
North Wales	10.739	10.739	11.426	11.452	11.595	19.812	20.152	22.460
Western Bay	7.805	7.805	8.371	8.345	8.424	-	-	-
West Glamorgan	-	-	-	-	-	11.329	11.651	12.813
Powys			2.466	2.530	2.523	4.309	4.362	4.742
Mid and West	10.739	10.739	-	-	-	-	-	-
West Wales	-	-	6.417	6.487	6.567	11.442	11.874	13.403
TOTAL	**47.301**	**47.301**	**49.346**	**49.174**	**49.470**	**86.978**	**77.359**	**100.304**

3.20 Given this, what can be said is that it is highly likely that a significant proportion of these funds were used to support the implementation of the Act, but the precise scale of this cannot be collected. It will have varied between sectors (e.g. local government, NHS, and third sector) and between regions.

3.21 Our conclusion therefore is that significant sums of non-core public funds have been used to implement the Act, but the lack of sufficiently precise data means that it is not possible to identify an approximation of the specific amounts involved.

Costs – Health Boards

3.22 We reached out to health boards as described above and tried undertaking a similar exercise to that done with the local authorities but without success. It was clear that there were activities undertaken by health boards which were funded by ICF/TF and which are attributable to the Act. It is also likely that health boards will have funded some Act-related activities from their core funding. However, for understandable

[11] Data provided by Welsh Government.

reasons given the pressure on capacity within the NHS, the lack of engagement from health boards meant it did not prove possible to identify attributable costs to health boards from implementing the Act.

Costs – Welsh Government and public agencies

3.23 As described above, no data was collected at the time of the initial implementation of the Act, and it was not possible retrospectively to analyse the level of opportunity cost, which expresses in financial terms the amount of time that a range of officials would have spent associated with the Act's implementation.

Outcomes/Benefits

3.24 In Chapter 2, we indicated that our original approach was to consider the potential outcomes and benefits arising from the implementation of the SSWBA in two main types.

Improvements in well-being of clients and staff

3.25 This would probably be seen as the measure which best indicates the delivery of benefits and outcomes consequent on the implementation of the Act. Hence, we our focus was on three areas:

- ***Analysis of national well-being data*** – analysis of the ONS wellbeing questions within the National Survey of Wales[12] indicate that following the implementation of the Act, there were slight reductions in well-being across Wales. While the analysis was subject to a number of notable limitations relating to the consistency and availability of data, and identifying respondents in receipt of care and support, scores for 'worthwhileness of life' and 'happiness' showed relatively small but statistically significant reductions, while increases for anxiety were also observed. The findings require caution as while changes in well-being may be associated to some extent as a result of the Act being implemented, the changes cannot be assumed to have been caused by the Act alone. Further complications, including the outbreak of COVID-19, introduced further difficulties in extracting the effect of the Act from wider exogenous and societal factors.

[12] This is described in detail in Lyttleton-Smith et al (2022), available at https://www.gov.wales/well-being-research-support-final-report-evaluation-social-services-and-well-being-wales-act-2014

- ***Analysis of the ONS well-being questions in the National Survey of Wales*** – analysis demonstrated small reductions across well-being measures following the introduction of the Act for both the general population and those either providing or in likely receipt of support. Well-being is nevertheless a complex multi-dimensional concept, which the four ONS measures attempt to summarise. The National Outcomes Framework report[13] presents trends in the determinants of well-being and demonstrates the wider impart of the Act on promoting well-being for carers and people receiving care and support, beyond the definition of well-being that was applied within this report.
- ***Availability of quantitative well-being data from participants*** – during the fieldwork on this project we tried to identify examples of where implementing agencies might have set up their own local systems to record and evaluate improvements in well-being consequent on the Act's implementation. Whilst some examples of this do exist (like data summaries of well-being, often measured over time, collected by national or local government) no additional data was available in a form that would allow for any meaningful exploration of this within our methodological approach.
- ***Qualitative findings on well-being*** – the qualitative findings from our evaluation are set out in the other publications from the study.[14] We had hoped that the data in the interviews might be able to provide insights that could be factored into the benefits analysis that we were hoping to undertake. However, the nature of the interviews and of the narratives provided which largely described challenges for service users and carers in respect of their well-being, means that little can be inferred about positive impact from those findings which is of use to this CBA.

Improvements in the use of resources

3.26 We have been unable to find any direct and specific evidence that that the implementation of the Act has let to improvements in the use of public resources.[15]

[13] See https://gov.wales/social-services-national-outcomes-framework.

[14] See https://gov.wales/evaluation-social-services-and-well-being-wales-act-2014 for details of these.

[15] See Table 1.2 and Paragraphs 1.11, and 2.35 for an understanding of the expenditure situation related to COVID-19.

The emphasis on prevention and multi-agency working contained within the Act would, in theory, lead to a possible realignment of roles and responsibilities, with consequential reductions in resources, but nothing emerged in conversations with local authority staff relating to this facet of the evaluation.

4. Conclusions and Recommendations

4.1 There are three points which should be emphasised in conclusion:

Costs

4.2 Given the absence of sufficient available data on the cost implications of the SSWBA implementation, a collection of methods were used to try and estimate the costs involved.

4.3 In some cases, such as for Welsh Government costs and health board costs, it is clear that some costs were involved but no estimates of these were obtained.

4.4 In other cases, such as local authority costs, from the pilot case studies we undertook, some estimates of the costs of implementing the SSWBA in the local authorities concerned were obtained. However, the data obtained was insufficient in volume or reliability and, therefore, reliable estimates of the all-Wales costs to local government of implementing the SSWBA were not able to be produced.

4.5 With regard to non-core costs such as ICF and transformation grants, it was possible to establish the total amounts of expenditure incurred, it was not possible, in the time available, to determine the allocations to local government, health boards and the third sector. Consequently, the degree of attribution to the implementation of the SSWBA was not estimated. However, analysis of the situation in a small number of individual implementing agencies, suggests that these costs were, in all probability, relatively large.

4.6 The anticipated outcomes and benefits from the SSWBA implementation were seen as being improved well-being and improved use of resources. Little or no data, quantitative or qualitative was available to verify these outcomes and benefits.

Overall findings

4.7 The original stated aim of this evaluation was to undertake a cost-benefit analysis to provide a ‘more accurate’ estimate of the costs and benefits to derive an indicator of the return on investment. We had also intended to comment on the degree of attribution of improved outcomes the SSWBA implementation and to comment on the distributional impact of the activities involved.

4.8 For all the reasons cited in this report, the lack of relevant data, plus the challenges associated with being able to obtain such data retrospectively, has meant that these aims were not achieved.

4.9 Analysis of information provided from three pilot local authorities enabled a degree of estimation to be made of the costs for each of those local authorities. However, the lack of a homogeneous approach and wide-ranging differences in estimates, has meant that no reasonable extrapolation could be made of the costs to Welsh local government of implementing the SSWBA and no firm conclusions could be arrived at.

4.10 It would be fair to conclude that the clarity and range of the Regulatory Impact Assessment for the Act[16] – that the additional benefits of implementing the legislation would outweigh the additional costs of implementation over the long-term – has to be seriously questioned. This is because there is no dataset currently available upon which a claim can be substantiated, and because the limited evidence that could be collected by this study suggests otherwise.

Recommendations

4.11 We strongly recommend that with any similar future projects, a framework of data needed for evaluation should be identified prior to the start of the project. Data collection methods should be put in place to enable robust evaluation to take place and evaluation viewed as an integral component of the implementation of programmes and schemes initiated. There are perhaps three aspects to this.

4.12 There is a need for an expenditure reporting system which keeps track of costs (and cost savings) which can be linked to the Act. This would apply to all implementing agencies including Welsh Government, local authorities, the third sector and the NHS. We are aware that a small number of local authorities in Wales may did develop a nascent form of such a system, but it is not widespread, nor standardised.

4.13 The making of amendments and improvements to the existing national well-being data collection system to ensure that data relevant to the evaluation of the Act is available is also a key component.

[16] See SSWBA Explanatory Memorandum (2014) – pp.78-94

4.14 The design and creation, in implementing agencies, of a number of local evaluation approaches for selected projects which are seen as relevant to the implementation of the SSWBA are also important. These evaluations, which would need to be set-up via to the implementation process, would involve a ‘deep dive’ into the project to assess the extent of improvements in a) well-being and b) improved use of resources in relation to the activity being evaluated. Because this is a selective approach, these evaluation projects would not provide a total picture of the whole of the SSWBA implementation, but they would potentially offer an approach that could extrapolated to the whole.

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