SOCIAL RESEARCH NUMBER:
37/2023
PUBLICATION DATE:
30/03/2023

Well-being

Research to support the Final Report of the Evaluation of the Social Services and Well-being (Wales) Act 2014

Digital ISBN 978-1-80535-352-2

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

Well-being

Research to support the Final Report of the Evaluation of the Social Services and Well-being (Wales) Act 2014

Jen Lyttleton-Smith, Pippa Anderson, Simon Read and Shaun Harris

Welsh Institute for Health and Social Care, University of South Wales;
Swansea University; Cardiff Metropolitan University; Bangor University.

Lyttleton-Smith, J., Anderson, P., Read, S. & Harris, S. (2023). *Well-being: research to support the Final Report of the Evaluation of the Social Services and Well-being (Wales) Act 2014.* Cardiff. Welsh Government, GSR report number 37/2023. Available at: https://www.gov.wales/well-being-research-support-final-report-evaluation-social-services-and-well-being-wales-act-2014.

For further information please contact:

Social Services and Integration
Welsh Government, Cathays Park, Cardiff, CF10 3NQ

E-mail: research.healthandsocialservices@gov.wales

Table of Contents

List of Tables

List of Figures

Glossary

Acronym/Key word	Definition
Assessments	Assessments are undertaken with individuals to focus on what the individual needs and try to meet those needs, and carers to identify the support they need. The Act states a local authority must offer an assessment to any adult, child, and carer where they may have needs for care and support.
CI	Confidence Interval. This is the mean of an estimate plus and minus the variation in that estimate.
Co-Production	The Act aims for people to be more involved in the design and provision of their care and support. It means organisations and professionals working with them and their family, friends and carers so their care and support is the best it can be.
Direct Payments, DPs	Direct Payments enable individuals and/or their carers assessed as having eligible social care needs to source care that is tailored to their needs, rather than using existing statutory providers. They are intended to provide greater flexibility, independence, and choice and control over the support people receive.
GLM	Generalized Linear Model. This is a statistical modelling technique enabling the relationship between a dependent variable and independent variables to be explored via a link function.
IMPACT	Independent evaluation of the Implementation of the Social Services and Well-being Act
LAs	Local Authorities
LLSIDI	Limiting long-standing illness, disability, or infirmity
National Survey	National Survey for Wales
Multi-Agency working	The Act aims to strengthen joint working between care and support organisations to make sure the right types of support and services are available in local communities to meet people’s needs.
Personal Assistants, PAs	A personal assistant provides person-centred care and support for individuals, so they can achieve personal well-being outcomes where the individual lives.
P-FE	Principles-Focused Evaluation
Prevention and Early Intervention	The Act aims to ensure that people can ask for the help they need when they need it to prevent their own situation from getting worse,

Acronym/Key word	Definition
	and carers can access support to assist them in their caring roles and maintain their own well-being.
SERG	Study Expert Reference Group
Voice and Control	Voice and Control is a principle of the Act which aims to put the individual and their needs at the centre of their care and support, using their 'voice and control' over the outcomes that can help them achieve well-being and the things that matter most to them.
Well-being	The Act aims for people to have well-being in every part of their lives. Well-being is more than being healthy. It is about being safe and happy, having choice and getting the right support, being part of a strong community, having friends and relationships that are good for you, and having hobbies, work or learning.
'What Matters' conversation	'What Matters' conversations are a way for professionals to understand people's situation, their current well-being, and what can be done to support them. It is an equal conversation and is important to help ensure the voice of the individual or carer is heard and 'what matters' to them.
WIHSC	Welsh Institute for Health and Social Care, part of the University of South Wales.
WIMD	Welsh Index of Multiple Deprivation. This is the Welsh Government's official measure of relative deprivation for small areas in Wales. It identifies areas with the highest concentrations of several different types of deprivation. WIMD ranks all small areas in Wales from 1 (most deprived) to 1,909 (least deprived)

1. Introduction

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 alongside Professor Fiona Verity, Professor of Social Work and Social Care, Swansea University.

1.3 The partnership also includes colleagues from 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.

Context

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: well-being; co-production; voice and control; multi-agency working, and prevention and early intervention. Aligned to it are structures, processes and a series of Codes of Practice.

1.5 It is really important to note the nature of the principles and how they are manifested in the experience of service users, carers and the workforce. The five principles do not exist in isolation – they are inter-related and inter-connected. There are overlaps between the underpinning philosophy of each, and as such in the experiences of people it is sometimes difficult to isolate one principle from another.

1.6 For example, it is almost impossible to conceive of how co-production as a principle can operate without first ensuring that people have voice and control over their care and support. Similarly prevention often presupposes that a multi-agency 'offer' will be in place for people in order that prevention of crisis can occur. And of course, all of the principles ultimately aim to deliver better well-being outcomes for people, which is a principle itself, and the subject of this report.

---

[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

1.7 As such, when reading this report, whilst it is ostensibly about well-being, there are occasions below when evidence concerning other principles is referenced. This reflects the inter-connected nature of the principles as noted above. Such evidence will be synthesised in the Final Report which draws material from this and the reports produced on the other principles.

1.8 Alongside the five principles, we have identified five domains within which the principles of the Act 'meet' the people or organisations for whom the Act should be having an impact – individuals in need of care and support, their carers and family members, the communities in which they live, the workforce that supports them, and the organisations that have responsibilities and duties to discharge as outlined by the Act and associated Codes of Practice:

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

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

1.9 The evaluation study represents an independent and objective assessment of the implementation of the Act and the way in which it has impacted the well-being of people who need care and support and their carers. To bring this about, we draw upon the approach espoused by Michael Patton (2018) in his 'Principles-Focused Evaluation' (P-FE) framework which we are using as the theoretical and conceptual underpinning of our study. [3] There are three key questions that Patton encourages us to consider as part of any P-FE (2018, pp.27-29):

1. To what extent have meaningful and evaluable principles been articulated?
2. If principles have been articulated, to what extent and in what ways are they being adhered to in practice?

---

[3] For more on P-FE see Patton, M. Q. (2018). *Principles-Focused Evaluation - The GUIDE*. New York: Guilford Press. For how P-FE relates to this study, see Chapter 2 in Llewellyn M., Verity F., Wallace S. and Tetlow S. (2022) *Expectations and Experiences: Service User and Carer perspectives on the Social Services and Well-being (Wales) Act.* Cardiff. Welsh Government, GSR report number 16/2022. Available at: Evaluation of the Social Services and Well-being (Wales) Act 2014: expectations and experiences.

3. If adhered to, to what extent and in what ways are the principles leading to the desired results?

There is a clear connection between Patton's questions, the areas for inquiry in our study, and the five principles underpinning the Act. These connections are considered in detail on a principle-by-principle basis in a series of reports, of which this is one. This report focusing on the principle of well-being has been authored by a sub-team within the IMPACT evaluation study group who have a special interest and expertise in this topic.

Summary of Key Points from the Well-being Literature Review

1.10 To enhance clarity for some of the discussions contained with this report it is necessary to be familiar with some of the key concepts and arguments discussed within the well-being chapter of the previously published literature review informing this study (Llewellyn et al., 2020).

1.11 There is a distinction between the direct measurement of well-being itself (i.e., a subjective view of how positive or negative a person feels their well-being is) and the determinants of well-being (e.g. circumstances of life, experiences in life that contribute positively or negatively to that person's feeling of well-being, that can be measured objectively).

1.12 The Welsh Government National Outcomes Framework ('NOF') (Welsh Government, 2019) is intended to guide well-being measurement and understanding for social care. While it contains some direct measures of well-being, it almost exclusively concerns the determinants of well-being.

1.13 These determinants of well-being, as articulated in the NOF indicators, relate to **objective** measures associated with well-being (i.e., measurable by factors external to the individual, such as housing quality or educational level). An assumption is made that positive well-being is achieved should the determinants of well-being meet satisfactory standards, and vice versa for negative well-being.

1.14 Research discussed in the literature review repeatedly highlighted the equal importance of measuring **subjective** well-being to evaluate public policy (i.e., asking people how they feel). The National Survey for Wales includes questions based on those designed by the Office for National Statistics ('ONS') to measure well-being (Welsh Government, 2022). [4] These offer a proxy measure for well-being, in that they concern life satisfaction and happiness, consistent with some literature which merges these concepts with well-being (though this is not an approach universally agreed upon among well-being researchers and theorists).

1.15 The literature review informing the evaluation concluded that the approach to measuring and understanding well-being at population level, that is best supported by the literature, is a relational ‘capabilities’ approach (Sen, 2009)[5]. The review suggested exploration of this conceptualisation for improved representation of well-being for people accessing social care services in Wales.

Purpose and Rationale

1.16 This report draws together the evidence around the well-being principle. The concept of ‘well-being’ anchors the Social Services and Well-Being (Wales) Act 2014 (‘the Act’) in both title and purpose, proposing implicitly that social care services take steps to increase national well-being (Welsh Government, 2014). While for some service areas, and by extension, people using those services, this language sits comfortably with previous conceptions of their purpose (for example, elder care), in others it is a dramatic shift away from prior policy framings (for example, children’s services which was previously organised around a risk-focused model (e.g. see: Broadhurst et al., 2010) though the degree to which risk remains the core principle of children’s services in Wales is worthy of exploration).

1.17 Due to the positive and desirable connotations of the concept of well-being as suggested by McLeod and Wright (2016), a contemporary re-branding of social care as a well-being focused service may help to develop positive impressions of its work among both staff and the public, with the outcome of creating an improved relationship. The concept also underpins the NOF (Welsh Government, 2019) which details the standards of well-being that should be expected by the public, including those receiving care and support under the Act.

1.18 This report shares the findings of a small qualitative study undertaken in 2019-2020 to support the well-being strand of the Evaluation of the Social Services and Well-being Act, and a quantitative analysis undertaken in 2022 of findings from the

---

[4] The National Survey for Wales has a dedicated webpage with the most recent results: National Survey for Wales

[5] “The capabilities approach claims that well-being can be assessed by understanding individual’s capabilities to do or be something and that individuals should be evaluated within the context of available and feasible opportunities, not their achievements (Alkire, 2015; Sen, 2009)”, taken from (Llewellyn et al, 2020).

National Survey for Wales (hereafter referred to as the National Survey) on questions relating to well-being.

1.19 In the published literature review for well-being (Llewellyn et al., 2020), we considered and commented on the nuances in the conceptualisation of well-being for public policy purposes, both at population level and at the personal level. For the purposes of this report, we accept the determinants of well-being as described within the NOF statement (Welsh Government, 2019) as the working framework for the Act. However, our analysis and discussion of the four National Survey measures, which are driven by determinants of well-being and are largely relatable to the NOF, but hold different conceptual and practical connotations, are the most appropriate for our analyses (see section 1.14).

1.20 For the qualitative study, we sought to obtain the views and opinions of people who use social care to understand whether relationships with professionals and perceptions of social care services have changed as a result of the language of well-being. This exploration supports inquiry as to whether people accessing services align with the same definitions and priorities around well-being understood and applied by professionals delivering those services, and, by extension, in the Act. We also wished to explore what meanings the term ‘well-being’ has for these people, and the extent to which it resonates with their experiences of those services. This enabled us to consider whether the definition of well-being applied through the Act fully captures all dimensions of well-being that matter to people accessing social care. To extend our understanding of this alignment, we sought views on the NOF and how it relates to people’s lived experiences of well-being, and how their relatable outcomes have been affected by the care and support services they have accessed. It is important to note that this data relates exclusively to the pre-COVID-19 period.

1.21 For the quantitative analysis, we sought to determine what changes in well-being-had occurred throughout the years 2014-2021, including any changes engendered by the COVID-19 pandemic. The National Survey utilises the four national well-being questions used by the ONS. As the National Survey does not ascertain whether people are directly accessing social care services in every year of the survey (though in some years it does capture whether someone has received help from care and support services, either for themselves or as a carer), we used a proxy to identify participants in the survey who were *likely* to have experience of social care provision and examined what changes and relationships between factors could be observed in this data.

1.22 It is important to note that the method for administrating the National Survey changed during the COVID-19 pandemic; as a result, data is not comparable. Due to the inability to select individuals who have received care and support directly in every year of the survey, plus the lack of consistent data over time, the data and analyses can only be indicative of possible views and experiences of the population of interest, rather than exhaustive.

Research Questions

1.23 The core aim of the qualitative study was to examine how people needing care and support and carers in need of support in Wales understand the concept of well-being and their experience of how it is being used in practice. Our research questions were designed to complement and extend on the other research we had conducted as part of the evaluation of the Act, and the literature review undertaken alongside this study (Llewellyn et al, 2020). In each of the questions, ‘participants’ refers to people needing care and support, and carers in need of support.

1. Do participants share the understanding of well-being that is applied within the Act and the NOF?
2. What aspects of personal well-being do participants raise that are not covered within the Act or the NOF?
3. How do participants locate well-being in relation to interlinked concepts, such as mental health, quality of life, life satisfaction, and happiness?

1.24 Additionally, we used quantitative methods using National Survey for Wales data to investigate the impact of the Act on people needing care and support and carers needing support through exploring what changes in well-being-related responses were reported for groups which were likely to be included in this population.

1.25 This report initially outlines the qualitative and quantitative methodologies deployed in more depth, before describing the findings emergent from each aspect of the study. The qualitative findings provide an overview of the thematic data analysis carried out on the interview data, demonstrating overlaps with the core dimensions of well-being identified in the NOF, as well as additional themes emergent from the data. These are then considered in respect of the research questions outlined above within the Discussion.

1.26 This report provides a focal point on the well-being principle for those who may be interested in it, but does not formally come to conclusions or make recommendations at this point. That will follow in the Final Report.

1.27 The scope of this report is to draw the evidence around well-being together, providing a focal point on this principle for those who may be interested in it. We draw such themes together in the summary of this document (Chapter 5) and provide recommendations that are specific to well-being. These need to be seen in the context of the overall findings, conclusions and recommendations made in the Final Report (Llewellyn et al., 2023).

2. Methods

Qualitative Methods

Recruitment

2.1 To identify participants, calls were distributed to pre-existing and new research networks across Wales. Local area co-ordinators, social worker networks, government agencies, charities, and voluntary organisations specific to each cohort were approached with information on the study's aims and objectives. Participants were primarily contacted in liaison with these gatekeepers, who introduced the study to potential participants. If potential participants expressed an interest in taking part, a member of the research team followed up with them. In addition to this, some of the adults and older people cohorts approached researchers directly upon being provided the study details.

Participants

2.2 The study incorporated 34 service user participants across four distinct age cohorts: children aged 5 to 13 (n=9); young people aged 14 to 19 (n=9); adults aged 20 to 64 (n=8); and older people aged 65 or over (n=8). The aim was to incorporate a range of service users within each cohort, though due to recruitment issues the children and young people cohorts were mainly comprised of young carers.

Procedure

2.3 Open-ended, face-to-face, semi-structured interviews were carried out individually with adults and older people, with these each taking between 25 and 90 minutes. While interviews were offered in both Welsh and English, all were conducted in English. Interview schedules were predominantly the same between these two cohorts, and were developed to explore participant perceptions of well-being, which aspects of their lives were felt to enhance or detract from this, their interactions with social services, and to what extent these were felt to influence their well-being (see Annex 1 for outline interview schedule). Follow-up prompts specifically around the dimensions of the NOF were also included to establish how relevant these were felt to be for participants. These dimensions are as follows:

(i) Physical and mental health and emotional well-being

(ii) Protection from abuse and neglect

(iii) Education, training and recreation

(iv) Domestic, family, and personal relationships

(v) Contribution made to society

(vi) Securing rights and entitlements

(vii) Social and economic well-being

(viii) Suitability of living accommodation

2.4 For the children and young people cohorts, interview sessions were carried out with one to four participants at a time. Group interviews were offered to all participants, as methodological literature demonstrates this can create a more comfortable and supportive experience for younger research participants; however, not all participants chose to take this up. The sessions lasted between 30 and 70 minutes. Young people sessions used a similar schedule to the older cohorts. The discussions generally commenced by establishing existing understandings of well-being. Following this, participants' views were sought on their interactions with social services and other partnered organisations, as well as how these influenced their sense of well-being.

2.5 The children cohort schedule differed in approach through the incorporation of creative method activities, aimed at heightening engagement with younger participants. Following an initial group discussion of well-being and how the term was understood and used, three distinct research exercises were conducted.

2.6 **Activity One – Talking about well-being:** This 'eco-map' exercise involved providing participants with a large A3 sheet of paper containing an outline figure in the middle. The figure was surrounded by three concentric circles. The innermost circle was titled "talks, listens and changes things", the middle circle "talks and listens but cannot change things" and, the outer circle states "Does not talk or listen to me but can change things". Participants were talked through the circles, discussing how the figure represented them and the circles related to different people or organisations in their lives that had a role in their well-being. Participants were asked to write the names of people or organisations in the different circles based on how they perceived them. Participants were offered examples such as 'my social worker' or 'my friends' for them to position in the most appropriate circle.

2.7 **Activity Two – Sorting well-being:** Participants were provided two sets of different, coloured, but otherwise identical, flash-cards. Each flash-card represented one of the 24 well-being criteria of the NOF. Participants were asked to choose the five things in their lives that they would most like to improve for their well-being from the first set of cards. Following that, participants were asked to choose five things they felt that the carers and workers from their Activity One worksheets tried to improve for their well-being.

2.8 **Activity Three – Defining support for well-being:** Participants were provided a large A3 worksheet with a drawing of a person walking in the centre. Two arrows extended forwards and backwards: the forward-facing arrow had ‘Things that move me forward’ written on it; the backward-facing arrow had ‘Things that hold me back’. Participants were asked to write down things in their lives that they felt made it better underneath the forward-facing arrow, and the things they felt stopped life getting better or made it worse beneath the backwards-facing arrow.

2.9 Following each activity, participants talked through their responses with the researcher(s) eliciting discussion on what they perceived as important to their well-being, what or who they felt helped make their lives better, and aspects of their lives felt to be detrimental.

2.10 All recruitment and research activity was conducted prior to the COVID-19 pandemic, between September 2019 and February 2020. Ethical approval was provided by Swansea University’s College of Human and Health Sciences Research Ethics Committee.

Qualitative Analysis

2.11 Audio recordings of interviews and group sessions, as well as images of the children cohort’s activity outputs, were transcribed and uploaded to NVivo 12 for data analysis. Following Ritchie & Spencer (1997) and Braun & Clarke (2006), a final thematic framework was developed over five iterative steps: i) familiarisation with the transcripts and images; ii) development of an initial thematic framework across cohorts; iii) coding data from the interviews and images onto the framework; iv) charting each theme with its corresponding sub-themes and data; and v) mapping connections or relationships between different themes. Throughout this process, regular check-ins were held with the research team to validate interpretations of where data should sit and the relationships between and within cohorts.

Quantitative Methods

Data source

2.12 The only data source specifically targeted at Wales that utilises the four ONS questions that directly ask respondents about their well-being is the National Survey for Wales. For this reason it was the optimal data source that would enable us to investigate changes in the well-being of people needing care and support and their carers since the Act was introduced, and to provide context for the findings relating to the three main research questions.

2.13 The National Survey is an annual, large-scale, cross-sectional survey, running all year across the whole of Wales. It is designed to be representative of all adults aged 16 or over living in private households. It excludes people living in institutional accommodation (e.g. care homes, halls of residence, prisons, hotels and B&Bs, and army bases) and children. Therefore, it will not include adults receiving social care support in a care home, or children who receive care and support (a limitation of using the National Survey for our purposes).

2.14 The survey was first initiated as the National Survey in 2012 and was redesigned in 2016 to incorporate the Welsh Health Survey, Active Adults Survey, Arts in Wales Survey, and Welsh Outdoor Recreation Survey. Until March 2020, the survey was conducted face-to-face in people's homes and achieved a sample size, of around 12,000 each year.

2.15 Since the COVID-19 outbreak, it has been conducted by telephone and achieved a similar sample size. During months May to December 2020 respondents from earlier years were recontacted to take part. From January 2021 the survey returned to a random sample selection from the Post Office Address File. In 2021-22 the survey took approximately 35 minutes to complete and covered a wide range of topics including children and education, health and social care, population health, culture and Welsh language. Respondents are offered a small financial incentive to take part, and the response rate was approximately 40% in 2021-22.

2.16 The quantitative analysis considers the difference in well-being following the introduction of the Social Services and Well-being (Wales) Act on 6 April 2016. This defines the pre-Act period as April 2013-March 2016 and post-Act period as April 2016-March 2021.

2.17 In order to monitor personal well-being across the UK, the ONS incorporated four survey questions within the Measuring National Well-being programme. The four measures of personal well-being covered by the questions are:

1. Life satisfaction ("Overall, how satisfied are you with your life nowadays?")
2. Worthwhile-ness of life ("Overall, to what extent do you feel that the things you do in your life are worthwhile?")
3. Happiness ("Overall, how happy did you feel yesterday?")
4. Anxiety ("On a scale where 0 is "not at all anxious" and 10 is "completely anxious", overall, how anxious did you feel yesterday?")

2.18 The four questions are measured on a 0 to 10 scale with 0 indicating "not at all" and 10 representing "completely". For life satisfaction, worthwhileness of life, and happiness scores, 0 to 4 are classified as low, 5 to 6 as medium, 7 to 8 as high, and 9 to 10 as very high. For anxiety, scores are grouped such that 0 to 1 are classified as very low, 2 to 3 as low, 4 to 5 as medium, and 6 to 10 as high. These questions have been included in the National Survey since 2014-15; an adapted version of the life satisfaction and worthwhileness of life were included in the 2013-14 survey, but directly comparable questions on anxiety and happiness were not included.

2.19 The National Survey has various other questions related to the eight aspects of well-being identified by the NOF as evaluated in the NOF report.[6] These questions relate to determinants of well-being, but are not direct measures of well-being (see 1.10-1.14), and as such are not pertinent to the purpose of our analyses.

2.20 The all-Wales dataset considers well-being outcomes for the Welsh population. This has been used in this analysis to understand the general trends in well-being in Wales during the pre-Act and post-Act periods. Comparisons can be made between the general population and individuals providing or receiving care and support to whom the Act is targeted.

2.21 Whilst the Act is targeted towards individuals either providing or receiving care and support, it is not possible to directly identify these individuals in every year of the National Survey (it is asked alternate years). In order to evaluate the year-to-year changes, and identify how well-being responds to changes in policy and wider societal factors, we opted to use survey data for those people who reported a

---

[6] See Social services national outcomes framework

limiting long-standing illness, disability, or infirmity (LLSIDI) as a proxy for those receiving support, as this is reported consistently each year. These individuals may or may not receive support as defined by the Act, but it is possible that a significant proportion of them receive care and support. Therefore, we decided to use this group as a proxy in the absence of knowing which individuals had received care and support each year. We do not know who is receiving care and support but have not reported as LLSIDI. In the 2020-2021 National Survey data, 87 per cent of respondents who self-reported as using social care also self-reported as having a limiting long term illness (LLTI).[7] Whilst the use of the LLSIDI definition as a proxy for social care users is not ideal, in the absence of more detailed data, the LLTI data suggest our proxy to be reasonable.

2.22 The National Survey includes information about carer status. However, the relevant question has been revised over time which makes it unsuitable for our analyses. We therefore restrict our analysis on carer well-being to the reporting of descriptive statistics rather than detailed analysis, to allow for the identification of general trends, during the years before and after the Act.

2.23 We will compare general trends in well-being of those providing or receiving care, who are most likely to be implicated by the Act, with the general population who are less likely to have experienced changes in well-being as a result of the Act, to ascertain whether there is a difference.

Quantitative Analysis

2.24 Descriptive statistics (mean and 95% confidence interval (CI)) for the four ONS measures of personal well-being are reported for respondents representing the Welsh population, people with LLSIDI and carers. In the primary analysis, a simple instrumental variable approach to identify responses before and after the implementation of the Act was used. An extended analysis separated the post-Act period into pre-COVID-19 (April 2016 – March 2020) and during COVID-19 (April 2020 – March 2021) sub-periods. Scores were estimated using a generalised linear model (GLM) and were adjusted for relevant covariates that were available for all years of the evaluation: namely, gender, age group, urban/rural locality, pre- or post-COVID-19 outbreak, local authority, response to the question about general

---

[7] 2020-2021 National Survey data provided by Welsh Government 08.12.2022

health and Welsh Index of Multiple Deprivation (WIMD) quartile. No adjustment for missing data was applied. Stata 17.0 was used for all statistical analyses.[8]

---

[8] StataCorp. 2021. *Stata Statistical Software: Release 17*. College Station, TX: StataCorp LLC.

3. Findings

Qualitative Findings

3.1 This section presents the qualitative findings in relation to each of the age-grouped cohorts with whom we generated data. This age grouping reveals distinct issues in play for each of the cohorts in relation to well-being.

3.2 A thematic analysis of the interview and creative methods data demonstrated coherence with the themes identified in the prior literature review on well-being (Llewellyn et al., 2020; 2023) and with the broader literature on well-being. Many concepts and constructs of well-being emerged across all cohorts, though nuanced interpretations were identifiable across different stages of the life-course. The findings are discussed in terms of their potential implications for how well-being is defined and measured in policy.

3.3 The section concludes with findings not delineated by age group that offer insight on the impact of the Act on well-being, considering the relationship between expectations, lived experience, and the understandings of well-being held by people accessing services.

Children, Young People, and Well-being

3.4 Our qualitative research with children and young people in contact with social care produced determinants of well-being that resonate with previous research exploring this subject and childhood more broadly. These include having strong, supportive and trusting relationships; opportunities for leisure and learning; and a sense of personal agency and participation in decision making about their lives.

3.5 The literature on children and younger people in care associates their well-being with the development of positive **domestic, family and interpersonal relationships** (Selwyn et al., 2017; Long et al., 2017). While our sample did not include many cases of children or younger people in care, the importance of strong professional and personal or familial relationships to the children and young people accessing social services in our sample was clearly evident. In keeping with this literature and our data, the NOF identifies strong relationships as a cornerstone of well-being, and thus the theme of relationships is recurring throughout this section.

3.6 As noted in the wider literature, **participation in decision making** of care-experienced children and younger people is often regarded as central to their well-being (Selwyn et al, 2017). Opportunities to participate in decision making relating to their lives is a universal right for all children under the United Nations Convention on the Rights of the Child (United Nations, 1989) and the centrality of this agency to well-being is recognised within the statements of NOF relating to rights and entitlements.

3.7 Where children and young people live in challenging conditions requiring the intervention of social care, additional support and opportunity is often required to enable their participation. This requires not only listening to children and young people's views but also responding to them and being accountable for decisions made that should have been informed by those views. Several participants identified interactions with social workers and other authority figures as problematic in this regard:

> *"They've* [social care professionals] *all tried to do stuff and not really done anything. And they've moved us from one register to another and we've gone up and back down because they don't really do anything"* (YA01)
>
> *"Before everything went downhill in social services, we had a 16+ team. That was brilliant. But I don't know what happened. I think the funding got cut or something. The team, all of a sudden it just went. We had no notification of what happened, or that it had gone even"* (AD04)

3.8 Both participants quoted above highlighted problems with being listened to and participating in decision-making in the context of social services. For YA01, this related to ongoing escalation and de-escalation of issues in their family home which left them with the impression that, while apparently listening, limited action was being taken by the services in response. Similarly, for AD04 the transition from child to adult social care brought about some inconsistency in their level of participation in decision-making: there were aspects of their life where they felt that their concerns were being noted and addressed (e.g. funding for gym membership and clothing) but others where key decisions were taken out of their hands (such as where they lived):

> *Interviewer: "This area wouldn't be where you would have picked?"*
>
> *Respondent: "Not really. Only because my mother lives here as well. And I get really upset if I see her. Because I don't really want to speak to her because of all*

> *of the stuff that happened. That's one of the reasons why I wouldn't really come back here"* (AD04)

3.9 Given the care context of AD04 and historic problems in their relationship with their mother, key decisions such as where they based their lives would ideally involve joint decision-making. The lack of joint decision-making meant that, while many facets of service provision were received positively, in certain key respects there remained a level of distrust. In order for effective participation to occur, it is important that a child or young person has trust in the adults around them who have the capacity to make decisions, so that they feel confident to speak out about their views and experiences (Cossar et al., 2016). Effective communication regarding decision making is a core aspect of this. Relationships with professionals are often key for children and young people accessing care, who may have few other trusted and supportive adults in their lives, and as such they hold a responsibility to enable them to feel seen and heard on issues relating to their lives. With relationships repeatedly highlighted in the literature as central to well-being, any distrust in professionals around the child or young person can be detrimental to their capacity for participation and also to their well-being more broadly.

3.10 **Personal relationships and a sense of belonging** frequently emerged in participant narratives as a strong source of emotional support for their well-being, highlighting how important it is for social care professionals to prioritise the quality of children and young people's relationships in planning and decision-making:

> *"My friends are usually there for me and usually help me all of the time. Kind of like they are paying the kindness back to me. And then my mum, she really helps me a lot, especially when I'm sad, because she tries to help me" (CH08)*
>
> *"My best mates. They understand what I've been going through" (YA09)*
>
> *"Yeah. Like my two closest friends, I can talk to them about it…and there's one person in my college I can probably talk to about it, the well-being officer" (YA06)*

3.11 Most participants from these cohorts mentioned friends, siblings, parents and other authority figures as important to their lives in terms of emotional support. As the points outlined above demonstrated, friendships and positive relationships can often be fostered in the school environment but the importance of relationships at home was also identified. Again, these relationships were often framed in terms of their mitigation of negative impacts on the participants' well-being, as exampled by CH08 above whose mother helped them when they were sad.

3.12 Children accessing social care services may often suffer stigmatisation or other limiting factors on their capacity to form positive relationships. Social care organisations often play a critical role in ensuring that marginalised or isolated children and young people are able to access a community of peers in a supportive environment, as seen in the data produced with young carer participants:

> *"When I'm feeling quite sad and then I go out with the young carers, I come back and I feel better. Because me and my mum argue quite a bit and then I get upset about the arguing and if I'm out with young carers, they help me clear my mind" (CH02)*

3.13 When considering the role of social care in supporting positive relationships for well-being, identifying and meeting with peers often occurred in tandem with building relationships with supportive professionals. CH02 identified the relationships forged through regular, organised young carers' meetings both in terms of their peers and the staff providing the service. The role played by staff in such organisations was also noted by several other participants within these cohorts:

> *"The people that work here, they are very supportive, and they are always there to listen to you and help you" (YA07)*
>
> *"I also struggle making friends. So making a friend that I can trust is what we've been kind of working on. I already trust [person] because today and last week we did quite personal stuff" (YA03)*

3.14 Often when social services were viewed with a level of distrust, the networking and emotional support associated with charities and voluntary organisations offered an alternative means for participants to feel listened to, with this often triggering more formal action on their care needs by statutory services.

3.15 This network of organisations and professionals around the child or young person demonstrates the importance of partnership or multi-agency working, including between statutory and third sector services, to supporting holistic well-being. Social care under the Act emphasises **partnership working** between different bodies responsible for the well-being of people accessing social services. Much work of this nature was already occurring prior to the introduction of the Act and it is useful that such collaborative approaches are well-recognised within the legislation.

3.16 In considering the role of multi-agency collaboration, it is apt at this juncture to explore the role that educational institutions and stakeholders hold in supporting the well-being of children and young people, given that education often acts as a gateway to and context for social care for this cohort. The literature indicates that school and education hold a critical role in the well-being of children and young people (Hart & Brando, 2018). Within this, it is highlighted that educational outcomes are only part of the equation, with a wider emphasis on the processes and policies being put in place to enable pupils to develop good relationships with peers and adults, a sense of agency, and recognition as an individual. This theme emerged within our interview data, with several participants describing how **aspects of school life influence well-being**.

> "*My head of year is really supportive, and he knows, like, what's happening with my life. I mean, like, the other week, I didn't wash my uniform, I couldn't wash my trousers. So I had to go to school in jeans and he was like 'I understand because you are a young carer, and you've got a lot of stuff happening at home, that's perfectly fine, just make sure they are washed for Monday'"* (YA08)

> *"I think maybe support (is most important) because I think people around you give you opportunities and encouragement. So I feel like if you haven't got that, and you haven't got a good mind-set or a positive mind-set, then I think that would hold you back quite a lot"* (CH04)

> *"I have a cool class actually in high school where we talk about things that happen, like kind of like just normal life. As in people don't get as sad or depressed about things, so we learn about how to make us feel better"* (CH08)

3.17 These three participants discussed how their relationships in school offered strong support for their well-being, with a basis of openness and empathy. Both CH04 and CH08 implied that, without the social support of their peers, their well-being would suffer, and YA08 pointed out the important role that trusted, supportive professionals can play in the everyday well-being of children and young people. This resonates strongly with the wider literature on the well-being of vulnerable children and young people, and with previous research on how education contributes to the well-being of young carers (Lyttleton-Smith, 2017). These data offer insight beyond how schools are supporting the Act; they also demonstrate what children and young people accessing social care value about individuals and contexts that impact their well-being.

3.18 Where strategies were in place within education to support children and young people's participation, these were perceived favourably by participants, resulting in greater engagement. Themes of support, understanding and participation were present in both cohorts, with schools often regarded as performing a key function within this:

> *"So we have a suggestions box and then we put our ideas on and then we put them in the box. And then they read it and they say which idea is the best and they put that in the school" (CH07)*
>
> *"They (mentors) talk to young people like me, and they can tell teachers about how we feel, if we are too nervous. And then teachers can help you. But if you don't speak up, then the teachers won't know how to help you" (CH01)*

3.19 Numerous children and younger people mentioned 'speaking up' as a means of discussing and resolving problems, often with specific roles in place to enable this. CH01 mentioned the school mentor system as an example, but other participants also stated the value of well-being or welfare officers and dedicated well-being spaces in offering a similar service:

> *"If I've had a good day and it's slightly turning bad, I'll be like 'okay, I need to talk to someone' before I get into my bad mood. So then I usually go to the well-being centre, and they are always there for me"* (YA09)
>
> *"There's someone in my school…and basically she's like a welfare officer and if I'm down then I see her"* (YA05)

3.20 These comments offer insight as to how well-being can best be supported at the intersection of social care and education, where education institutions act as a context for social care delivery but also act as well-being-focused spaces in their own right. This latter opportunity to identify children and young people in need of additional well-being support resonates with the Act's principle of prevention and early intervention, with schools providing a core context for enacting this principle with younger cohorts.

3.21 However, several participants felt that their schools were not providing enough support in this regard, or alternatively saw them as a negative environment due to issues of bullying:

> *"I feel that my school isn't very supportive as other schools. And it doesn't matter if it's a big thing or a little thing, I feel like other schools get more support. And*

> *other schools have well-being officers and things like that. Whereas my school don't, they are like if you have anything wrong, just go to anyone, anyone is here to support you. But they don't act on that enough, they don't actually show us that we can trust them"* (YA07)

3.22 YA07 identified no dedicated resource to assist with well-being in their school, suggesting that the assistance and support present elsewhere was detrimentally absent. While this participant reported no issues with bullying, their role as a young carer was felt to be overlooked, with little opportunity to discuss this with a trusted party. Certainly, for those young people who outlined experiences with bullying, the value of emotional offloading and solution-finding within the school setting was all the more pertinent. In these cases, the support of a dedicated teacher, welfare officer or other confidante was felt to mitigate the negative impact on the participants' emotional well-being:

> *"My mum has this one teacher who has known me around since I was in year 5 and whenever I'm upset I go to him and like he'll sort it out and all that"* (CH03)

> *"The last time I saw them (the welfare officer) was sometime in January. Because some people were bullying me and calling me names. And it's been dealt with already"* (YA05)

The benefit that such positive well-being support in educational contexts offers to children and young people, and the variation in experience, suggests further development of this opportunity to implement the Act's principles would be a positive step for this cohort. For example, this might include ensuring uniformity in the availability of well-being support services in schools to all pupils both known and unknown to social care services.

Adults and Well-being

3.23 Compared to children, young people and older people, adults receiving social care and support were less commonly mentioned in the literature on well-being. Adult interview data suggested that service user understanding of the determinants of well-being outlined in the NOF (Welsh Government, 2019) were closely entwined with the discourse of mental health, happiness and emotions. An example would be the NOF indicator of **securing rights and entitlements** which, when felt to be overly **bureaucratic** by service users, prompted considerable stress and anxiety:

> *“Even when we had my PIP [Personal Independence Payment] funding assessment, I’ve got to complete all these forms again, finding time and remembering everything and writing it all down, that in itself…that is more stressful than anything else. And then most of the time you’ve got to challenge them because they can turn it down even though nothing has changed or your health has gotten worse than when you had it the last time, you have to then go to tribunal again” (AD01)*

> *“And I had one company…obviously I had Direct Payments when I was with the company so they would invoice me and then I’d write a cheque and send it to the company. And this one company, they drove me around the bend. She would invoice me for eight mornings of a week” (AD07)*

3.24 **Distrust** of social services was occasionally mentioned as a related factor in this process. Several participants expressed anxiety that assessments may result in a lowering of their care provision, even when these fears were not ultimately borne out:

> *“I have had one increase since 2010. I started out on 15 hours and then they increased it to 25. I’d like 35. That would be perfect. But I daren’t ask because they’ll do a reassessment if I ask” (AD08)*

3.25 For some, this distrust of services was maintained despite a perceived improvement in provision over time. As with the example above, this ingrained suspicion left some participants reluctant to engage fully with assessments. Where there was felt to be genuine understanding between social workers and service users, it was recognised that individual needs were more likely to be reported and acknowledged:

> *“You’re supposed to just meet individual needs. It doesn’t happen. Well-being should be to give good quality of life. Ease as many of the problems as possible. Work as a team, not a constant battle against one another” (AD01)*

> *“I have a dislocated hip so there are ways that they handle me that they can’t necessarily handle someone else with. So each person is individual, so all of my needs have got to be taken into account” (AD02)*

> *“I think it’s evolved. It’s just evolved in that dynamic. It’s not something I would have…I didn’t have any idea of what was available or what wasn’t available or what could help me and what couldn’t help me. That’s evolved over the years” (AD06)*

3.26 Service users in Wales' individual needs in relation to well-being are largely determined through conversations with social workers, often initially through **'What Matters?'** conversations (Social Care Wales, 2019). This approach aims to address such issues, highlighting the uniqueness of individual need and offering a means of identifying previously unknown, but beneficial interventions. However, data offered examples of this varying between participants, in some cases leading to perceived improvements in well-being, and in other cases appearing to provoke frustration and stress. This variation is demonstrable in the cases of AD06, a reformed alcoholic, and AD08, a rural service user who deeply valued caring for her animals, both in relation to the provision of Direct Payments. AD06 developed a strong relationship with their social worker over a long period of time, which led to a greater understanding of what may be beneficial for the individual based on continued dialogue and re-assessment:

> *"I think I've known [social worker] for over ten years. She's seen me at my worse both mentally, physically and psychologically and seen me at my shining, like. So, yeah. It's been a great help" (AD06)*
>
> *"I said I wanted to go fishing and I said I liked browsing around in charity shops and things like that. So if there's time and they are up for it, I've got a blue badge so we go in the car and we can do something more social, like" (AD06)*

3.27 Comparing this to the long-term experiences of AD08 highlights the importance of developing this mutual understanding between social workers, carers and service users:

> *"And my PAs, they do stuff around the house that I can't do, like housework. They help me look after my animals. Because I've got some animals and they are very important to me. And they help me go out and about and access opportunities in the community" (AD08)*
>
> *"Oh, they told me to get rid of them because I can't afford them. And it's like, 'yeah, but I can't get rid of them because I wouldn't be here without them' you know. And I still get very depressed sometimes and I use pills to stop myself killing myself. That sounds a bit dramatic. But obviously the dog is here, he'll come up to me and I'll think I can't leave him…before I had the PAs, I did use to act on my feelings more often and that's why I used to have to go to hospital all the time. Because I've got a habit of self-harm. And I had a habit of small overdoses just to make myself feel better and then large overdoses to try and get*

> *rid of myself and even the animals didn't stop me sometimes when I wasn't getting the right support" (AD08)*

3.28 AD08 attributed some of their previous self-harming behaviours to the level of support being provided. With the arrival of their PAs to aid them and, importantly, a common understanding being reached in relation to their animals, these issues dissipated over time. Such examples outline the importance of positive, genuine interactions between service users and the services themselves. This includes interactions not only with carers or social workers, but also with administration staff. Several participants highlighted a deficit in this regard, suggesting that there was considerable variation in the **quality of interactions** experienced:

> *"I prefer living with [person] now. Because the man I was living with, the man didn't even speak to me in the mornings. He didn't even…you know, when he took me out, he didn't even speak to me, and I felt very confused and upset about why" (AD05)*

> *"So before that I had care agencies to do what mum is doing now. And my experience was generally bad but the odd person was good" (AD07)*

> *"One criticism we both have is that they don't seem to be consistent in the type of people they send as carers. When you look back at the history of this set up, they take on anybody whether they've done any sort of practice at all. And in some cases, they don't seem to know what they ought to be doing" (OP06)*

3.29 The root of most of the complaints outlined above was in poor **communication** and differing **expectations** of how care interactions should be performed. Returning to the notion of unique needs, establishing what these needs may be, what is most valued, and which elements may fluctuate over time requires both initial and ongoing negotiation. It appeared that the prerequisite conversations that enable such negotiations were lacking in many service user interactions, or often where present, little meaningful action had been taken as a consequence.

Older People and Well-being

3.30 As with the children and young people cohorts, there was a cluster of studies and literature on the well-being of older people. Key themes identified as part of the literature review included the importance of family relationships, as well as maintained friendships into later life (Frijters & Beatton, 2012); the growing importance of physical health on perceptions of well-being, and on the well-being of those providing care (Martyr et al., 2015); and the value associated with ongoing activities and social engagement. These were found to broadly align to similarly named dimensions of the NOF (Welsh Government, 2019) such as physical and mental health and emotional well-being; domestic, family, and personal relationships; social and economic well-being; and contribution made to society.

3.31 Each of these themes saw overlaps with the interview data, numerous participants highlighting the role that **interpersonal relationships** played in their well-being:

> *"And my friend I take swimming, I took her last night, totally can't see a thing but never stops. And people are swimming in the lane next to her and she'll get a black eye. And I'm her guide, I've got to shout down the pool to people. It's funny. Everyone laughs at us" (OP03)*
>
> *"I'm happy. The carers are funny, you know. They make me laugh. And anything we want, we've only got to ask them. They'll do anything for you. And even if they are busy, whatever you ask for, they'll do it. Maybe not right away, but it'll be done. And the bosses are great, they're not like bosses" (OP01)*
>
> *"My nephew who is in the area, I don't know exactly where he is, he keeps in touch with me by telephone and he comes to see me…and he also takes me out to the pub because he said, 'I'm not coming here unless you have a drink', so, I'm not a drinking man but I have a glass, it's cordial" (OP08)*

3.32 As noted in the literature (Moreno & Vicente-Virseda, 2016), while family was often regarded as one of the key relationships for well-being (OP08), others such as friendships (OP03) and those with care staff within homes also offered similar positive influences on well-being (OP01). Notably, numerous participants highlighted the impact on their well-being once such relationships became more difficult to maintain, or were not actively encouraged:

> *"There is a communal room but it's not used at all. Which I think is a bit sad, really. But everyone gets on with everybody but there's no, how can I put it? There's no coming together. Everyone keeps themselves to themselves" (OP04)*
>
> *"But it was going down the club and seeing the boys. I didn't go down every night, obviously. But I used to go down maybe three or four times a week. But as it changed and I needed a wheelchair and I had to get down the stairs on my own…" (OP05)*

3.33 The interplay between various determinants of well-being for older people was evident, with this often provoked by gradual physical deterioration. The importance of **physical health** for well-being in older age is well-documented (Llewellyn et al, 2020), with declining health and mobility limiting opportunities to engage with and contribute to society. Numerous older participants highlighted diminished social circles, isolation, problems with accommodation due to mobility issues and becoming increasingly reliant on others, often family members. This, in turn, appeared to provoke self-perceptions of becoming burdensome in some participants, and also sometimes triggering the transition into the care home environment:

> *"It would just be playing on my mind that I'm stopping them from going to [place] . Because that's, well he's less Irish because he lived in the [place]. But I felt like I was stopping them going to [place] or wherever else they wanted to go. The only thing I do miss, really, is seeing my grandchildren" (OP01)*

> *"It was only the last 18 months I was living in the flat that I was finding difficulty with movement. And my brother saw that enough was enough and said they couldn't keep coming around so much, so he said would I mind if they put me into a home…I was a bit peeved at the time but when I sat down and thought about it, and looked at it from his point of view, it was good sense as far as he was concerned" (OP05)*

> *"I decided to come here in July. I made my own mind up that I couldn't cope at home anymore, I lived on my own. My family have been marvellous, but I didn't want to be a burden to them" (OP07)*

3.34 Perceptions of how the transition to the care home environment influenced well-being were particularly nuanced. Many participants stated that they previously valued their independence but ultimately realised more care was required. Adjusting to care home life was aided both by the relationships fostered between residents and staff as outlined above, but also by fostering and encouraging these through **activities and social engagement.** While the literature suggests there is variation in this as people grow older (Litwin & Stoeckel, 2013), the study data demonstrated that recreation and day trips were largely well-received by care home residents, as well as being valued by adults and older people still living and receiving care at home:

> *"I go to my art teacher who lives nearby. She is marvellous with me because she has known me all this time now. If I have a seizure when I'm down there, she just carries on and steps over me. Which is what I'd rather happen, because I don't like people calling ambulances and nothing, there's no need to" (AD03)*

> *"They took us to the Millennium Stadium one year. We closed our eyes and pretended we were rugby players running out. But there weren't any rugby players there. That was a long time ago" (AD05)*

> *"That is my social network really, now, is art group. Because I don't have time to do anything else. But I've made some good friendships through the group. And it's been nice to know that I've been helping other people" (AD08)*

> *"So wherever we go, it's local. Because the driver of the minibus has to go elsewhere. But it's nice to just get out and about for a couple of hours. Get a cup of tea and a cake or an ice cream or whatever" (OP01)*

> *"In the summer, I do a lot of the gardening. We potted the plants and things like that. I put the pots up and the trays and whatever wants doing with the repotting. They buy the plants in anyway, so that's all taken care of" (OP05)*

> *"This bowls thing, I can't stand up and do it, but I can sit down and do it. And we go to concerts. We go to singing. Every morning from 11 to 1, I think it's 11 to 1, if you go down to the entrance, you'll hear us all. We're all sitting around in the corner there and we are singing songs. We've got somebody on the piano" (OP07)*

3.35 Certainly the frequency with which activities and recreation were mentioned in relation to well-being suggests that, while not benefitting everyone, offering a range of inclusive activities in care homes may enhance well-being for many. This aligns with much of the research outlined in the literature review suggesting that such activities may counter-balance some of the detrimental impacts of ageing on well-being (Simone & Hass, 2013; Ku et al., 2016).

The relationship between expectations, lived experience, and well-being

3.36 The reference (or 'stable') points for a baseline sense of subjective well-being vary between individuals, and shift over time based on life experiences (Lucas et al., 2004). In other words, some people have a consistently higher sense of subjective well-being than others with similar lived experience; however, in all cases, life events can alter that baseline temporarily or permanently. This supports the notion that interactions with social care have the potential to improve or damage well-being.

3.37 In our qualitative findings, an important aspect of these service interactions was how a service user's expectations of the support they should receive was carried through to their lived experience of the actual support offered. Where expectations of social care support were higher than they experienced, this disjuncture appeared to lead to stress and frustration, produce negative impressions of social services and, subsequently, negatively impact their subjective well-being. AD01, for instance, was involved with various co-production initiatives and felt that this had informed their perspectives on social services provision. The knowledge of the Act gained through this participation left AD01 aggrieved when they felt service provision did not meet their expectations. Where service users feel that their concerns are not being addressed, that services are not as expected, or that they are not being listened to, this has the potential to negatively impact subjective well-being.

3.38 Conversely, where expectations were relatively low or uninformed, participants appeared to be more satisfied with their interactions with social services. Opaque expectations, however, are not a sustainable pathway to better subjective well-being for those accessing social care due to their contradiction with the voice and control, and co-production principles. A greater understanding of how service user expectations influence both their well-being and their experiences of service provision may be an important future consideration.

3.39 A key forum in which the interplay of expectations and experiences can be observed is through the 'What Matters?' conversations and assessments. During these discussions, service user expectations of social care provision can be managed ahead of their lived experience of care provision and the outcomes of the assessment to mitigate disparities between those expectations and experiences. In other words, professionals should ensure that during What Matters? conversations they do not over-promise on service capacity or availability, or the ability of services to solve every issue raised. In positive cases where interactions with social care improved subjective well-being, participants reported feeling consistently listened to, being clear about what support was available, and their wishes being acted upon in meaningful ways. For instance, AD06 saw their interactions with social workers and carers evolving over time, addressing various aspects of their well-being in the process. AD06 also saw meaningful dimensions of their well-being, such as going shopping with carers or taking other trips outside, become normalised in their day-to-day life. Crucial to this positive impact is that the conversation led to tangible action in ways that were highly impactful on the life of AD06. It is therefore important that ‘What Matters?’ conversations are transparent regarding what services and support are possible to avoid raising expectations that may then not be met.

Quantitative Findings

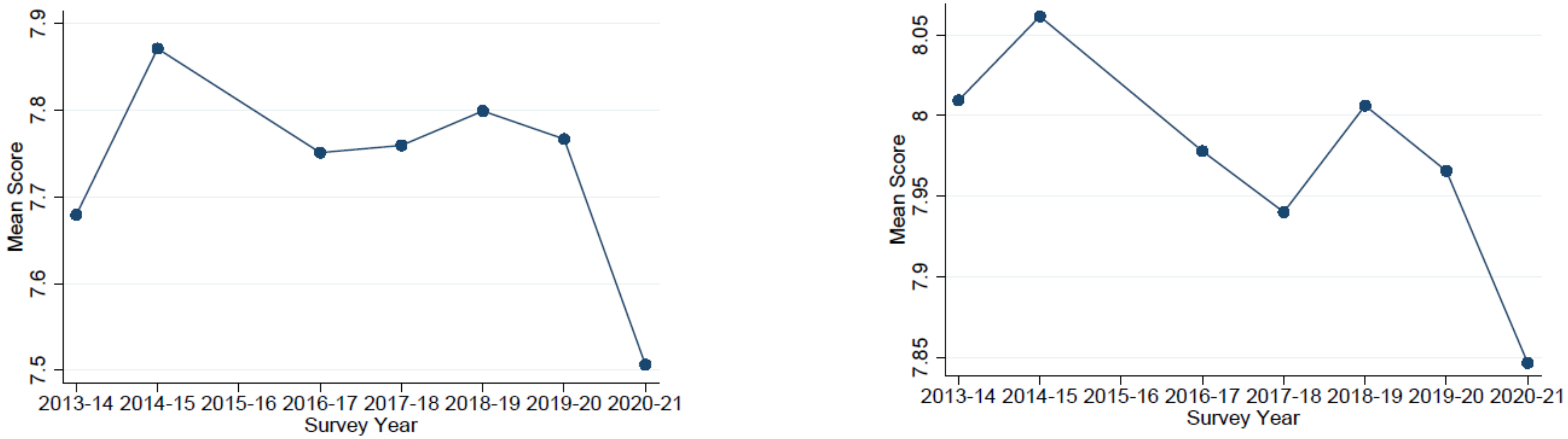
3.40 For various reasons, the National Survey sample size varies over the study time period with a minimum of 10,520 participants in 2016-17 and a maximum of 15,795 participants in 2020-21. No data was available for 2015-16 due to the piloting of the wider redesigned survey from 2016 onwards.

3.41 Figure 3.1 shows how the four ONS personal well-being measures captured within National Survey have changed for the general Welsh population over the seven years for which survey data is available. Between 2013 and 2020 there were fluctuations through time, overall resulting in slight reductions in the well-being measures relating to life satisfaction, life worthwhileness, and happiness. Average anxiety scores also increased over this period. However, the most notable change in the four well-being measures was during the COVID 19 pandemic. In 2020-21, scores across all four measures indicate a substantial reduction in well-being in the general population, following the start of the pandemic. While the change in the method of administrating the National Survey may have played a role, it is also likely influenced by respondents' experience of the pandemic.

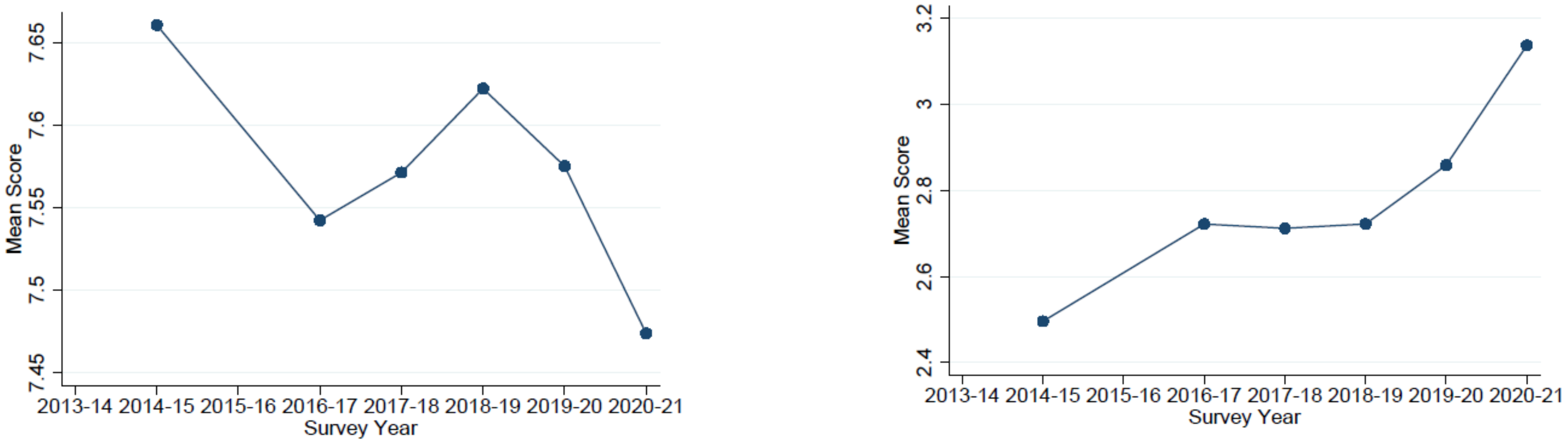
3.42 Figures 3.2 and 3.3 show how the four well-being measures captured within the National Survey changed for the carer and LLSIDI groups. Compared to the general population, the LLSIDI group have lower mean scores for life satisfaction, life worthwhileness, and happiness measures, and higher mean anxiety scores.

3.43 However, unlike the general population scores, from 2013 to 2020, life satisfaction, worthwhileness of life, and happiness either remained stable or slightly increased, though anxiety scores increased over time. For the COVID-19 period, both carers and the LLSIDI group experienced reductions in well-being, including a decrease in life satisfaction, worthwhileness of life and happiness scores, and increased anxiety scores.

Figure 3.1: General Population Mean Well-being Scores 2013-2021


Satisfaction with Life

Life Worthwhile


Felt Happy Yesterday

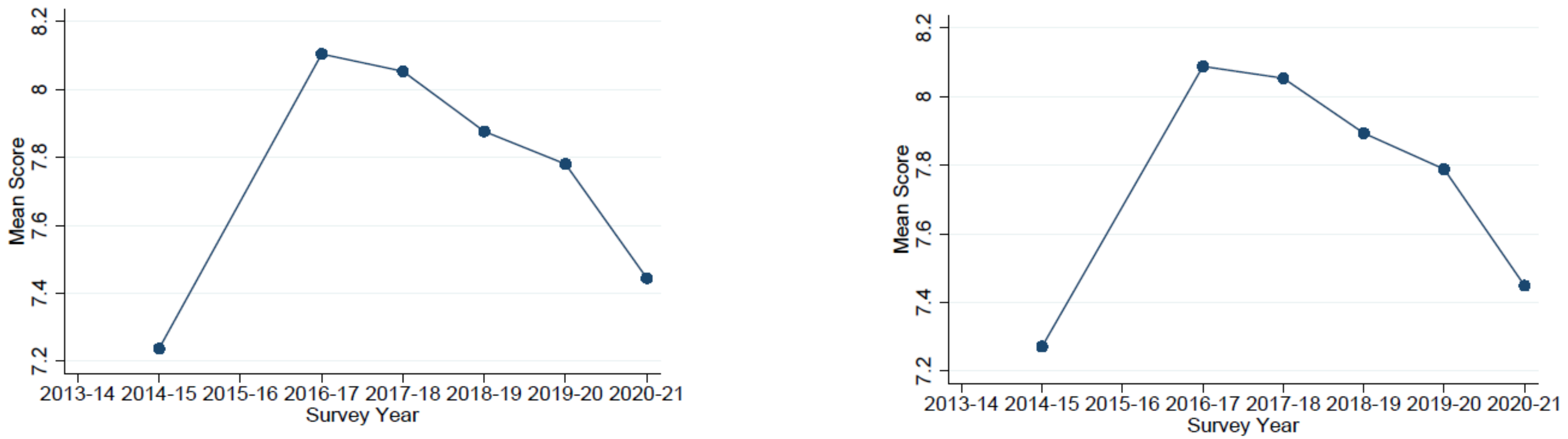
Felt Anxious Yesterday

Mean wellbeing scores adjusted for adult sample weight

Figure 3.2: Carer Mean Well-being Scores 2013-2021[9]

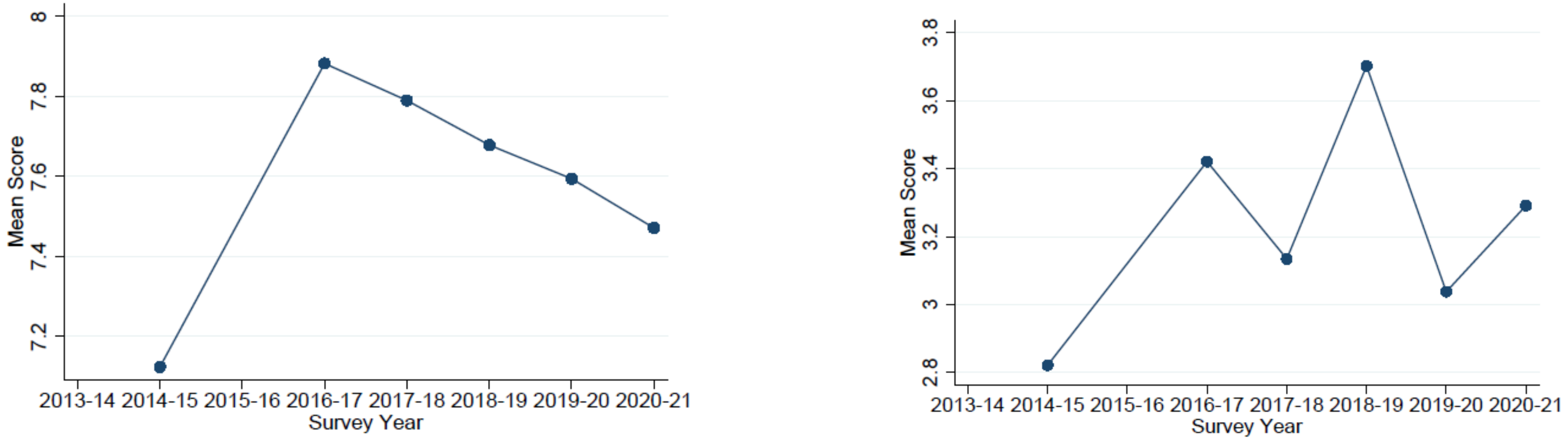
Satisfaction with Life

Life Worthwhile



Felt Happy Yesterday

Felt Anxious Yesterday

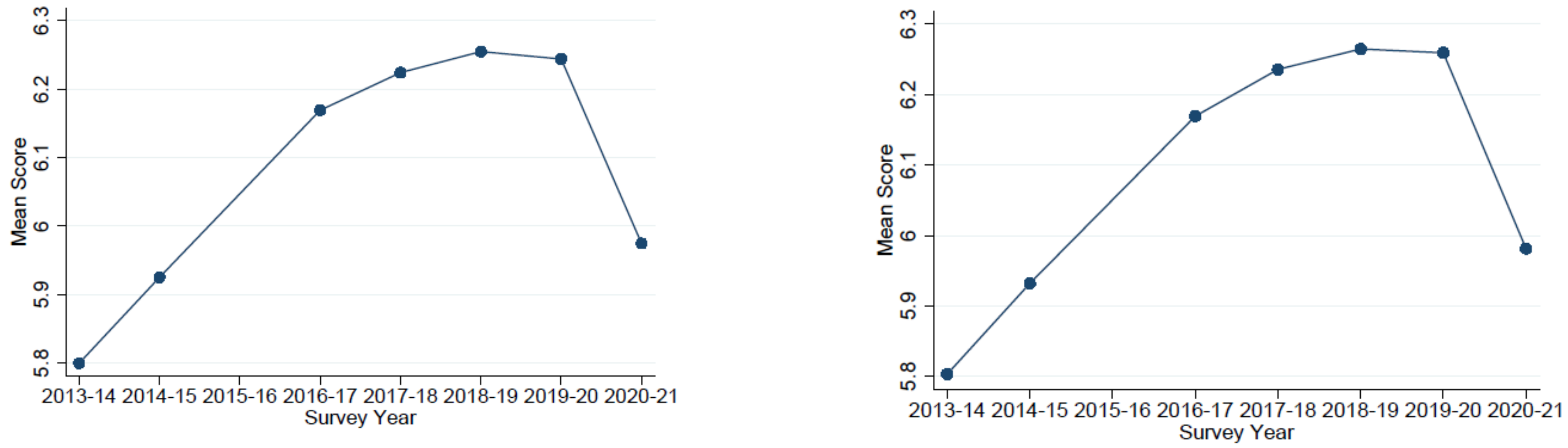


Mean wellbeing scores adjusted for adult sample weight

---

[9] The data on which these graphs are based has not been consistent over the period. The question on carer status was revised and introduced for the 2017-18 NSW.

Figure 3.3: People with a limiting long-standing illness, disability or infirmity Mean Well-being Scores 2013-2021


Satisfaction with Life

Life Worthwhile


Felt Happy Yesterday

Felt Anxious Yesterday

Mean wellbeing scores adjusted for adult sample weight

3.44 A comparison between the general population and carer well-being (Figures 3.1 and 3.2) reveals that, whilst the scores for 'satisfaction with life' and 'felt happy yesterday' are broadly similar across the two groups, carers have higher scores on both the 'life worthwhile' question, representing higher well-being, and higher scores on the 'felt anxious yesterday' question, representing lower well-being. The between group difference in all four scores appears smaller in the years 2020-21, which might indicate a greater negative impact of the COVID-19 pandemic on the well-being of carers than the general population.

3.45 Changes in well-being cannot be attributed to the Act due to the many other factors that could have impacted well-being over this period. However, there are interesting differences between changes in well-being pre and post Act for both the general population and people with a LLSIDI.

3.46 When the GLM analysis was undertaken for the pre-Act and post-Act time periods for the general population, the findings suggest that since 2016, slight reductions in well-being occurred in the general Welsh population.[10] An additional reduction in well-being associated with the COVID-19 outbreak was observed for all four measures. For life satisfaction, worthwhileness of life, and happiness, average scores in both the pre-Act and post-Act periods are classified as high, whilst average anxiety in both pre-Act and post-Act periods is classified as low. Whilst the reductions since 2016 were small for worthwhileness of life and happiness, they were statistically significant. The largest difference in score was observed for the anxiety measure when COVID-19 struck, with a statistically significant increase in scores of 0.28.

3.47 Compared to the general population, people with LLSIDI have lower well-being scores across all four measures in both the pre-Act and post-Act periods. There are however subtle differences in how well-being for this sub-group changed in the post-Act period compared to the general population. A statistically significant improvement in life satisfaction is observed in the post-Act period, whilst there was no statistically significant change in either the worthwhileness of life or happiness measures. Analogous to the general population, an increase in anxiety scores was observed for the LLSIDI group in the post-Act period.

---

[10] It was not possible to conduct this analysis for data on carers due to changes in how carers are identified in the NSW as described in Paragraph 2.2.

3.48 Similar findings are observed in the LLSIDI group in the separate post-Act COVID-19 sensitivity analysis. Pre-COVID, there was a significant increase in life satisfaction but no change in worthwhileness of life or happiness compared to the pre-Act period; significant increases in anxiety were also observed. During the COVID-19 outbreak, scores across all four well-being measures for the LLSIDI group were impacted negatively. For the life satisfaction, worthwhileness of life, and happiness measures, the reduction in well-being during the COVID-19 outbreak was larger than for the general population. However, the increase in anxiety was greater in the general population than in the LLSIDI group.

4. Discussion

4.1 Our discussion is framed around the research questions presented in the introduction to this report and the related quantitative analyses. Firstly, we explore the overlaps and disjuncture between service user conceptions of well-being and those highlighted in the Act and NOF. We then highlight elements of well-being identified within the data that extend beyond or problematise existing government criteria within the NOF, before discussing how participants associated well-being with other related concepts such as happiness, mental health and quality of life. We consider the quantitative data analyses which approach the issue of well-being under the Act from an alternative angle. Finally we conclude the discussion with a consideration of how well-being is measured under the Act, which has implications for the Welsh conceptualisation of well-being and for how we might track the Act's impact in the future.

Do participants share the understanding of well-being that is applied within the Act and the NOF?

4.2 Yes, to a significant degree, with participants introducing some additional considerations. The findings outlined above demonstrate substantial overlap between the determinants of well-being listed within the NOF and the experiences and views reported by participants from all cohorts. Aspects of life such as personal relationships, living accommodation, securing rights and entitlements, physical health, recreational activities, education and contribution to society (all important determinants of well-being) emerged in interviews as being of significance to at least some participants. Additionally, these understandings of well-being also align with many of the national well-being outcomes in the National Survey (Welsh Government, 2020) suggesting that the National Survey could be an appropriate method of capturing objective and simplified subjective well-being measures in the context of the Act and NOF. Change in these determinants should drive change in well-being and be reflected in the four well-being questions in the National Survey.

What aspects of personal well-being do participants raise that are not covered within the Act or the NOF?

4.3 **Accountability for decision making:** The capacity to secure rights and entitlements, such as the right to participate in decision making and have views accounted for, is the first, and hence most prominent, indicator of well-being outlined within the NOF. This prominence aligned with the importance of rights and entitlements to those we interviewed for this study. However, our interviews did reveal a shortcoming within the outcomes relating to this aspect of well-being that would suggest the NOF is not fully capturing what it means to people who need care and support: the accountability for decision making by care organisations. In other words, people wished not only to have a voice in decision making, but also to understand why decisions had ultimately been made through the transparent and timely communication of those decisions where they affected them directly, along with a justification if those decisions did not align with their own views or wishes.

4.4 While participants strongly valued being able to share their views and experiences and have them incorporated into decisions around their care and support, several participants shared a feeling of dissatisfaction around how social services decisions were communicated, as well as their level of knowledge or input around those decisions. The opaque nature of decision making in social care led some participants to feel disillusioned or distrustful of professionals and organisations. This could apply to both service level decisions and individual care planning decisions.

4.5 One pertinent example is the dissolution of the dedicated 16+ team within a local authority, where those whom this internal decision affected were unaware that the decision had been made or the reasons for it, leading to a sense of abandonment in the participant reporting this. A further example is AD02's frustration at not being permitted to see the criteria through which care and support services had been denied. AD06 described how they had no idea about what services were or were not available and did not know how to obtain this information. Repeatedly participants described how decision making at local authority level was opaque and how this provided them a frustrating lack of control or input.

4.6 The national well-being outcomes for those who receive care and support include "My voice is heard and listened to", "My individual circumstances are considered", and "I speak for myself and contribute to the decisions that affect my life or have someone who can do it for me" (Welsh Government, 2016). However, these intended well-being outcomes are at risk if people using services are not offered any indication they have been listened to, or their individual circumstances considered. Alternatively, people may be more accepting of social care decision making even if it does not meet their wishes or expectations when a viable rationale has been offered for this shortfall. This suggests the consideration of an additional criteria for securing rights and entitlements as an aspect of well-being: that those making decisions about care and support be meaningfully accountable for those decisions through appropriate information sharing or providing opportunities to provide input or feedback regarding those decisions. Should accountability for the decisions made, to people accessing services, be incorporated into the expectations for service delivery in the above manner, it will contribute to the mitigation of multiple concerns and disillusionment we heard from participants within this study regarding how services handle their expressed wishes and needs, and thus support the improvement of their well-being related to a sense of agency. It will also support improved trust and relationships with professionals, which relates to our next point.

4.7 **Relationships with professionals**: Our findings reveal that the ways in which the positive relationships indicator is described within the NOF may not capture importance to our participants. The NOF references the quality of 'domestic, family and personal relationships' as a core aspect of well-being, but excluded from this are relationships with professionals, which for many in need of care and support may be a relationship of great personal significance. This is captured within the narratives of AD06 and OP01. While we were unable to capture many views of children and young people in care within this study, a multitude of other studies have found that a looked-after child's relationship with their social worker, and their sense of security and trust in that relationship may have a profound influence on their well-being outcomes. Our findings, paired with those of other studies, raise the question of whether well-being standards should include expectations around the quality and consistency of relationships with professionals.

4.8 **Choice over level of control over care planning**: Despite the positive framing of 'personalised' social care within the Act, including the responsibility of managing one's own care and support delivery, several participants identified this responsibility under the Act as a source of stress detrimental to their well-being. It could therefore be proposed that an element of well-being absent from the NOF could be the ability to choose the degree to which an individual is asked to adopt the responsibility for control over their care planning and associated budgets. Importantly this would also impact the Codes of Practice associated with the Act alongside the NOF; this may be helpful in improving well-being for those who lack the time, capacity or inclination to engage in care planning and budget management.

4.9 Desired levels of agency and confidence around managing care and support differ between individuals. However, the policy drive towards personalised social care does not sufficiently address this variability. Judgements of whether someone is able to manage their care are made by professionals according to their deemed mental capacity, rather than being based upon the preferences, lifestyle capacity, and well-being of an individual. This finding speaks to a broader, more fundamental question around personalisation and social care: is it always reasonable to expect an individual receiving care and support to have a better understanding of their own well-being needs, and the capacity to express those needs and act upon them, than a professional? This question is beyond the scope of this study and too complex to answer here. Nevertheless, some of the narratives shared by participants suggest that an assumption that more individual control over care and support is universally positive for well-being may be problematic.

How do participants locate well-being in relation to interlinked concepts, such as mental health, quality of life, life satisfaction, and happiness?

4.10 Within our data, well-being emerged as an umbrella term that encompassed all the above interlinked concepts to some degree and depended on them each being adequately fulfilled in order to achieve some sense of ‘positive well-being’. For many participants the concept of well-being appeared to primarily cohere around physical and mental health, with additional reference to having their own views and choices respected in their daily life.

4.11 The concept quality of life has its basis in health literature and presents a meeting point between the states of physical condition and social well-being. Appropriate support for physical health and the impact of health conditions on daily lives was a very frequent topic for adult participants to focus on, though less so for children and younger adults, perhaps due to less physical health problems occurring in their lived experience. In this sense, adult participants seemed to locate quality of life – in its medicalised definition – as a cornerstone, but not the whole of well-being. In other words, in middle and later life it appears that a standard of living appropriate to physical state was key to achieving positive well-being.

4.12 AD01 was particularly strong on the importance of quality of life to well-being, sharing their views that their care should be adapted to their medical needs to ensure they could still exercise agency without being limited by their physical health. AD02, AD03, AD06, and YA03 highlighted whether or not they were in pain that day or their general physical health as a core criterion for a sense of well-being.

> *"To me, the word well-being, is like a person's state. So their physical and mental state and how well they are mentally and physically… So it's all about making sure an individual person is physically and mentally okay and to make sure they are stable and have the help that they need" (AD06)*

4.13 From this we can understand that quality of life may not be a separable concept from well-being for adults and older people receiving care and support and must be incorporated within our understandings. The implication of this may be a further conflation of health and social care outcomes to locate them as fully interlinked. However, while quality of life, in a physical respect, may be necessary to achieve well-being, this relationship may not be reciprocal; one's physical health needs may be fully met and yet if other aspects of well-being are not addressed then a person's sense of well-being may be low.

4.14 Numerous participants mentioned mental health directly, alongside related notions such as 'stress' or 'anxiety', as being important to their well-being. Interestingly, this emerged relatively often in relation to several indicators in the NOF including **securing rights and entitlements, accommodation, relationships, recreation and physical health**, as well as a factor in and of itself. Within the realm of each indicator, participants implied that their emotional well-being could be influenced both positively and negatively, with social services often a contributory factor in this. For instance, AD01 and AD07 highlighted how negative interactions with social workers, or the services more broadly, prompted detrimental effects on their mental health. Similarly, AD03 contextualised some of their historic mental health issues in respect to loneliness and the absence of personal relationships, something alleviated by social services intervening and offering sheltered accommodation. The interlinked nature of many of the NOF indicators became more apparent through participants framing them in relation to issues of mental health.

4.15 Some participants were very clear that 'feeling happy' was a core aspect of well-being, but interestingly this emerged in a very specific way. Throughout the interviews where participants talked about feeling 'happy', they usually grounded this in positive communication, trust, and social experiences, suggesting that for many participants 'happiness' is a state of well-being specifically linked to quality relationships. OP01 and YA09 highlighted that good times and trust with professionals supporting them were crucial to their own sense of happiness, while AD06 recounted how relationships with their family and, importantly, the capacity to support them was something that made them feel happiness. OP02 expanded this definition, discussing how they felt happiness in their security and feeling safe in their care home with freedom in relation to activities, a sentiment echoed by YA09, who linked happiness to being able to express oneself through hobbies. These data suggest that happiness for our participants encompassed the more emotional aspects of well-being around relationality and reciprocity.

4.16 Finally, while rarely mentioned directly by participants, ‘life satisfaction’ was entwined with numerous themes emerging from the analysis, often in association with other related terms such as ‘quality of life’. Generally, satisfaction was related to issues of agency and control, most clearly demonstrated through autonomy in deciding on recreational or day-to-day activities. A primary example of positively influenced life satisfaction came through AD06’s arranged day trips with carers, negotiated over time. Likewise, OP07’s reporting of their involvement with activities in their care home, suggested that these played a key role in their well-being and day-to-day enjoyment of life. As a counterpoint, AD01 felt that the aspects of life offering them satisfaction were curtailed by a lack of support from social services. Again, as with the concepts outlined above, service users’ sense of life satisfaction was apparently influenced both positively and negatively by their interactions with the service through linkage to activities or social networks, advice on accommodation issues, and sometimes in their contribution to society. Consideration of each of these interlinked concepts should inform how social services attempt to deliver support and assistance so as to maximise individuals’ potential for positive well-being.

How is the implementation of the Act reflected in the National Survey for Wales?

4.17 Our analyses suggest that since 2016, there were slight reductions in well-being across Wales for the general population; scores for worthwhileness of life and happiness measures showed small but statistically significant reductions, whilst increases for anxiety were also observed. Similar trends were also observed for the carer and LLSIDI sub-groups.

4.18 The Act was one of many factors which may have influenced well-being during the sample period. For example, significant reductions in well-being were observed across all groups during the COVID-19 outbreak. These findings were expected, due to a variety of factors associated with pandemic. These factors are likely to have included issues around the imposed restrictions on individual freedoms alongside more personal responses to the loss of life and concern for others caused by COVID-19. Given these factors, results from the National Survey for this period are not directly comparable to previous years.

4.19 There are limitations to the approach used for the analysis. Whilst we are able to identify trends in well-being (subject to the issues raised in Paragraph 4.18), it has not been possible to directly attribute these to the Act. In addition, the data used are from a general population survey and the proxy chosen may not accurately capture the population who receive care and support. Additionally, there were changes in how the survey was conducted over the period of interest, including survey design, delivery method and average length, which may have resulted in differences to how people respond to the questions of interest. Furthermore, the survey content is not fixed from one survey round to the next, with some questions used in some years and not in others.

4.20 The National Survey does not include any data for adults living in institutionalised accommodation who are more likely to require care support. The omission of any data for children is a further limitation in using the National Survey for our purposes, with the Act also targeted to meet the needs of children and young people.

4.21 Sub-group analyses considered individuals with LLSIDI. This was chosen as a proxy for those receiving care due to availability in the National Survey throughout the study. Whilst it is possible that these individuals would be in receipt of care and support, it is not inclusive of all individuals who have been implicated in the Act. The National Survey does include a question allowing identification of people who receive care and support, but this was not chosen for analysis due to its omission in some years relevant to our study.

4.22 The Act has implications for carers. Our analysis has looked at descriptive statistics for those identifying as carers but has not been able to conduct full analysis on this dataset due to changes in the survey design including changes to the question on whether individuals are carers.

4.23 Nonetheless we were able to use the four ONS well-being measures which were consistently collected throughout the study period. The four well-being measures have provided insight regarding how various aspects of individual well-being have changed since the introduction of the Act.

4.24 The COVID-19 outbreak in 2020 and the associated restrictions imposed on society in Wales appears to have had a negative impact on all measures of well-being, with those living with LLSIDI, or who have caring responsibilities experiencing the largest reductions. Whilst this is unsurprising, this has likely mitigated any improvement in well-being associated with the Act.

4.25 The analyses performed cannot attribute change to the Act. Well-being is a complex concept, impacted by various factors not directly related to the Act. In addition, the Act is targeted to those receiving or delivering care and support; therefore any reduction in well-being in the general population is unlikely to be predominantly caused by the Act. Interpretation of our analyses should be cautious, and in the context of these background changes.

Measuring Well-being Under the Act

4.26 Our findings produced some reflection on the implications for the measurement of well-being under the Act. Here we reference the three measurement groupings outlined by Dolan & Metcalfe (2013): i) evaluation; ii) experience measures; and iii) eudemonic measures (see Table 5.1 for examples).

Table 5.1: Dolan and Metcalfe (2013) measures of well-being and application in Welsh Government

Dolan and Metcalfe's Well-being measures	Welsh Government
Evaluation	Life satisfaction questions and indicators are included in the National Survey e.g., 'Overall, how satisfied are you with your life nowadays?' though these predominantly satisfy Dolan & Metcalfe's criteria for monitoring progress as opposed to informing or appraising policy
Experience	Anxiety and happiness questions are also included within the National Survey - 'Overall, how happy did you feel yesterday?'; 'Overall, how anxious did you feel yesterday?'
Eudemonic	National Survey also incorporates a question on the worthwhileness of life - 'Overall, to what extent do you feel that the things you do in your life are worthwhile?'

4.27 Nevertheless, as Dolan and Metcalfe (2013) also note, there is considerable conceptual complexity associated with how well-being is measured. Within this, what is perceived to influence well-being is seen as dynamic, evolving over time. The National Survey offers an annual national picture of well-being, inclusive of (many of) those receiving care and support, though the level of detail associated with each of the well-being determinants, as well as specific issues unique to those receiving care and support, have varied over time.

4.28 A potential gap within these measures may be the disjuncture between the achievement of personalised well-being outcomes at an individual level (as identified through national surveys such as the National Survey) and change in the determinants of well-being associated with the NOF indicators. The NOF itself states:

> *“When people who need care and support and carers who need support co-produce their personal well-being outcomes with services, people can expect to achieve personal outcomes which reflect the national well-being outcomes defined in the well-being statement” (Welsh Government, 2019; 6)*

4.29 Yet, given the complexity of well-being, its use in informing design, progress and impact of policy outlined by Dolan and Metcalfe (2013), as well as the aggregation of personal outcomes, this statement may not wholly align with that of the wider well-being outcomes.

5. Conclusions

5.1 Our findings highlight considerable overlap both between the concepts of well-being anchored in the Social Services & Well-being (Wales) Act 2014 and those outlined in the literature, as well as the data from service users. Many of the key themes emanating from the literature review specifically in relation to the well-being of children, younger people, adults and older people were echoed by these participant cohorts, particularly with regard to cross-cutting themes such as family and personal relationships.

5.2 In terms of how experiences of social services interact with well-being, it was evident that initiatives identifying suitable accommodation for and with service users, as well as information provision around recreational activities and volunteering were beneficial to many. However, for some of the adult cohort in particular, issues around securing rights and entitlements highlighted a ‘hotspot’ where service provision had potential to negatively influence well-being.

5.3 Stemming from this, we have identified three apparently important dimensions to well-being that are not overtly outlined in the Act or the NOF: accountability; relationships with professionals; choice over level of control. Users across each of the cohorts offered narratives and examples where each of these aspects negatively influenced their well-being. Conversely, in positive narratives it was evident that people’s well-being had benefited from positive and transparent relationships with professionals or social workers. Also, being able to decide the level of control, independence and autonomy that was suitable and desirable for individuals had a positive impact on well-being.

5.4 In order to further develop the well-being principle of the Act, we recommend further exploration of how and to what extent subjective personal well-being outcomes entwine with the objective national indicators of well-being. Well-being is notably complex and contested, incorporating subjective notions of what is good for oneself. National outcomes, for instance, on the proportion of service users on direct payments is potentially a determinant of well-being, but there is the potential to overlook the key issue of whether the user feels this way of working is the best for them. Careful consideration is needed of the influences on well-being at the individual level as well as at a population level, and the interplay between these different influences will need further exploration.

5.5 We found that the concept of well-being applied in Welsh policy and practice largely resonated with the lived experiences and views of people using services. However, while this conceptual alignment is a positive finding in terms of delivering improvement to well-being, clear challenges for well-being focused services also emerged, such as the level of responsibility desired for managing payments, the maintenance of relationships and social life, and, in relation to rights and citizenship, that service user views were not only listened to but subsequently acted upon.

5.6 Finally, given that the qualitative data were collected prior to the COVID-19 pandemic and subsequent lockdowns, this report is unable to take into account how service users' well-being and perceptions of service delivery were impacted. However, given the findings outlined here, and the withdrawal of many standard services, it is likely that some features of relationship-based well-being (e.g., community groups, day centres, care home visits) will have been compromised.

Recommendations

5.7 The well-being element of the Act proposed an ambitious aim for social care in Wales: to extend its reach beyond offering core care services by actively engaging in the promotion and improvement of the well-being of people accessing such services.

5.8 Well-being is, by definition, a holistic concept that draws from all domains of a person's life including the relational, emotional, and physical. Herein lies the admirable ambition of the Act, as to accomplish holistic, measurable well-being improvements in a substantial group of the population. who are generally facing hardship of varying kinds in key areas of their lives, is an extremely challenging task.

5.9 Whilst this aim is commendable, this evaluation study has identified two fundamental problems relating to delivering that improvement in well-being which are hindering the ambitions of the Act:

- **The definition of well-being applied within the Act, and the related measurement strategies that this definition has produced, are not fully coherent with evidence surrounding the conceptual use of well-being within other policy contexts.** The outcome of this partial coherence is that the ability to measure and understand the impact of the Act on the well-being of people accessing social care is very limited. The data sources are restricted, and in available data (such as the National Survey for Wales), the ability to identify the people who access and use social care, and their carers, is inconsistently available. Additionally, the measurement tools employed and cited as capturing well-being status and its change after implementation of the Act are not sufficient to capture its impact in driving change in well-being within the relevant population.

- **There is a significant degree of ambition demonstrated within the language of the Act around well-being. However, there has been a substantial gap between that ambition and the reality of delivering – and receiving – social care services under strained budgets and an unstable workforce, latterly further impacted by the COVID-19 pandemic.** In relation to well-being, this gap is particularly problematic. Our study has identified that where expectations of services are raised by the language employed within or around the Act and not met, there is a detrimental effect on well-being. The disappointment produced is followed by mistrust and disengagement, fuelling negative impressions of and relationships with professionals who otherwise may have the capacity to contribute positively to people's well-being. In other words, unfortunately the ambition of the well-being elements of the Act may be contributing negatively to both people's impression of social care in Wales and their well-being. Furthermore, this may have a secondary effect on the workforce who at times expressed a sense of disillusionment originating from the gap between the aspirational language of the Act and the reality of their capacity to deliver it.

5.10 There are three responses to these two issues that we recommend are adopted:

1. **Establish and communicate a simple, clear definition of well-being, aligned with the literature and with the intent of the Act.** Though the NOF and the Welsh Government Well-being Statement look to provide clarity on the indicators that underpin well-being, these do not help to understand what the state of well-being is, in and of itself as it relates to people's personal, subjective sense of their well-being. Cementing this definition could be used as a moment of re-engaging with the overarching principle of the Act and could be easily communicated to all engaged in monitoring, delivering, and receiving social care.

2. **Investment in improved measurement of well-being in numerous settings delivering social care services at the interface of service delivery.** These should be in addition to the National Survey for Wales and in line with the established definition as above with the following criteria – that they are:[11]
    - Measuring subjective well-being with equal weighting to objective/external well-being;
    - Designed for and relevant to people accessing social care services at the interface of service delivery, with age, language, and capacity modifications to allow broad implementation;
    - Routinely measured by local authority departments and organisations, and collated at both local and national level; and
    - Collected through the above to be published, analysed, and acted upon at local and national level to support service and well-being improvement.
3. **Modification of three criteria in the NOF.** Changing the three measures below could help to engage social care and health professionals in the wider use of, and reference to, the revised NOF in practice:
    - Extension of ‘relationships’ to include relationships with supporting professionals as key to well-being;
    - Extension of ‘rights and entitlements’ to include the accountability of services to people accessing them, including information on what decisions were made relating to their care and personalised reasons given for those decisions; and
    - Change in control over services to include a choice over the degree of control an individual would like to have over their services.

---

[11] Given the multiple barriers to additional routine data collection at local and organisational level, it is critical that the above recommendation is undertaken in a fully collaborative manner with social care stakeholders at both senior and local level to ensure success

References

Broadhurst, K., Hall, C., Wastell, D., White, S., & Pithouse, A. (2010). Risk, instrumentalism and the humane project in social work: Identifying the informal logics of risk management in children's statutory services. *British Journal of Social Work*, 40(4), 1046-1064.

Burrows, D., Lyttleton-Smith, J., Sheehan, L., & Jones, S. (2021). Voices of carers during the COVID-19 pandemic: messages for the future of unpaid caring in Wales. *Cardiff University Report/NHS Wales.* Available at: Voices of carers during the COVID-19 pandemic [Accessed 05/05/22]

Cossar, J., Brandon, M., & Jordan, P. (2016). 'You've got to trust her and she's got to trust you': Children's views on participation in the child protection system. *Child & Family Social Work*, *21*(1), 103-112.

Dolan, P., & Metcalfe, R. (2013). Measuring subjective well-being: Recommendations on measures for use by national governments. *Journal of Social Policy*, 41(2), 409-427.

Frijters, P., & Beatton, T. (2012). The mystery of the U-shaped relationship between happiness and age. *Journal of Economic Behaviour & Organization*, 82(2-3), 525-542.

Hart, C. S., & Brando, N. (2018). A capability approach to children's well-being, agency and participatory rights in education. *European Journal of Education*, 53(3), 293-309.

Ku, P. W., Fox, K. R., & Chen, L. J. (2016). Leisure-time physical activity, sedentary behaviours and subjective well-being in older adults: An eight-year longitudinal research. *Social Indicators Research*, 127(3), 1349-1361.

Litwin, H., & Stoeckel, K. J. (2013). Social networks and subjective well-being among older Europeans: does age make a difference? *Ageing & Society*, 33(7), 1263-1281.

Llewellyn M, Verity F, Wallace S, Calder G, Garthwaite T, Lyttleton-Smith J, and Read S (2023). *From Act to Impact? Final Report of the Evaluation of the Social Services and Well-being (Wales) Act 2014.* Cardiff. Welsh Government, GSR report number 36/2023. Available at: Final Report.

Llewellyn, M., Verity, F. and Wallace, S (eds) (2020). *Evaluation of the Social Services and Well-being (Wales) Act 2014: Literature Review*. Cardiff. Welsh Government, GSR report number 60/2020. Available at: Literature Review.

Llewellyn, M., Verity, F. and Wallace, S (eds) (2023). *Evaluation of the Social Services and Well-being (Wales) Act 2014: Literature Review*. 2nd Edn. Cardiff. Welsh Government, GSR report number 42/2023. Available at: Literature Review.

Long, S. J., Evans, R. E., Fletcher, A., Hewitt, G., Murphy, S., Young, H., & Moore, G. F. (2017). Comparison of substance use, subjective well-being and interpersonal relationships among young people in foster care and private households: A cross sectional analysis of the School Health Research Network survey in Wales. *BMJ Open*, 7(2), 1–10. A cross sectional analysis of the School Health Research Network survey in Wales.

Lucas, R. E., Clark, A. E., Georgellis, Y., & Diener, E. (2004). Unemployment alters the set point for life satisfaction. *Psychological science*, *15*(1), 8-13.

Lyttleton-Smith, J. (2017). *Young carers speak out! Final Report. Project Report*. Cardiff: Cardiff University.

Martyr, A., Nelis, S. M., Quinn, C., Wu, Y. T., Lamont, R. A., Henderson, C., ... & Morris, R. G. (2018). Living well with dementia: a systematic review and correlational meta-analysis of factors associated with quality of life, well-being and life satisfaction in people with dementia. *Psychological medicine*, 48(13), 2130-2139.

McLeod, J., & Wright, K. (2016). What does wellbeing do? An approach to defamiliarize keywords in youth studies. *Journal of Youth Studies*, *19*(6), 776–792.

Moreno, A., & Vicente-Virseda, J. A. (2016). Family Situation, Social Protection, and Well-being of Older Adults from an European Comparative Perspective. *Research on Ageing and Social Policy*, 4(2), 96-127.

Selwyn, J., Wood, M., & Newman, T. (2017). Looked after children and young people in England: Developing measures of subjective well-being. *Child Indicators Research*, 10(2), 363-380.

Sen A (2009). *Idea of Justice*. Oxford. Oxford University Press.

Simone, P. M., & Haas, A. L. (2013). Frailty, leisure activity and functional status in older adults: Relationship with subjective well-being. *Clinical Gerontologist*, 36(4), 275-293.

Social Care Wales (2019). *What matters conversations and assessment* [online]. Available at: What matters conversations and assessment - [Accessed 16/12/2020].

Welsh Government (2014). *Social Services and Well-being (Wales) Act 2014 [online].* Available at: Social Services and Well-being (Wales) Act 2014 - [Accessed 16/12/2020].

Welsh Government (2016). *Well-being statement for people who need care and support and carers who need support [online].* Available at: Well-being statement for people who need care and carers - [Accessed 11/11/2022].

Welsh Government (2019). The national outcomes framework for people who need care and support and carers who need support. Available at: Social services national outcomes framework.

Welsh Government (2020). *National Survey for Wales headline results: April 2018 to March 2019* [online]. Available at: National Survey for Wales headline results: April 2018 to March 2019. [Accessed 16/12/2020].

Welsh Government (2022). *National Survey for Wales: quality report, January 2021 onwards* [online]. Available at: National Survey for Wales: quality report [Accessed 29/09/2022].

Annex 1: Outline Qualitative Interview Schedule (Adults and Older People)

1. What is the nature of the care and support you have received through social services over the past 4 years?
2. Did you receive care and support through social services prior to the past 4 years?
3. If I asked you, “How is your wellbeing today?” what do you think I would be asking about? *E.g. Physical health, mental health, life conditions, happiness, recent events etc*

OR

4. What do you think the term ‘wellbeing’ means? *Supply WG definition after their own **

5. Thinking about the past 4 years, what events or circumstances in your life do you feel have most benefited your wellbeing (using the WG definition)?
6. Thinking about the past 4 years, what events or circumstances in your life do you feel have most damaged your wellbeing (using the WG definition)?
7. Have you had much contact with social services around those particular issues discussed in question 4?

Annex 2: Analysis of Well-being data

The figures in this annex relate to the analysis presented in Section 3 and Section 4. Data was obtained on the four measures of personal wellbeing used by the Office of National Statistics (ONS) and adopted by the National Survey for Wales (National Survey). Results are presented from 2013-14 to 2020-21 where relevant data is available.

Table A1 presents sample adult weighted mean scores for the four National Survey measures of well-being for the general population in Wales with Table A2 and Table A3 considering these measures only for those identifying as carers or having a limiting long standing illness, disability, or infirmity. Table A4 presents results from generalised linear model (GLM) assessing the effect of the SSWB act on wellbeing for the general population in Wales, with Table A5 explicitly considering the additional impact of COVID-19 in 2020-21. The GLM analyses are also presented for the LLSIDI (Tables A6 and A7) sub-group.

Table A1: Mean scores for Well-being Measures – General Population

Year	Satisfaction with Life		Life Worthwhile		Felt Anxious Yesterday		Felt Happy Yesterday	
	N	Mean (95% CI)	N	Mean (95% CI)	N	Mean (95% CI)	N	Mean (95% CI)
2013-14	14,700	7.68 (7.56, 7.80)	14,616	8.01 (7.89, 8.13)				
2014-15	14,195	7.87 (7.75, 7.99)	14,102	8.06 (7.94, 8.18)	14,169	2.50 (2.42, 2.57)	14,160	7.66 (7.54, 7.78)
2016-17	10,470	7.76 (7.63, 7.87)	10,413	7.98 (7.86, 8.10)	10,466	2.72 (2.64, 2.80)	10,464	7.54 (7.42, 7.66)
2017-18	11,368	7.76 (7.66, 7.86)	11,331	7.94 (7.84, 8.04)	11,363	2.71 (2.64, 2.78)	11,369	7.57 (7.47, 7.67)
2018-19	11,884	7.80 (7.69, 7.90)	11,850	8.01 (7.90, 8.11)	11,888	2.72 (2.65, 2.79)	11,880	7.62 (7.52, 7.73)
2019-20	12,293	7.77 (7.66, 7.87)	12,258	7.97 (7.86, 8.07)	12,294	2.86 (2.79, 2.93)	12,296	7.58 (7.47, 7.68)
2020-21	15,759	7.51 (7.39, 7.62)	15,726	7.85 (7.73, 7.96)	15,758	3.14 (3.06, 3.21)	15,767	7.47 (7.36, 7.59)

General population wellbeing scores multiplied by sample adult weight

Table A2: Mean scores for Well-being Measures – Carers

Year	Satisfaction with Life		Life Worthwhile		Felt Anxious Yesterday		Felt Happy Yesterday	
	N	Mean (95% CI)	N	Mean (95% CI)	N	Mean (95% CI)	N	Mean (95% CI)
2013-14								
2014-15	460	7.24 (6.70, 7.77)	457	7.76 (7.19, 8.33)	461	2.83 (2.45, 3.21)	459	7.10 (6.54, 7.67)
2016-17	499	8.10 (7.59, 8.62)	496	8.68 (8.14, 9.23)	496	3.43 (3.04, 3.82)	496	7.88 (7.37, 8.39)
2017-18	2,740	8.05 (7.86, 8.25)	2,737	8.40 (8.20, 8.60)	2,733	3.13 (2.98, 3.29)	2,737	7.79 (7.59, 7.99)
2018-19	583	7.88 (7.44, 8.31)	582	8.47 (8.01, 8.93)	583	3.70 (3.30, 4.09)	583	7.67 (7.23, 8.11)
2019-20	3,477	7.78 (7.60, 7.96)	3,473	8.16 (7.98, 8.34)	3,482	3.05 (2.91, 3.18)	3,482	7.59 (7.40, 7.78)
2020-21	3,859	7.44 (7.24, 7.65)	3,857	7.94 (7.73, 8.15)	3,858	3.29 (3.15, 3.43)	3,861	7.47 (7.26, 7.68)

Carer well-being scores multiplied by sample adult weight

Table A3: Mean scores for Well-being Measures – People with a limiting long-standing illness, disability or infirmity

Year	Satisfaction with Life		Life Worthwhile		Felt Anxious Yesterday		Felt Happy Yesterday	
	N	Mean (95% CI)	N	Mean (95% CI)	N	Mean (95% CI)	N	Mean (95% CI)
2013-14	4,383	5.80 (5.64, 5.96)	4,347	6.30 (6.13, 6.46)				
2014-15	4,182	5.93 (5.76, 6.09)	4,134	6.23 (6.06, 6.40)	4.166	2.76 (2.63, 2.88)	4,161	5.78 (5.62, 5.94)
2016-17	3,914	6.17 (6.01, 6.32)	3,872	6.48 (6.32, 6.64)	3,909	3.08 (2.95, 3.21)	3,912	6.05 (5.89, 6.20)
2017-18	4,453	6.22 (6.09, 6.36)	4,431	6.49 (6.35, 6.62)	4,453	3.05 (2.93, 3.16)	4,457	6.08 (5.94, 6.21)
2018-19	4,555	6.25 (6.12, 6.39)	4,536	6.55 (6.41, 6.69)	4,559	2.99 (2.88, 3.10)	4,552	6.15 (6.02, 6.29)
2019-20	4,993	6.24 (6.12, 6.37)	4,967	6.57 (6.44, 6.70)	4,990	3.11 (3.00, 3.22)	4,991	6.11 (5.98, 6.23)
2020-21	1,859	5.97 (5.72, 6.23)	1,855	6.51 (6.22, 6.79)	1,859	3.18 (2.96, 3.40)	1,861	6.06 (5.80, 6.32)

LLSIDI well-being scores multiplied by sample adult weight

Table A4: Primary GLM Analysis of Well-being Measures – General Welsh Population

Category	N	Adjusted Score	Difference
		Mean (95% CI)	Mean (95% CI)
Satisfaction with Life			
Pre-SSWBA	28,882	7.83 (7.76, 7.91)	
Post-SSWBA	61,656	7.68 (7.63, 7.72)	-0.16 (-0.24, -0.07)
Life Worthwhile			
Pre-SSWBA	28,707	8.13 (8.06, 8.20)	
Post SSWBA	61,467	7.90 (7.85, 7.95)	-0.22 (-0.31, -0.14)
Anxious Yesterday			
Pre-SSWBA	14,163	2.62 (2.55, 2.69)	
Post SSWBA	61,657	2.83 (2.79, 2.86)	0.21 (0.13, 0.29)
Happy Yesterday			
Pre-SSWBA	14,154	7.64 (7.54, 7.74)	
Post SSWBA	61,633	7.56 (7.52, 7.61)	-0.08 (-0.19, 0.03)

General population wellbeing scores multiplied by sample adult weight

Results are adjusted for gender, age group, urban/rural locality, COVID period, local authority, general health, and WIMD quartile

Table A5: Sensitivity GLM Analysis of Well-being Measures with COVID-19 period – General Welsh Population

Category	N	Adjusted Score	Difference
		Mean (95% CI)	Mean (95% CI)
Satisfaction with Life			
Pre-SSWBA	28,882	7.85 (7.78, 7.92)	
Post-SSWBA (Pre-Covid)	45,920	7.69 (7.64, 7.75)	-0.16 (-0.24, -0.07)
Post-SSWBA (during Covid)	15,736	7.61 (7.52, 7.70)	-0.24 (-0.35, -0.12)
Life Worthwhile			
Pre-SSWBA	28,707	8.11 (8.04, 8.18)	
Post-SSWBA (Pre-Covid)	45,765	7.89 (7.84, 7.94)	-0.22 (-0.31, -0.14)
Post-SSWBA (during Covid)	15,702	7.96 (7.87, 8.05)	-0.15 (-0.27, -0.04)
Anxious Yesterday			
Pre-SSWBA	14,163	2.49 (2.42, 2.56)	
Post-SSWBA (Pre-Covid)	45,921	2.70 (2.66, 2.74)	0.21 (0.13, 0.29)
Post-SSWBA (during Covid)	15,736	3.31 (3.25, 3.37)	0.82 (0.73, 0.91)
Happy Yesterday			
Pre-SSWBA	14,154	7.62 (7.53, 7.72)	
Post-SSWBA (Pre-Covid)	45,919	7.54 (7.49, 7.60)	-0.08 (-0.19, 0.03)
Post-SSWBA (during Covid)	15,744	7.62 (7.53, 7.71)	0.00 (-0.13, 0.13)

General population wellbeing scores multiplied by sample adult weight

Results are adjusted for gender, age group, urban/rural locality, local authority, general health, and WIMD quartile

Table A6: Primary GLM Analysis of Well-being Measures – People with a limiting long-standing illness, disability or infirmity

Category	N	Adjusted Score	Difference
		Mean (95% CI)	Mean (95% CI)
Satisfaction with Life			
Pre-SSWBA	8,561	6.13 (6.04, 6.23)	
Post-SSWBA	19,746	6.09 (6.02, 6.15)	-0.05 (-0.17, 0.07)
Life Worthwhile			
Pre-SSWBA	8,476	6.57 (6.47, 6.67)	
Post SSWBA	19,635	6.39 (6.33, 6.46)	-0.18 (-0.30, -0.06)
Anxious Yesterday			
Pre-SSWBA	4,165	2.84 (2.72, 2.95)	
Post SSWBA	19,742	3.05 (3.00, 3.10)	0.22 (0.09, 0.34)
Happy Yesterday			
Pre-SSWBA	4,159	6.04 (5.90. 6.17)	
Post SSWBA	19.744	6.04 (5.98, 6.10)	0.01 (-0.15, 0.16)

LLSIDI well-being scores multiplied by sample adult weight

Results are adjusted for gender, age group, urban/rural locality, COVID period, local authority, general health, and WIMD quartile

Table A7: Sensitivity GLM Analysis of Well-being Measures with COVID-19 period – People with a limiting long-standing illness, disability or infirmity

Category	N	Adjusted Score	Difference
		Mean (95% CI)	Mean (95% CI)
Satisfaction with Life			
Pre-SSWBA	8,561	6.18 (6.08, 6.27)	
Post-SSWBA (Pre-Covid)	17,891	6.13 (6.06, 6.19)	-0.05 (-0.17, 0.07)
Post-SSWBA (during Covid)	1,855	5.48 (5.28, 5.68)	-0.70 (-0.92, -0.47)
Life Worthwhile			
Pre-SSWBA	8,476	6.59 (6.50, 6.69)	
Post-SSWBA (Pre-Covid)	17,785	6.42 (6.35, 6.48)	-0.18 (-0.30, -0.06)
Post-SSWBA (during Covid)	1,850	6.03 (5.82, 6.24)	-0.57 (-0.80, -0.33)
Anxious Yesterday			
Pre-SSWBA	4,165	2.81 (2.70, 2.93)	
Post-SSWBA (Pre-Covid)	17,887	3.03 (2.97, 3.08)	0.22 (0.09, 0.34)
Post-SSWBA (during Covid)	1,855	3.30 (3.13, 3.48)	0.49 (0.28, 0.70)
Happy Yesterday			
Pre-SSWBA	4,159	6.07 (5.93, 6.20)	
Post-SSWBA (Pre-Covid)	17,888	6.07 (6.01, 6.14)	0.01 (-0.14, 0.16)
Post-SSWBA (during Covid)	1,856	5.68 (5.48, 5.88)	-0.39 (-0.63, -0.14)

LLSIDI well-being scores multiplied by sample adult weight

Results are adjusted for gender, age group, urban/rural locality, local authority, general health, and WIMD quartile