directors of adass
adult social services

Time to act

A roadmap for reforming care and support in England

Anna Dixon and Kate Jopling

April 2023

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About the authors

Dr Anna Dixon MBE

Anna Dixon is a strategy, governance and policy consultant working with national charities and organisations in the health and social care sectors. She has over 20 years' experience in health and social care, with expertise in ageing and public health. She has held a number of senior positions including Director of Strategy and Chief Analyst at the Department of Health and Social Care and Director of Policy at The King's Fund. She also worked internationally for the World Health Organisation and European Observatory on Health Systems and Policies.

A former Chief Executive of the Centre for Ageing Better and trustee on several Boards, Anna has led the development and delivery of both organisational and national strategies. She received an MBE for services to wellbeing in later life in the 2021 New Year's Honours List. Anna chaired the Archbishops' Commission on Reimagining Care (June 2021-Jan 2023) and served as a member of the Advisory Group to the Independent Review of Adult Social Care in Scotland (Sept 2020-Jan 2021). She was selected as Labour parliamentary candidate for Shipley in July 2022.

Kate Jopling

Kate Jopling is a policy and strategy consultant, with extensive experience across the fields of health, care and ageing, and particular expertise on loneliness. She has authored a wide range of influential reports for organisations including National Voices, the British Red Cross and Age UK. Her work on the final report of the Jo Cox Commission on Loneliness led to the development of the Government's loneliness strategy.

A former Director of the International Longevity Centre and the Campaign to End Loneliness, and Head of Public Affairs for Help the Aged, Kate has a wealth of experience of building collaborations, supporting learning and influencing policy and practice. Her campaigning work to secure a ban on age discrimination in the provision of goods, facilities and services was recognised with five major campaigning awards.

Foreword

This report is for all of us. It's about the future we want for ourselves, for our mums and dads, for our siblings, children and wider family and friends. Because at some point in our lives we all rely on care and support to help us through the physical and mental health challenges we face.

Social care is about fighting for social justice, for equality, saving and improving lives. It is about human kindness. The people who work in social care are courageous, committed, empowering and they give people hope.

But our adult social care system in England is broken. We've been trying to patch it up for decades, and that's not working. It's been underfunded and stretched to breaking point. The people who feel the pain that causes are our friends and families.

We can't have more of the same. Now's the time to act. That's why we commissioned this independent report. It draws together the thinking that's been done on the future path we could take and develops a roadmap to get us there. Undeniably, there is consensus about the kind of care and support system we need. A fair system that enables everyone to live in the place we call home, with the people and things that we love, in communities where we look out for one another, doing what matters to us. But what we haven't had is the collective and political will to make it happen.

There will be different views on some of the steps along the road, but the degree of consensus on what needs to be done is striking. This Roadmap is a resource for everyone who makes policy about, works in or relies on adult social care. Some things we can do now, some without significant extra resources. And there are things we'll need to do over the next five to ten years to radically shift care and support in England.

We can't expect any Government to wave a magic wand. What we need from the Government – whatever its colour – is a long-term commitment to fund the transformation we need, and it will take significant investment. We need national leadership from politicians, regulators, providers and others, but we also need strong local leadership.

That means this is a challenge to all of us. To Directors of Adult Social Services, to lead change with our communities, so care and support genuinely enables people to live fulfilling lives. To our public service partners, corporate colleagues and providers in the private and voluntary sectors, who all need to contribute to a better future. And to everyone in England to participate in a bigger public conversation about the importance of care and support and to agree a new social contract on how to fund social care and what we can expect from it. So that all our family and friends can rely on the care and support they need to be there, when they need it, wherever they live, and whoever they are.

This is about all of us. It's time to act. We'll only fix social care together.

Sarah McClinton
President,
ADASS

Beverley Tarka
Vice-President,
ADASS

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Introduction

Good care and support already makes a positive difference to many people, enabling them to live their lives in ways that matter to them. Yet the enormous contribution care and support makes to our lives as individuals and to us all, as a society, remains invisible and undervalued.

Recent pressures on the NHS have again brought the challenges facing social care to the fore. This attention is welcome but tends to frame care as an adjunct to the NHS. Similarly, during the COVID-19 pandemic the plight of care home residents, staff and families was frequently featured in the news. But again the emphasis was placed on residential care, with the impact on the many more disabled and older people living at home, and on the carers supporting them, less visible. While the spotlight periodically falls on social care, too often the focus moves on, leaving those who draw on care and support, their families and carers, and those working in care and support to struggle on out of the public gaze.

While the most recent government White Paper in 2021[1] focuses on reform, others, including the Archbishops' Commission,[2] and the House of Lords' Adult Social Care Committee[3] have suggested a need for a more thorough "reimagining". Despite this, things only inch forwards, with the Government's recently published plan the latest in a line of public policy disappointments.[4]

This report aims to build on the optimism of those setting out a bold vision, to propose a practical, but realistic agenda for action over the next ten years to build towards a better future for care and support.

About this report

We have reviewed many previous reports on social care to draw out the different visions of care and support and the outcomes that they set for the social care system. We have also sifted through the actions these reports have recommended.

Our review has convinced us that there is now a shared vision across the majority of people and organisations involved in care and support, and a good deal of consensus on the outcomes. There is more work to be done to prioritise and agree on the most important actions. We hope the roadmap proposed here can contribute to securing agreement on the latter, by demonstrating how different actions come together to deliver change.

We suggest actions that can be taken now, without root and branch reform or a complete overhaul of funding. These are the things that are already happening in some places, but which are not consistently applied in every area, or for all groups of people who draw on care and support.

We also set out what needs to happen in the medium to longer term, to build on the things we do now. Some actions – particularly those to be implemented in the medium to long term – require significant investment and may require legislative change.

The actions we include in our roadmap have been recommended repeatedly over the years. However, implementation has either not happened, been delayed, inconsistent, or fallen short of expectations. There continue to be roadblocks to progress.

Key to unlocking both the additional funding and further legislative reform that are needed for long term change, is a shift in political will.

Political failure lies behind the lack of progress in reform of care and support. Commitments have been made and broken by successive governments and Prime Ministers. Despite the fact that caring impacts on so many of us either directly or indirectly with 9.8 million disabled adults and 5 million people who identify as family carers[5] and a further 1.8 million who work in social care,[6] it does not have the political salience of, for example, the NHS or crime. The case for additional funding for care and support needs public backing. Unlocking this will require a movement for change that goes beyond those currently involved in care and support and brings together those who draw on care support, both paid and unpaid carers, and the general public. This work is vital and is being led by organisations such as Social Care Future, who are working to set out a different narrative and to build a social movement for change.

This report looks beyond that work, to focus on the actions that need to be taken as momentum for change builds. We offer a practical route through a change process to provide confidence that as political will is unlocked, practical change can quickly follow to create a system that will deliver the care and support that we all want for ourselves and our loved ones.

Along the way we identify other barriers to implementation of reform and propose actions that could clear the road ahead.

Of course our roadmap is not the only possible route to the future – other paths are possible – and the way may well look different in different parts of the country. However we offer it as a starting point for what we hope can be a more purposeful and optimistic discussion about how a range of organisations and individuals can together make faster progress.

Who this report is for

Our aim in writing this report is to enable and empower leaders in care and support who are frustrated with the current pace of change. This includes many people who draw on care and support and their families and carers. It is aimed at everyone involved in adult social care, including regulators, providers, policy-makers and user-led organisations.

In particular we want this report to enable Directors of Adult Social Services (DASSs), and their professional association (ADASS), to drive progress, in partnership with people who draw on care and support, towards realising the shared vision for care and support.

DASSs have legal responsibilities for ensuring adults who need care and support get what they need to maintain their wellbeing, according to the Care Act 2014. Their roles are complex – they have a wide range of statutory responsibilities, set out in a range of legislation, and support people across a broad spectrum of need and in different circumstances. They face significant risk and complexity on a day-to-day basis and they work to meet their obligations in increasingly challenging circumstances, often with little time or space to think strategically or plan for the future. We hope this report will enable them to navigate the array of ideas for reform proposed by different reports and to begin, or continue, a journey of transformation.

As we look ahead to the medium term and the prospect of a new Parliament, we also consider the priorities for funding, legislation and policy. There will be many demands on the Treasury for spending, and on Parliamentary time for legislation, so this document aims to clarify what the priorities must be.

Scope of the report

Care and support is much more than the statutory services commissioned and provided by local authorities and covers a wide range of support types and levels.

Care and support needs vary widely from needing a hand with shopping and cooking, or someone to accompany you when you go out and about, to needing specialist support to be mobile or communicate with others, or needing support to stay safe and manage complex life circumstances.

There are a wide range of private and voluntary, community, faith and social enterprise (VCFSE) sector providers who deliver services. There are many people who self-fund their care. A huge amount of care and support is given in-kind by family members or in the community by volunteers, friends and neighbours. Organisations that provide education and training, leisure activities, and employers may offer support to enable disabled and older people to live full lives. People who draw on care and support and their carers may also need support from health services, housing services, benefits advice, or employment support. People with complex needs may also be in contact with drug and alcohol services, prison and probation services, or hostels, night shelters and refuges. Wider provision of transport and housing makes a huge difference to the quality of life of older and disabled adults.

The main focus of this report is on the social care system and the changes that are needed to enable it to deliver quality care and support. However we also touch on cross-sectoral and cross-Departmental actions.

Where are we trying to get to?

A shared vision

Since Social Care Future launched their vision in November 2021 it has gained widespread support. It encapsulates succinctly a set of ideas, and values that have been developed with people who draw on care and support and which have been reflected in other documents over time.

We all want to live in the place we call home, with the people and things that we love, in communities where we look out for one another, doing what matters to us.[7]

The Social Care Future vision goes on to say the role of social care is to provide the support to be able to do these things if we have a disability or health condition.

The recent report of the House of Lord's Adult Social Care Committee borrowed the words of leading advocate Tricia to describe the simple aspiration of disabled people and their families: "*A gloriously ordinary life*". The ability to do everyday things like see friends, have a relationship and a job, go out to shops and join in activities that we enjoy is currently denied to too many disabled people and older people. The right care and support enables these simple things, and more.

Other vision statements, from other organisations, are similar in emphasising that care and support are a means to enable people to live life to the full, free from abuse or neglect.

Care and support enables people to flourish and live life to the full.[8]

This emphasis on outcomes is to a large extent reflected in the Care Act 2014, which frames social care around a duty to promote individual wellbeing which is defined broadly (see Box).

This ultimate goal of wellbeing is reflected in other policy documents, as a shared goal across health and social care services.

Individual Wellbeing as defined in the Care Act 2014 encompasses:

- personal dignity (including treatment of the individual with respect);
- physical and mental health and emotional well-being;
- protection from abuse and neglect;
- control by the individual over day-to-day life (including over care and support, or support, provided to the individual and the way in which it is provided);
- participation in work, education, training or recreation;
- social and economic well-being;
- domestic, family and personal relationships;
- suitability of living accommodation;
- the individual's contribution to society.[9]

Services that are organised and delivered to get the best possible health and wellbeing outcomes for citizens of all ages and communities.[10]

Other reports have framed their visions in terms of outcomes such as dignity, respect and independence. Choice and control are also commonly mentioned in other reports and policy documents.

When care supports people's independence it allows them to have real choice and control over the things that matter, enabling them to live healthier, happier, and more fulfilling lives in the place that they choose.[11]

However, the overwhelming sense is one of increasing convergence of visions, and a growing consensus around the system we want to see. We therefore take the Social Care Future vision as the "North Star" of this roadmap.


Visions for social care
Dignity, quality and respect
Staying safe
Purposeful lives
A life, not a service
Making a contribution
Live life free from discrimination
An equal, meaningful, ordinary life
Being healthy
Social, mental, physical, emotional wellbeing
Spiritual and psychological wellbeing
Healthier, happier and more fulfilling lives
Choice, independence and control
Feeling valued and worthwhile
Active citizens
Flourish and live life to the full
Live in the place that you choose
Active members of families and community
Learn, work, play, worship, love, care
Safe from harm
Right care, right place, right time, right cost
A shared vision
We all want to live in the place we call home with the people and things that we love, in communities where we look out for one another, doing things that matter to us

A common understanding of outcomes for a better system

Also common across different reports is an understanding of the features of the system that is needed to deliver the vision. While there is, perhaps, less convergence around the precise terminology we have identified significant commonality in the outcomes described.

We have distilled these into eight features of a better system – which we take as the "destination" of our roadmap. The first three describe the care and support experienced by people who draw on it and their carers. The second two describe features of how the system of care and support is organised. The other three are wider and relate to the system as experienced by all of us as citizens.

A better system of care and support is:

1. Focused on outcomes and wellbeing

Care and support is focused on promoting our wellbeing in all its facets – physical, mental, emotional and spiritual – and the outcomes we decide are important to us. It also promotes equity and inclusion by ensuring different groups in the population experience similar outcomes.

2. Personalised, co-created and flexible

We have a say and shape care and support both individually and at community/ local level. Care and support adapts to our needs as they change, and recognises our diversity and individual preferences, beliefs and circumstances. When we lack capacity there are advocates to represent our prior wishes and best interests.

3. Proactive and preventative

We can access support to enhance our health and wellbeing and reduce inequalities across communities. Care and support is easily available at an early stage to help slow or prevent escalation into crisis, or before we have acute care needs.

4. Integrated and coordinated

The care and support we receive is better joined up around our needs and those of our carers. Care and support links to and / or includes support around health, housing and employment.

5. Local, community-based and relational

We can access care and support near to where we live, or where our close family and friends are. Care is relational rather than transactional, recognising our interdependence and mutuality. We feel at home and are part of our local community.

6. Sustainable, efficient and effective

Whether care and support is funded by the state, or by me and my family, it offers good value for money, is of good quality and achieves the desired outcomes. To deliver this, the market for high quality care and support is stable and well-functioning.

7. Fair in what it asks of people

Who pays and how much we pay for care and support is fair with regard to both charges and where the responsibility for funding collectively through taxation falls. It is also fair in what is demanded of unpaid family carers, and of communities. Paid workers are fairly rewarded for what they do.

8. Accessible and affordable

We can all get care and support at prices we can afford and without a fight. Care is available to more people on an equal basis as eligibility is widened and there is a more generous universal offer.

As people who draw on care and support, we want a system that is more...

Where are we now?

Care and support is an essential part of our social and economic infrastructure and yet has consistently been overlooked for investment. The system of statutory social care provision has now been under intense financial pressure for years, due to local authority budget cuts over the past decade, with significant implications for the quality and availability of care and support for those who draw on it, placing more pressure on families and communities to fill gaps in paid support. The COVID-19 pandemic increased the challenges, with shortages of care at home, difficulties in recruiting personal assistants and many care homes running at lower occupancy.

A tighter labour market, impacted by changes to the national living wage, Brexit and changes in immigration rules, and early retirements triggered by the pandemic, has driven up wages in other parts of the economy making care relatively one of the worst paid jobs. At the same time the ability to recruit easily from overseas has reduced. Inflation and energy costs have substantially added to providers' woes, with implications for councils, self-funders and those using Direct Payments. The additional pressure now being put on organisations working in care to support discharge from hospitals to free up beds, alongside shortages in NHS community, mental health and primary care services, is further adding to the challenges faced.

The facts speak for themselves.

Financial pressures

Government funding for local authorities fell by 55 percent between 2010/11 and 2019/20.[12] This has led to rationing of paid-for care services to focus only on those with the highest need alongside reductions in support for carers and investment in the voluntary, community, faith and social enterprise (VCFSE) sector. Individuals who draw on care and support and their families and communities have been left to fill the gaps as best they can.

In the financial year 2022/23, DASSs were expected to deliver £597m of savings – 3.5% of their total adult social care budgets. Only one in four reported that they were confident they could deliver these. Cumulatively they have had to find savings of £1.8bn over the last three years.[13]

Workforce shortages

Vacancy rates among care providers have risen sharply and there are now estimated to be 165,000 vacancies. At 10.7 per cent, the vacancy rate is higher than in the wider economy (4.3 per cent) albeit with regional variations.[14] People with Direct Payments also face challenges in recruiting personal assistants.

Almost seven in ten DASSs reported, in an ADASS survey in Spring 2022, that care providers in their area had closed, ceased trading or handed back contracts. Difficulties in workforce recruitment and retention was cited as the key driver for the problems in the home care market, while this came second to the cost of overheads for residential and nursing care providers.[15]

Unmet need

The impacts on people who have cause to draw on care and support are very real with too much unmet, under met and wrongly met need.

More people are requesting support and on current trends requests for care are expected to exceed two million in 2022/23. Four in five of these originate in the community. According to analysis by the International Longevity Centre, there are 8.9m inactive adults under 65, of whom 2.5 million are long term sick. Spending on working-age health and disability benefits is over £45bn a year and accounts for about 1.6% of GDP.

There are also large inequalities in disability life expectancy: in the poorest areas of the country on average people experience the onset of disability in their early 50s.[16]

Yet fewer people are getting long-term support and there has been a decline in the number of older people receiving long term care. There are also estimated to be 246,000 people waiting for assessment. Even when people do get some support, too few have the opportunity to truly direct their own care and support.

It is difficult to be positive in these circumstances.

Making a difference

But the story that is less often told is that every day nearly 1.5 million people are offered care and support in the UK. There are around 361,000 people resident in care homes, of whom 35% fund their own care.[17] Some 818,000 people got publicly funded care in care homes or in the community in 2021/22, of whom 289,000 were aged 18-64 years old. The majority of care providers are rated good or outstanding by the Care Quality Commission (CQC) (84 per cent of all registered care providers).

Care and support services create jobs for more than 1.5 million people – a workforce significantly larger than that of the NHS.[18] At the same time 117,000 people manage their own care and support with a Direct Payment.

Meanwhile a staggering 4.7 million people provide some unpaid care to friends or families – contributing care equivalent to that of four million paid care workers. Although, more worryingly, most do so without ever receiving support for a break (only 33,000 received access to short breaks support in 2021/22).[19] An estimated 15 million people (one in three of the population) take part in informal volunteering at least once a month. This includes a range of help including care for people who are not relatives such as keeping in touch with someone who has difficulty getting out and about, or helping out with tasks such as cleaning, laundry or shopping.[20]

Building on what's strong

Given the current pressures on the social care system, it can be hard to imagine reaching the shared vision. However, there is a strong track record of delivering quality care and support, examples of good practice and innovation from around the country, and the amazing resilience and contribution of disabled and older people, carers and communities to build on.

In the next section we set out how we can enable and accelerate the work towards a better system of care and support.

The roadmap

To develop this roadmap we reviewed a wide range of actions proposed over the past decade, or more, in policy reports and independent reviews and explored innovative and promising practices from around the country. Working back from the change we wanted to see, we considered which of these many actions to prioritise and in which timeframe they should and could be implemented. We benefited from the input of a wide range of people to test the prioritisation across two workshops and in informal discussions.

Overview

The roadmap sets out the actions that would be needed to make progress in ten broad "areas for action" which we identified through our review as supporting the shift towards the system we want to see in the future (defined in terms of the eight outcomes identified on page 7).

We have charted which actions would need to be taken in the short, medium and long term:

- In the short term we have focussed on action that could happen in the next financial year. Although some enabling funding is required (see page 30 for more detail), no legislative change is envisaged. Many of these are actions that are already being taken in some areas
- Over the medium term (c. 2–5 years) we expect to see incremental increases in investment and start more major reforms
- In the long term (c. 6–10 years) we envisage putting in place and working within new legal frameworks and moving to new funding structures

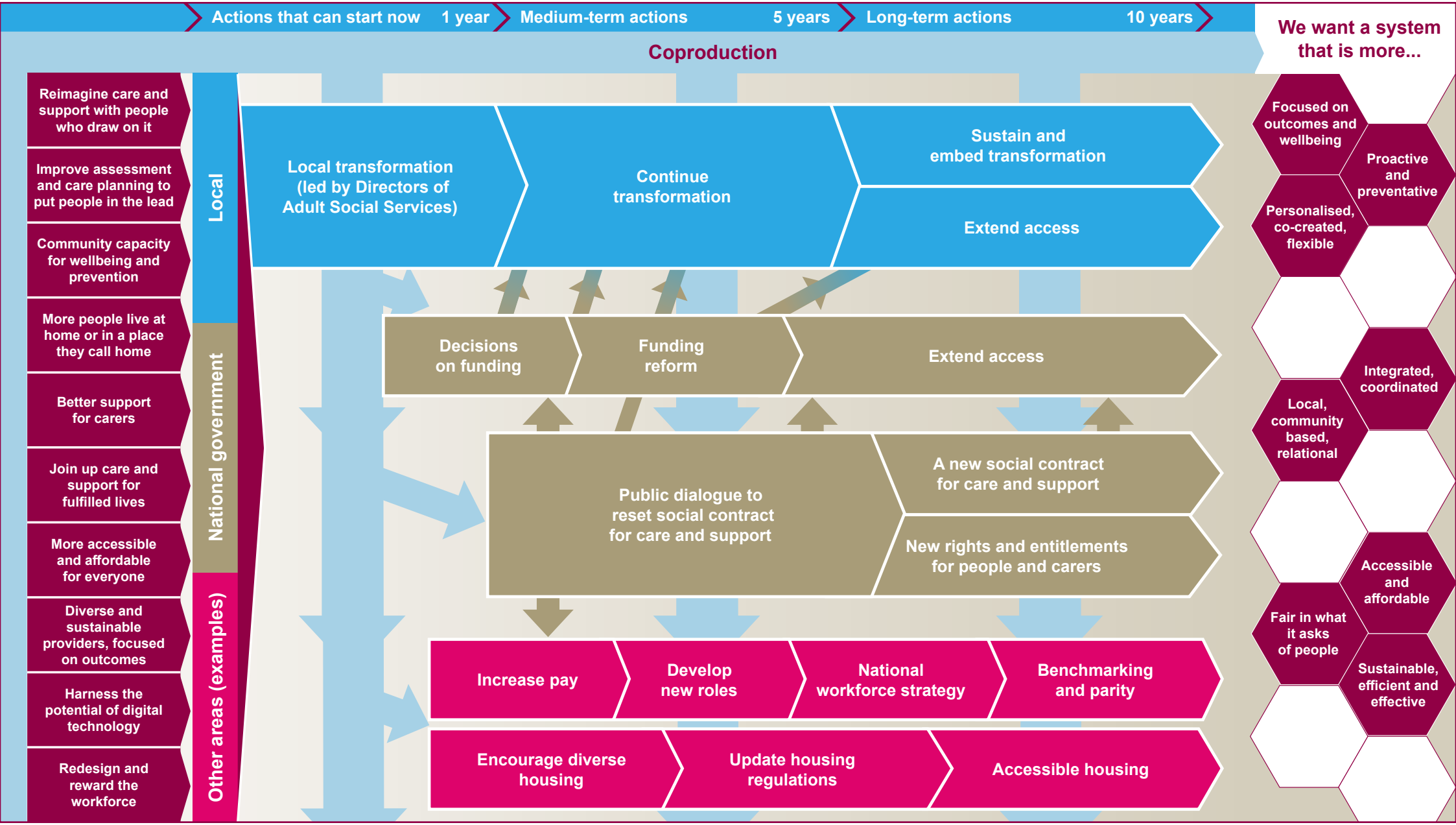
Fundamental to the changes we want to see in the medium and long term are two key actions which we have captured under the first area for action in the roadmap. These would unlock progress across all areas for action and contribute to all outcomes. These are:

- **Public and cross-sector dialogue** to redefine care and support and to reset our understanding of the individual and collective rights, responsibilities, entitlements and obligations within the care and support system; which would then feed into
- Embedding (through legislation if necessary) **a new social contract** between individuals, families, communities and the state around care and support, defining clear rights and responsibilities for all parties. This would likely include renewed arrangements for funding care and support

Much of the work that we have identified in the short term would need to be led by Directors of Adult Social Services (DASSs). We recognise that this could look like a daunting agenda. However in many areas at least some of this work is underway and there is a foundation of good practice to build on. Furthermore many of these actions complement and reinforce one another.

We include the full range of actions to demonstrate the breadth and depth of action that is both possible and necessary to drive towards the vision. We have grouped these actions into an "agenda for action" which is set out on page 13.

We are also clear that these actions can only progress at the pace we envisage with some enabling funding – discussed in more detail on page 30. Without this funding progress will be slower, action will be less comprehensive, and some areas (particularly those which are more deprived, more rural, and/or which have larger populations of older and disabled people) will struggle.


Actions that can start now
1 year
Medium-term actions
5 years
Long-term actions
10 years
We want a system that is more...
Coproduction
Reimagine care and support with people who draw on it
Improve assessment and care planning to put people in the lead
Community capacity for wellbeing and prevention
More people live at home or in a place they call home
Better support for carers
Join up care and support for fulfilled lives
More accessible and affordable for everyone
Diverse and sustainable providers, focused on outcomes
Harness the potential of digital technology
Redesign and reward the workforce
Local
National government
Other areas (examples)
Local transformation (led by Directors of Adult Social Services)
Continue transformation
Sustain and embed transformation
Extend access
Decisions on funding
Funding reform
Extend access
Public dialogue to reset social contract for care and support
A new social contract for care and support
New rights and entitlements for people and carers
Increase pay
Develop new roles
National workforce strategy
Benchmarking and parity
Encourage diverse housing
Update housing regulations
Accessible housing
Focused on outcomes and wellbeing
Proactive and preventative
Personalised, co-created, flexible
Integrated, coordinated
Local, community based, relational
Accessible and affordable
Fair in what it asks of people
Sustainable, efficient and effective

An agenda for action: Directors of Adult Social Services leading change

The actions we've identified in the short-term are those that can be taken within the current legislative framework, enabled by smaller amounts of enabling investment (see page 30 for details). Some of these actions are already underway in some areas, but for change to go further, faster, DASSs will need to take a lead.

This agenda for action **starts with a commitment to co-production** with people who draw on care and support, their families and carers, and working in partnership with local providers and community organisations.

The aim is to **co-produce a local strategy and approach to care and support** – many areas have chosen to do this using the Social Care Future Vision, and Think Local Act Personal's (TLAP) *Making it Real* framework.[21]

This will lead to a shift in the **language and cultures** of social care practice to emphasise individuals' rights, the pursuit of equity and justice, and professionals' roles as enablers.

Out of this will flow a set of further actions, which will need to be determined locally, but are likely to encompass work in the areas set out on the next page.

An agenda for action: Directors of Adult Social Services leading change

Co-producing local plans

- Map local assets and needs to inform plan for building and developing community capacity (C£)
- Ensure diverse housing options for older and disabled people are included in local / neighbourhood plans
- Improve commissioning, for example using guidance from SCIE (T£)

Training and development

- Shift mindsets away from "provision" to co-production
- Support person-centred care planning and self-directed support
- Embed use of digital tools in care and support (T£)

Improving assessment and care planning

- Streamline processes to reduce waiting times (T£)
- Avoid unfair / unreasonable assumptions about carer capacity within assessment processes
- Make care planning more transparent
- Simplify processes around Direct Payments (drawing on TLAP's recommendations) (T£)

Working in partnership

- Build links between social care, public health and population health across Integrated Care Systems (ICSs)
- Rebuild capacity in intermediate care with NHS discharge funding (S£)
- Work across local authorities and with health bodies to establish integrated support offers and pathways of support across health, social care and housing
- Ensure social prescribers, link workers and community hubs are working together to provide coordinated approach to information and advice

Improving choice and shaping provision

- Implement and extend the Home First approach, so more people get care at home (T£)
- Ensure commissioning processes take account of the needs of diverse communities, and address equity and inclusion, including through ethical commissioning
- Invest in the growth of micro providers (T£)
- Align budgets to reasonable local Cost of Care assessment rates (S£)

Widening access

- Measure and share data on unmet need, including those waiting for assessment
- Make better use of Disabled Facilities Grant funding and ensure consistent access to aids and adaptations (T£)
- Commission support for carers including breaks (S£)
- Fund a range of community-based support that is available without means-testing / eligibility criteria (C£)
- Review local charging to ensure it is fair, and to consider reductions

Improving work in care and support

- Support staff to work in integrated, more autonomous, place-based teams
- Give the lowest paid care workers an uplift in pay (S£)
- Create local workforce plans for social care – in collaboration with ICS level workforce planning across health and social care
- Increase the diversity of the social care workforce and inclusive leadership in line with the Diverse by Design principles
- Encourage volunteers within VCFSE organisations to be involved in care and support (C£)

The roadmap in detail

For each area of action, we set out the shift that is needed, some examples of work already underway and specific actions that are needed in the short, medium and long term to make progress. In defining long-term priorities we have focused on the change we expect to see at the end of the decade of action.

This roadmap cannot comprehensively identify every action that will be needed in every area and they may look different, in different areas and for different people. The actions identified are for a range of different organisations, both national and local.

Key

In the text below the following symbols are used to identify where there is a need for funding or legislative change to support these shifts. These are somewhat subjective though we have drawn on other analyses of costs.[22]

Level of funding

- £ Modest increases in line with historical spend/future demand
- ££ Substantial investment required e.g. to improve access or increase pay
- £££ Significant increases in funding year on year as % GDP

Type of spend

- T Investment for transformation
- S Investment for stabilisation
- C Investment in building community capacity
- A Investment to improve access and affordability

Legislative change

- \+ Simple, e.g. change in guidance or secondary regulations
- ++ Moderate, e.g. requires changes to primary legislation, regulations
- +++ Major reform, e.g. new primary legislation, or total overhaul of current arrangements

Reimagine care and support with people who draw on it

What is the shift?

We want to shift away from viewing social care as a service where decisions about what is on offer are made by local authorities, towards care and support that is rooted in clear rights and entitlements, where decisions are made by, and with, people who draw on care and support and their families and carers, and a diversity of organisations work with people to create the conditions and deliver the services and support, which enable them to live life to the full.

In practical terms this means:

- Engaging in genuine co-production with people who draw on care and support and with the wider community
- Shifting attitudes within social services departments and among care providers about their role within the broader system of care and support in communities
- Using frameworks like TLAP's *Making It Real*[23] and concepts like the *Asset-Based Area*[24] to shape change in care and support
- Working towards a new shared understanding of our individual and collective rights, responsibilities, entitlements and obligations in relation to care and support

There are already some examples of this happening in practice, such as:

- Social services directors co-producing social care strategies with people who draw on care and support (e.g. Leicester City)
- Social services departments redefining their role as enablers and supporters of care and support, rather than as commissioners or providers - (e.g. Your Life Doncaster practice framework)

What actions are needed?

In the short term

- Bring local partners together with people who draw on care and support to define local strategy and approaches to care and support
- Adopt different language and cultures around social care practice emphasising individuals' rights, the pursuit of equity and justice, and professionals' roles as enablers
- Reassert the core principles of the Care Act 2014 and the Mental Capacity Act 2005, including in particular their focus on wellbeing as the core aim of mutual decision-making, care and support and safeguarding
- Train and develop staff in provider and commissioner bodies to support a shift in behaviours and mindset away from "provision" to co-production

In the medium term

- Public and cross-sector dialogue to redefine the individual and collective rights, responsibilities, entitlements and obligations in relation to care and support
- In light of the above, review the need to strengthen the legal framework for social care including, in particular, the Care Act 2014
- Create a mechanism to support co-production of strategy on care and support with people who have cause to draw on it at national level
- Improve access to information and advice about rights and entitlements and how to uphold these (i.e. legal support and/ or complaints processes)

In the longer term

- There is a renewed and mutually agreed social contract for care and support with clarity around individual and collective rights, roles and responsibilities embedded in legislation where necessary (+++)

Improve assessment and planning to put people in the lead

What is the shift?

We want to move from a system which can still feel like it is led by professionals to one in which care and support is co-produced with the people who draw on it and which realises the right to self-directed support. From a system of assessment, care planning, support and review, that is bureaucratic and complex to one that is clear and simple.

In practical terms this means:

- People define the outcomes they wish to achieve and have support to be aspirational
- The focus is on what matters to the person and recognises their individual characteristics and circumstances
- People can set out in advance what their goals are, for when they may lack capacity
- Advocacy is available to support people in getting what they want
- Assessment focuses on the individual's needs, using clear and consistent criteria, and does not take account of the contribution of unpaid carers

There are already some models in place which make it more likely that people can get these things, they include:

- Tools like 'This is Me' to support people in communicating their needs, preferences and wishes
- Tools to support advanced care planning such as My Living Will
- Advocacy services, for example Lambeth Living Well Network
- New models of assessment and care planning such as The Three Conversations
- The Making Safeguarding Personal programme

What actions are needed?

In the short term

- Training and permission to engage staff, families, and people using Direct Payments in person-centred care planning
- Focus assessments on conversations about what matters to the person and what a good life looks like to them
- Streamline paperwork and free up social workers to use their time to work directly with people and reduce numbers waiting
- Simplify processes around Direct Payments by implementing TLAP proposals
- Improve transparency about how care plans are developed
- Review the quality of information and advice available including to self-funders

In the medium term

- Expand options to help people to self-direct support including by increasing access to Individual Service Funds (T£)
- Widen access to information, advice and advocacy services including self-advocacy and peer-advocacy (C£)
- Support self-funders to access tools and support for care planning (T£)

In the longer term

- Everyone has an opportunity to complete an advanced plan within their digital health and care records
- People have a right to advocacy and there is sufficient capacity and quality of advocacy support to enable this (++)
- There is a simplified system of assessment to determine entitlement, undertaken separately from care planning (+++)

Community capacity for wellbeing and prevention

What is the shift?

We want to build the capacity of communities to provide wellbeing support for everyone whether they also draw on formal care and support or not. This should ensure that people have opportunities to build connection and find purpose in their local areas. This will not only contribute to individual wellbeing, but also improve population health and reduce demand for more costly and intensive services.

In practical terms this means

- Investing in community development activity and community-based support
- Supporting the inclusion of people who draw on care and support in wider community activity
- Investing in connectors and navigators who can link people up to local activities
- Re-emphasising the role of care and support in promoting equity and inclusion and reducing health inequalities

There are already some examples of this happening in practice, such as:

- Investment in Local Area Coordination in Thurrock
- Age-friendly and dementia friendly communities
- Long-term funding for the VCFSE in Leeds Neighbourhood Networks

What actions are needed?

In the short term

- Work with partners, including people who draw on care and support, to map assets across the community and identify gaps
- Co-produce plans for community development with people and communities with a focus on equity and inclusion
- Build links between social care, public health and population health across Integrated Care Systems (ICSs)
- Work with ICSs to build capacity across the VCFSE sector (C£)

In the medium term

- Secure additional funding to develop community capacity from diverse sources (C£)
- Widen access to connectors, investing in approaches such as Local Area Coordination (A£)
- Invest in social infrastructure (e.g. public spaces) in communities identified via mapping exercises (C££)
- Define a core universal, non-means-tested and open-to-all offer of care and support that should be available in all areas, as part of a new social contract for care and support

In the longer term

- A minimum universal offer is embedded as part of a new social contract for care and support (+++) (A£)
- Shared investment pots for community infrastructure and capacity draw together funding from across social care, public health and the NHS, along with philanthropic funding (C£)

More people live at home, or in a place they call home

What is the shift?

From a situation where disabled people and older people with complex needs sometimes have little choice but to live in large institutional settings that are impersonal and may be far away from their community/family connections, to one where more people are supported to live at home, or in place they can call home that is embedded in, and connected to a local community, of which they feel part.

From the current position where those with less complex needs live in unsafe or unsuitable housing that limits their ability to manage at home and to do the things they want, to one in which there is a diverse range of housing which can adapt as people's needs change through their lives.

In practical terms this means

- Increasing the number and variety of accessible homes across tenures
- Providing easy access to retrofitting and adaptations
- Designing and building more options for homes with care and support

There are already some examples of this happening in practice, such as:

- Care villages which foster a strong sense of community and forge links with the local community such as, Woodside Dementia Care Village, Warwick
- Innovations in home adaptations and the use of the Disabled Facilities Grant
- Communal living, cooperative living and supported living arrangements where friends choose to live together

What actions are needed?

In the short term

- Implement and extend the Home First approach, to support more people to get care at home (T£)
- Co-produce local housing strategies and plans which can deliver more diverse housing options for disabled and older adults across a mix of tenures
- Make maximum use of Disabled Facilities Grant funding and streamline access

In the medium term

- Commission more capacity in household models such as Shared Lives, and continue to develop and trial new models of care in homely environments (T£)
- Develop a national housing strategy which includes the need for more accessible and diverse housing options including supported living
- Invest in high quality, person-centred residential care that is embedded in communities (T££)
- Review and bring together piecemeal funding for individuals to support the purchase of aids, adaptations, tech enabled support and other capital costs for independent living (++)
- Implement reforms to housing regulations to ensure all new homes are built to higher accessibility standards (e.g. Part M Cat 2 previously known as Lifetime Homes Standards) (+)
- Review and simplify regulation of supported housing and ensure people in supported housing are able to choose their care provider (+)

In the longer term

- The planning system supports the development of a diverse range of housing options in places (++)
- People are supported to plan their housing to meet their physical, social, mental health and wellbeing needs across the life course
- Social and private developers build a higher proportion of new homes to accessible standards (+)

Esk Valley – Shared Lives at Camphill

The Esk Valley Camphill Community brings together around a hundred people of all ages and abilities to live and work together as part of a self-supporting community. At Esk Valley residents with learning disabilities live with co-workers and their families in house communities of 5-9 people. Residents and co-workers are registered as Shared Lives customers or carers with the Avalon Group. The community runs a number of social enterprises which offer vocational volunteering opportunities to all members of the community, including a village shop used by the wider community in Danby. The ethos of Esk Valley is that all members create the community together, according to their strengths and ability.

The Esk Valley community was originally part of a larger charity, the Camphill Village Trust (CVT), which decided to replace shared, community living with vocational volunteer co-workers with a more conventional supported-living model provided by employed, non-resident staff. The community broke away in order to ensure that both those who provided and those who needed care and support were able to live in the way they had chosen. Operating within the Shared Lives model offered a route through which to do this.

The community at Esk Valley recognise that their way of living would not work for everyone, but are clear that Camphill communities are an option which offers belonging and purpose. For a long time they struggled to communicate the value of their model to commissioners, but have found that working within the wider Shared Lives family, with its existing recognition, has supported them in better communicating the value of their model to local commissioners. This has led to an increase in referrals to the community.

Better support for carers

What is the shift?

We want to move from a situation in which many family carers have to care out of necessity, and do so without the financial, practical or emotional support they need. In the future, we want family care to be truly voluntary. Where people choose to provide substantial care, this should be recognised and rewarded with financial, as well as practical and emotional support.

In practical terms this means

- Making sure all family carers have access to support, information and advice to maintain their own health and wellbeing
- Enabling carers to continue work with support and take time off when they need to
- Offering those who provide substantial care appropriate financial, practical and emotional support, and the opportunity for regular breaks

There are already some examples of this happening in practice, such as:

- Carers Emergency Schemes with options for paid care back up, e.g. Gloucestershire
- Peer support for carers with diverse needs, e.g. Carers Leeds
- Short break services, e.g. Time Out Bradford

What actions are needed?

In the short term

- Commission universally-accessible support for carers, including peer support groups, training etc, from the VCFSE sector (C£)
- Invest in options to support carers to take breaks (S£)
- Train staff to ensure assessment processes do not make unfair / unreasonable assumptions about carer capacity
- Share examples of existing practice in using Direct Payments to fund care from family members

In the medium term

- Introduce a right to unpaid carers leave and flexibility from Day 1 of hire
- Commission more flexible breaks for carers (S£)
- Implement carer blind assessment, in line with the Care Act 2014
- Increase financial support for carers, by reforming Carer's Allowance (A££)
- Engage the public in a discussion about a new deal for carers, as part of a new social contract for care and support

In the longer term

- There is a right to paid carers leave (similar to parental leave) and a right to breaks (A££)
- Allocated budgets for care can be spent on family carers who live with the individual (A£££)

Join up care and support for fulfilled lives

What is the shift?

We want to move away from a system that is fragmented and disjointed, forcing people to engage with separate processes to access the support they need to lead fulfilling lives. Instead we want social care that works well with other public services e.g. housing, NHS, benefits, criminal justice and employment support. We want people to be able to access support to work and to engage in other activities that matter to them as part of a joined-up package.

In practical terms this means

- Health, care and housing authorities and others work together to ensure there is a whole-person approach to care and support for people who draw on it and for their families and carers
- There is better access to and availability of primary, community and mental health support and early intervention, crisis resolution and active rehabilitation
- People can easily access employment support, training and education, transport, social and leisure activities that are inclusive and accessible

There are already some examples of this happening in practice, such as:

- Integrated discharge hubs and discharge to assess schemes provided by multi-disciplinary teams (see page 22)
- Models which integrate employment opportunities within independent living schemes (see page 19)
- Connector services which help join up access to information, advice, activities and services in the community, and support people to access them, for example Reconnections in Guildford and Waverley
- Community hubs where people can access a range of services and support in one place

What actions are needed?

In the short term

- Work across local authorities and with health bodies and housing associations to establish integrated support packages
- Improve access to NHS rehabilitation, and start the process of rebuilding capacity in intermediate care with NHS discharge funding (S£)
- Work with local employers to increase the number of supported employment placements for adults with disability (T£)
- Ensure existing social prescribers, link workers and community hubs are working together to provide coordinated approach to information and advice

In the medium term

- Commission integrated health, social care and housing packages around the person and establish integrated teams to deliver them (T£)
- Use wider powers and public funds at local and national level, to shape opportunities for people who draw on care and support (e.g. planning, leisure, transport, etc) (T£)
- National campaigning and local activity to change employer attitudes to older and disabled workers
- Introduce stronger employment rights for carers and disabled people (+++)

In the longer term

- Integrated health and social care commissioning and budgets are the norm (+)
- The employment gap for older workers and disabled people is closing
- Social care is measured against outcomes across all aspects of life – as envisaged in the Care Act 2014's definition of wellbeing (+)

Manchester – Integrated Neighbourhood Teams

Adult Social Services in Manchester have been going through significant improvement and transformation over the last five years, focused on embedding strength-based approaches, providing more targeted, enabling support to people when and where they need it. Integrated working across the NHS and social care has been central to the delivery of this vision.

The context for integrated working is somewhat different across Greater Manchester, as integration across the region has been driven by the devolution deal. In Manchester, staff working in Adult Social Services have been working as part of Manchester Local Care Organisation since 2018.

In this integrated health and care organisation, social workers are co-located and work together with district nurses and other community health teams in a one team approach. They link with GPs, mental health and other professionals to plan and deliver care to people in their part of the city as part of 12 integrated neighbourhood teams. More specialist teams, for learning disabilities for example, operate at a city-wide level on the same integrated basis.

Staff maintain reporting lines within the Adult Social Services departments for the purposes of professional supervision, support and development. The difference is that their day-to-day work is coordinated at neighbourhood level. This way of working enables teams to focus on meeting needs in the community as they present, rather than seeing people stuck at institutional boundaries. Co-location of staff means that care and health teams share information about the people they are working with – passing information between different professionals seamlessly, undertaking joint visits and planning around the person's needs.

This approach is also part of a wider transformation programme in adult social care in Manchester called Better Outcomes, Better Lives. This is a staff-led programme of change focused on supporting people to be as independent as possible in their community, anticipating need, and taking a strengths-based approach that manages demand, which also helps reduce costs in the system.

Neighbourhood working and transformation is based on a robust approach to risk-stratification, backed by data shared across health and social care to enable the provision of timely, targeted support and monitor what is working. For example, reablement is a core component of the Manchester strategy and investment in this area has had a significant positive impact on overall costs - 66% of those who receive reablement support now require no ongoing care and support. This approach has supported them team manage within budget and has freed up resources to further invest in staffing and upstream support.

More accessible and affordable for everyone

What is the shift?

We want to move from a system in which the costs fall unevenly and unfairly upon people who have cause to draw on care and support, and in which some are left with unmet needs due to cost barriers, to one which is accessible and affordable to those who need it.

In practical terms this means

- Ensuring that people are not priced out of care and support services that they need
- Making care charges clear and transparent
- Sharing the cost of care and support more equitably across society

There are already some examples of this happening in practice, such as:

- Widening the range of care and support services that are available without charge – e.g. providing cheap and cost effective home adaptations without a means test such as in St Helens
- Disregarding certain benefits in the calculation of care charges
- Promoting the option of and support with deferred payment agreements

What actions are needed?

In the short term

- Work across social care and public health to fund a range of community-based prevention support that is available without means-testing / eligibility criteria (C£)
- Ensure consistent access to entitlements, e.g. to aids and adaptations, across local areas(+) (S£)
- Review local charges and consider whether these could be reduced (A£)

In the medium term

- Bring in changes permitted under the Care Act 2014, in phases:
  1) Increase the means-testing threshold for paying for care, so that fewer people have to contribute to the costs of care (A£££)
  2) Reduce the cap on care costs to zero for working age adults under 30 (A£££)
  3) Introduce a cap on care costs for all adults (A£££)
- Undertake an independent national review of user charges and set consistent and fair charging across local authorities (++)
- Review NHS Continuing Care and make recommendations about redrawing the boundaries between NHS and social care – in alignment with broader public debate about the future care system (++)
- Consult on a national approach to allocating funds for care based on simpler categories of need
- Consult on further extension to entitlements and potential options for universal care and paying for care

In the longer term

- There is a more universal system of care and support and closer alignment of entitlements to social care with those to health care (A£££)
- There is a welfare-based entitlement to funds for care / care packages, and NHS Continuing Care is reformed in line with review (+++)

Coventry – Rehabilitation first approach

Coventry City Council's approach to social care – which emphasises independent living and which has been described as a "therapist led" approach – is now well-embedded having been operating over two decades. The approach sees the vast majority of new referrals to adult social services being seen first by an occupational therapist (OT) who puts in place a six-week programme of reablement or recovery support.

This approach started some 15–20 years ago, in the face of growing demand and associated costs, when it was identified that, on average, people who had OT-led interventions ended up needing less ongoing support than those who were social worker-led. As a result the council started to shift the skill-mix of its workforce, investing in OTs and placing them at the front door of care and support.

Consequently there has also been investment in reablement capacity among home care providers and in residential settings, with a higher rate paid for reablement support. Despite the fact that the six week support package is not charged for, Coventry's social care spend remains among the lowest in the country.

However, in recent years there have been increasing challenges for this approach – firstly because of difficulties recruiting sufficient OTs to fill vacant posts and secondly because the existing workforce has been spread increasingly thinly across a growing hospital discharge caseload, leaving less time for "front door" assessments in the community.

At the same time the local authority invests in low-level support from the VCFSE sector, including in Carers Trust who carry out all carers assessments on behalf of the Council. They are able to link carers up to a wide range of support in the city, including the local Carers Response Emergency Support Service (CRESS), which enables them to continue in their roles.

Diverse and sustainable providers, focused on outcomes

What is the shift?

We want to move away from a system where commissioners have to ration care and can't pay providers a reasonable price and where services are often bought on a task and time basis, or spot purchased with short term funding. We want to shift to a system where commissioning plans are developed in co-production with people who draw on care and support, their families and carers, whether they receive support paid for by the state or not. We want fair and sufficient funding for those who are responsible for care, with contracts focused on outcomes for people who draw on care and support, and procurement rules which support a diversity of providers.

We want to move from a situation where the options for care are limited, providers are financially precarious, and find it difficult to deliver high quality care, or to invest in shifting to different models of care, to one where there is more investment and capacity available in new types of provider and providers are more sustainable.

In practical terms this means

- Shifting commissioning practice towards commissioning with people and communities
- Making fairer allocations to commissioners so they, in turn, can pay providers a reasonable price
- Investing in new models of care, encouraging new providers to enter the market, and enabling existing providers to adapt their care to changing requirements and demographics
- Improving procurement processes to make it easier for smaller and not-for-profit providers to enter the market/ expand

There are already some examples of this happening in practice, such as:

- Projects to encourage new micro providers in social care such as the Somerset Micro Enterprise Programme and the TRIBE project
- Authorities developing new commissioning models, drawing on TLAP's Commissioning for Better Outcomes guidance or SCIE's Commissioning for a Better Future

What actions are needed?

In the short term

- Co-produce commissioning plans with people who draw on care and support, and their families and carers.
- Improve the transparency of commissioning processes and decisions, and support ongoing review
- Ensure commissioning processes take account of the needs of diverse communities, and address equity and inclusion, as well as generating social value in the local economy
- Invest in accelerating the growth of micro providers (T£)
- Measure and make more visible the level of unmet, undermet and wrongly met need including those waiting for assessment
- Act on the findings of the NAO market review in particular the recommendation for Care Quality Commission (CQC) to look at increasing visibility of provider finances and costs
- Align budgets to reasonable local Cost of Care assessment rates (S£)

In the medium term

- Redefine roles for commissioners in market shaping, clarifying roles at national, system and place levels
- Identify gaps in provision based on data from care plans and signal these to the market through regularly updated market position statements, providing funding to stimulate market entry where needed (T£)
- Review CQC's role and frameworks to support co-production and collaborative commissioning (+)

In the longer term

- Capital and social investment is easier to access, especially for not-for-profit providers to fund renewal of capital assets (A£)
- Whole system/ whole person commissioning is the norm, and commissioners can delegate budgets to groups and organisations as appropriate (+)
- CQC's role in regulating providers of care and offering assurance to people who draw on care and support (or those choosing a provider on their behalf) is aligned with the new system (+)
- Mechanisms are in place to support providers to identify and respond to care and support market opportunities, driven by what people want

Harness the potential of digital technology

What is the shift?

We want to move from a system where digital technology is an add-on and digital innovation processes too often exclude people who draw on care and support, to one in which appropriate and affordable digital tools enhance the experience of providing and drawing on care and support. We want to ensure that there is appropriate and affordable technology to support the delivery of care and support systems, and this supports integrated working.

In practical terms this means

- Co-producing digital solutions with people who draw on care and support
- Making more use of everyday technology to enable care and support
- Working across localities to procure digital solutions together
- Improving the interoperability of digital systems used across different services
- Ensuring staff have the skill they need to use digital tools
- Making sure people can use Direct Payments to pay for technology

There are already some examples of this happening in practice, such as:

- Suffolk is building a digital platform for care and prevention
- Using technology to support the care workforce
- Organisations sharing good practice such as the TEC Action Alliance

What actions are needed?

In the short term

- Co-produce digital strategies with people who draw on care and support
- Train staff, and people who draw on care and support and their families, on the use of digital tools and the options and opportunities available (including social tariffs for broadband etc.)
- Make more use of existing digital tools within care delivery, including ensuring that Direct Payments can be used to buy technology (T£)
- Include digital support and roles within community hubs (T£)

In the medium term

- Widen access to technology-enabled care as part of normal care and support planning and ensure availability and access alongside more traditional aids and adaptations (T£)
- Trial the use of AI and robotics to support delivery of good care and support (T£)
- Improve interoperability of digital systems to support integration across health, care and other services (+)
- Develop national procurement and/ or standards for software and digital tools (e.g. to support cost tracking for care caps) (+)

In the longer term

- Digital technology supports the delivery of care and support as part of business as usual
- People are able to use the latest technologies to support them in the way they choose

Redesign and reward the workforce

What is the shift?

We want to move from a workforce which is poorly paid and feels undervalued and often dissatisfied with their work, and a labour market beset with problems in both recruitment and retention. We want a workforce which better meets the needs of people who draw on care and support, which recognises the breadth of care and support roles including personal assistants, and in which the roles and conditions under which people work mean they are motivated and feel valued.

In practical terms this means

- Improving levels of pay across social care and celebrating and valuing the contribution of care staff in high-profile communications
- Supporting recruitment processes which drive a high-quality workforce – e.g. values-based recruitment
- Developing workforce plans and strategies to meet the demands of the future
- Enabling more staff to work as part of integrated place-based teams, with greater autonomy, confidence and ability in the social model of disability
- Building on plans for the Care Workforce Pathway to make it easier for people to transition between roles and progress their careers within social care and social work

There are already some examples of this happening:

- Community Catalysts supporting micro providers who can offer flexible employment within care and support
- Care providers offering salaried positions, e.g. Just Ask

What actions are needed?

In the short term

- Give the lowest paid care workers an uplift in pay (S£)
- Explore new models of recruitment and training – e.g. values-based recruitment – to deliver improvements in quality
- Act to increase the diversity of the social care workforce and to support Inclusive Leadership, in line with the Diverse by Design principles
- Support staff to work in integrated, more autonomous, place-based teams
- Encourage volunteers within VCFSE organisations to play a role in the system of care and support

In the medium term

- Create local workforce plans for social care, including improving social work capacity – in collaboration with ICS level workforce planning across health and social care
- Invest in encouraging new roles and new models – including micro provision (T£)
- Sustain and build on uplifts in pay across care and support roles, including personal assistants paid through Direct Payments (S£)
- Implement local workforce plans, including experimenting with new roles
- Grow and develop the care and support workforce (including volunteers) to encompass a range of flexible options and opportunities for progression
- Co-produce a national workforce strategy for social care with people who draw on care and support, their families and carers
- Task a national body to set national pay scales across social care

In the longer term

- Roles are benchmarked and there is pay parity with the NHS for care workers in registered settings (A£)
- National workforce strategies are in place and implemented, and are regularly updated in conjunction with people who draw on care and support, their families and carers, and staff who provide care
- New models and new roles in care and support are defined with people who draw on care and support, their families and carers, and staff who provide care

Camden – Self-Managing Teams at Charlie Ratchford Court

When Camden Council decided to develop a new Extra Care Housing unit at Charlie Ratchford Court in Chalk Farm, the then Director of Adult Social Services challenged the team to do something different. Working in co-production with people who draw on care and support locally, a decision was taken for the Council to develop the scheme in-house rather than commissioning an existing Extra Care provider, so that the scheme could trial new ways of working on a "test and learn" basis.

A core part of the plan for Charlie Ratchford Court was that the workforce would be different – with self-managing teams co-producing care with residents. With consultancy support from Wellbeing Teams, plans were made for values-based recruitment of a self-managing team. While the team includes a registered manager, for the purposes of meeting CQC registration requirements, it operates on a flat structure, with wellbeing workers, coordinators and community connectors working together as equals to design and agree rotas, offer peer supervision and problem-solve together. Staff at the scheme work with residents to co-produce their support, focusing on their strengths and what matters to them, rather than the things that they can't do. Support is flexible, high-quality and helps people live as independently as possible.

Charlie Ratchford Court is now a thriving community of adults from aged 19 to 90+. There is a strong social life within the scheme. People who live there are supported to participate in, and lead activities of interest. Local groups and individuals also run events in the communal areas, open to the residents and neighbouring community. A home-cooked meal is served once a day.

While the workforce approach taken at Charlie Ratchford Court is considered successful and the values-based recruitment approach has brought in staff from a wide range of backgrounds, there have been some challenges. Officers within Adult Social Services had to work closely with colleagues within the Local Authority's HR team to pave the way for using a different approach to recruitment. Staff have also needed to "translate" some of the Charlie Ratchford Court ways of working for CQC inspectors, to help them understand how legal obligations are being met in new ways. Another challenge has been that agency staff have struggled to adapt to new ways of working when they have been required in the Court.

Over time lessons have been learnt – for example around the need for the registered manager to have prior experience within social care to fulfil the technical requirements of the role. However, scepticism in some parts of the Council around this new way of working has now been overcome and the person-centred and resident-focussed way of working is now recognised as important.

The next step for Charlie Ratchford Court is to develop its wider offer to the local community (as people move into new housing nearby), which will centre around opening the Court's kitchen to provide a community café.

Barriers and enablers

In this section we explore some of the barriers to, and enablers of, change in social care and discuss who needs to act to address them.

Investment

Social care is a system that is "running hot" and has been for many years. It is marked by significant instability; substantial unmet need; and insufficient capacity in the face of increased demand and acuity of need, in part due to the retraction of NHS community services. These are not conditions conducive to transformation: although some local authorities and providers have managed to shift the approach to care and support despite the circumstances.

In recent years we have seen small-scale injections of funding into social care, usually in the form of time-limited and use-restricted pots, such as the Better Care Fund or winter pressures funding. This has been ineffective in enabling sustained long-term change.

To accelerate progress towards the long-term vision, collectively we will need to invest more and invest better.

We use the term investment purposefully rather than spending or funding. Care and support is a vital part of the social infrastructure, which enables people to remain economically active. Investment in social care can contribute to reducing geographical economic inequalities and growing the national economy. The social care sector is an important part of local and national economies, a large employer, and demand for it is growing.

Our roadmap demonstrates that there are actions that can be taken now to build towards the system of care and support we need. Indeed, many are already being implemented in some places. In order to see this change happen systematically, everywhere, further investment is needed.

We propose that investment in the short-to-medium term be made across three key aims simultaneously.

These aims are:

- **Investment to stabilise** – this funding is to prevent further reductions in the support available to people. Primarily, in the short-term, this funding should be used to improve pay through increased rates to Direct Payment recipients and providers, together with new pay requirements.
- **Investment to transform** – this funding is to create the capacity and capabilities for transformation. The priorities for transformation should be agreed locally through co-production with people who draw on care and support, their families and carers, and will depend on what is already in place. Skills and space to lead transformation are needed everywhere given the breadth and depth of changes needed.
- **Investment in community capacity** – this funding is to support the development of a stronger network of community support, in pursuit of the prevention and wider wellbeing duties within the Care Act 2014. Again there are a range of approaches that could be taken, but the key is to identify and build upon existing assets in the wider community, with a focus on supporting inclusion and tackling inequity.

In our roadmap we indicate how these funds would be spent across the different short term actions we have identified. Even with transformation funding, this is a potentially daunting change programme and will require significant leadership from Directors of Adult Social Services (DASSs).

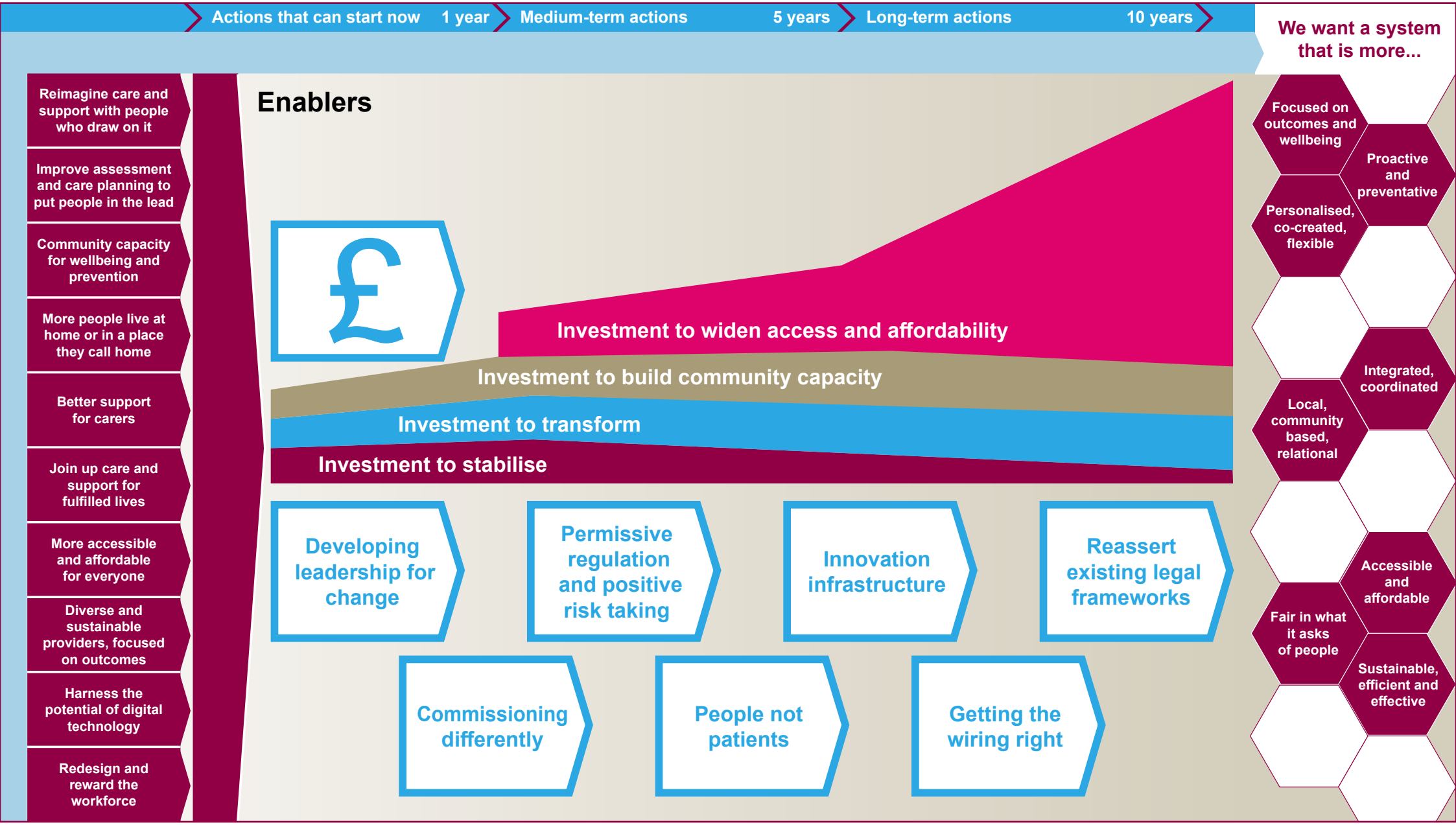
Moving beyond the short term, to achieve our collective vision for social care in full will require a step change in how much society invests in social care. Increasing access to the system by widening eligibility criteria and

ensuring more people are entitled to support, and improving affordability from an individual perspective, will require radically different levels of funding. To get there over the long-term, will require an open dialogue to be started in the medium term, including with the public, about the options for extending entitlement and changing the balance between individual, family, communities and the state for both providing and paying for care. This is about resetting the social contract around care and support: the Archbishops' Commission characterised this as a new National Care Covenant.[25]

While funding is critical and ultimately sits with national government, there are other things that need to change to enable progress against our roadmap. Some of these lie within the control of DASSs and their local partners, both within and beyond their Local Authorities.

Action needed

- The next local government settlement to include a substantial uplift (over and above the social care precept from Council Tax) specifically for social care to be allocated by local authorities to support stabilisation, transformation and building community capacity
- In the medium term, national government to develop a fairer and sustainable allocation formula to ensure that local government has sufficient funding to match need in their area, meet Cost of Care rates for providers, and to cover a mandated pay uplift
- In the medium to long term, national government to give local government a multi-year settlement which is aligned to the funding commitments made to the NHS/ Integrated Care Boards (ICBs).


Actions that can start now
1 year
Medium-term actions
5 years
Long-term actions
10 years
We want a system that is more...
Reimagine care and support with people who draw on it
Improve assessment and care planning to put people in the lead
Community capacity for wellbeing and prevention
More people live at home or in a place they call home
Better support for carers
Join up care and support for fulfilled lives
More accessible and affordable for everyone
Diverse and sustainable providers, focused on outcomes
Harness the potential of digital technology
Redesign and reward the workforce
Enablers
£
Investment to widen access and affordability
Investment to build community capacity
Investment to transform
Investment to stabilise
Developing leadership for change
Permissive regulation and positive risk taking
Innovation infrastructure
Reassert existing legal frameworks
Commissioning differently
People not patients
Getting the wiring right
Focused on outcomes and wellbeing
Proactive and preventative
Personalised, co-created, flexible
Integrated, coordinated
Local, community based, relational
Accessible and affordable
Fair in what it asks of people
Sustainable, efficient and effective

Bringing down other barriers

Developing leadership for change

The vision for social care requires a significant shift in perceptions from seeing care as a service towards seeing it as enabling people to live their lives to the full.

At a national level, there is a role for social care leadership bodies, including the Association of Directors of Adult Social Services (ADASS) and the Chief Social Worker, to clearly articulate the purpose and value of social care in a way that helps to unify voices. It would also be helpful for providers to bring a more unified voice to this debate.

At a local level, DASSs and Principal Social Workers can use their position to signal clearly their commitment to a new vision for social care, and articulate confidently the critical role social care plays in delivering wider ambitions for places around health and wellbeing. They can also advocate within their own local authorities and Integrated Care Systems (ICSs) and build strong collaborations to deliver shared objectives around population health and wellbeing. However, they need support to develop the skills and to access the tools they need to do this effectively.

Co-production with people who draw on care and support, and the wider communities in which they live, is central to the vision. A co-production mindset and commitment to equity and inclusion will be key leadership values for all involved in social care in future. Creating clearer mechanisms at national, regional and local level, through which power can be shared with the full diversity of people who draw on care and support, their families and carers, will also be essential.

Action needed

- ADASS to build on successful programmes such as Accelerate to strengthen the leadership support available to its members to enable them to lead the culture change
- ADASS to signpost members to the practical tools available to implement early parts of the roadmap working collaboratively with people who draw on care and support, local providers and others
- Local authority leadership bodies to recognise and support the crucial contribution of social care and social services departments to core objectives around wellbeing, economic growth etc
- Local authority leaders to work with ADASS and others to promote inclusive leadership and to improve the diversity of adult social care leaders, drawing on programmes such as Diverse by Design
- The Department for Health and Social Care (DHSC) re-establish a national co-production group involving people who draw on care and support and user-led organisations of disabled and older people (to work alongside bodies such as the Health and Wellbeing Alliance)
- Local authorities to establish co-production processes with people who draw on care and support, families and carers, and to invest in leaders who themselves draw on care and support

Innovation infrastructure

While there are a number of established bodies that support NHS organisations around the development and adoption of innovations, innovation infrastructure to support care providers is relatively under-developed.[26] At the same time the fragmented nature of the care market means that the barriers to the spread of innovation are significantly higher than in the NHS. Initiatives like the Social Care Innovation Network held promise, but due to a lack of funding have not continued; meanwhile centres such as IMPACT are in their infancy.

As Integrated Care Systems (ICSs) continue to develop, and to break down the boundaries between health and social care, arguably the NHS's existing innovation infrastructure should become more accessible to those working in social care, but it is unlikely that expertise and ways of working born in the NHS would easily lift and shift to social care organisations. It may therefore be preferable to re-invigorate or scale up support for innovation in social care, to ensure it has the required expertise and understanding of care and support and is of a size to match the transformation in structures, processes and ways of working needed. It is not yet clear whether the "social care innovation and improvement unit" outlined in the recent plan for adult social care will be of sufficient scale to meet this challenge.[27]

The skills and capacity to lead innovation are also lacking in many care providers. Programmes such as GenerationQ, funded by the Health Foundation, and others like it within the NHS, have built up an extensive network of clinicians with quality improvement skills which they can apply in their work. As part of work to address the wider lack of training and career progression in the social care workforce, building a community of care leaders who have skills in change management and quality improvement methods is critical.

Action needed

- National organisations such as UKRI (Innovate UK and research councils), National Institute for Care and Health Research (NIHR) or DHSC to provide funding for one or more existing organisations to take on a greater role around testing and promoting the adoption and spread of innovation in social care
- Other support organisations to build on existing networks / collaboratives to support teams and develop change management / improvement skills

Permissive regulation and positive risk taking

While central guidelines may make clear that innovative approaches are to be encouraged, this does not necessarily translate into how regulation is interpreted on the ground. Inspection approaches are built around more established structures and ways of working and local inspectors may not necessarily embody the values set out at the centre.

Regulation is often lagged, identifying problems after they have already happened. It is clear that a poor rating is not necessarily a sufficient driver of improvement with a small number of providers repeatedly being rated "requires improvement". These persistent poor-quality providers need further intervention. This requires closer working between regulators, commissioners, social workers and people who draw on care and support.

Perceptions around risk can act as a barrier among commissioners to addressing poor quality and encouraging innovation in the provider market. For example the financial fragility of a local care provider could stop commissioners from changing expectations or contract requirements. Awarding exclusive or guaranteed contracts can help to stabilise providers financially, but also reduces choice for individuals in an area. In some cases, concern about the viability of local services can lead to a view that self-directed support and Direct Payments are not to be encouraged. However these risks can be mitigated without limiting choice, for example rather than continuing to commission low-quality services, a better response would be for commissioners to work with local people to identify the kinds of support and activities they want to access, and to support the market to deliver these.

There is work to be done to create the cultures and headspace needed for innovation among providers and commissioners. The new Care Quality Commission (CQC) assurance framework, currently being introduced, could play a positive role in driving improvements in commissioning as well as some of the other shifts required, given its remit to look across ICSs, providers and local authorities.

Recognising and managing risks, rather than eliminating them, will be key to ensuring that there is a smooth transition away from some existing services to new models which better meet the needs of people.

There are also challenges around the approach taken to risk at the individual level, in particular in relation to self-directed support and Direct Payments. In recent years, in some areas, the progress made in previous years has gone backwards, as budgetary pressures have led to more stringent and detailed controls being imposed on people with Direct Payments, at the same time as support for people to take and manage Direct Payments has reduced. Concerns about financial abuse, and the need to meet obligations around safeguarding, have in some cases led to unhelpful blanket approaches being imposed. Positive risk taking is essential if we want to enable people to live their best lives and should trump the commissioner/provider cultures of risk aversion.

Action needed

- CQC to signal through its regulatory structures and market engagement that it is able to regulate innovative care models and ensure local inspectors are trained to be flexible
- CQC to look again at the value of a regulatory sandpit to support care commissioners and providers to experiment and learn with the regulator
- Local authority commissioners to review their risk appetite in relation to market failure and ensure they are not limiting choice for people who draw on care
- DASSs and Principal Social Workers to review the ways in which staff are supported and trained to empower people who draw on care and support to take positive risks and ensure the implementation of Direct Payments does not impede this

Reasserting existing legal frameworks

Much of the change we want to see is in line with existing legislation set out particularly in the Care Act 2014, but also in the Equality Act 2010, Human Rights Act 1998, Mental Capacity Act 2005 and Mental Health Act 2007.

There is a strong view among people involved in care and support that if the Care Act 2014 had been fully implemented (with the funding to boot) then care and support would already be much closer to our vision.

The fact that existing legal frameworks are generally well-regarded is a positive enabler to change, removing the need to wait while legislation for a future social contract is drafted and introduced. However, these legal frameworks are not currently well understood by the public, have not always been fully implemented, and there are cases where local authorities fail to uphold the law or discharge their duties under the Act.

Better articulating and enforcing existing legal frameworks could therefore be a key enabler of progress as well as over the long-term strengthening rights and the mechanisms for enforcement as proposed by the Equality and Human Rights Commission (EHRC).[28]

Action needed

- Local authorities to uphold the rights of people under the Care Act 2014 and Equality Act 2010 and be clear where lack of funding makes it impossible to discharge their duties
- Government to accept and implement the EHRC recommendations including to strengthen the role and give new powers to the Local Government and Social Care Ombudsman

Commissioning differently

Current commissioning structures and procurement processes can be a barrier to reform. They drive competition and division between providers and do not create space to take account of people's own assets and capabilities and the assets and resources of communities. They also tend to favour large organisations with significant capital assets, leaving smaller local organisations, including cooperatives and self-managing teams on the side lines. Contracts that are based on time and task limit the quality of care.

While many authorities have taken steps to commission more collaboratively, further work is needed to promote the close working between providers, the VCFSE sector, and those who draw on care and support. At times these new processes can come up against opposition from within local authorities – particularly in relation to financial accounting procedures, procurement rules etc (see below).

Local authority leaders can play a critical role in ensuring that bureaucratic barriers do not hamper innovative commissioning practice. Social care leadership bodies can play a role in sharing best practice around collaborative commissioning models (for example SCIE's guidance on Asset-Based Commissioning).

Action needed

- Local authorities to create the conditions for people to commission their own support with Direct Payments and Individual Service Funds
- Local authorities to draw on data from across health, care and other services, to develop their strategic commissioning plans in co-production with people who draw on care and support to identify how best to build on local assets to best meet people's needs
- Commissioners to work with providers to ensure gaps in current provision are widely understood, and to collaborate to bring down barriers to entry into new markets
- Commissioners to use transformation funding to develop the necessary skills in market management to enable tolerance of market failures and orderly exit of some existing provision (for which demand may be in decline)

People not patients

In recent years most public debate and media coverage of social care has focussed on its role in enabling hospital discharge and most of the new money unlocked for social care has been tied to aspirations around speeding up “patient flow”. This narrative and emphasis is fundamentally at odds with the understanding of social care as about people’s lives and not about services.

The fortunes of the NHS and social care are inextricably linked. While emphasis has been placed in recent years on how under-investment in social care causes challenges for hospitals, there is far less recognition of how long-term under-investment in community-based NHS services such as district nursing, mental health services and rehabilitation support have fundamentally shifted the levels of complexity and acuity being supported by social care.

Among the public there continues to be a strong attachment to hospitals and higher recognition and value placed on NHS staff. In contrast, the public have a very poor understanding and low awareness of social care.

There is an opportunity in the context of the current NHS crisis to reset understanding of the value of social care. Social care providers and commissioners are delivering against the challenge set at the outset of the current winter crisis and the results are tangible across the NHS. This is creating a unique moment of opportunity to make the case for sustained investment in a system which can deliver change at pace and to powerful allies.

ICSs also provide an opportunity for a rebalancing within the NHS to focus more on primary and community services and on prevention, as Patricia Hewitt recognised in her recent review.[29] There are already some good local examples of integrated teams working across health and care in the community. These should be easier to establish and scale in the context of integrated governance structures. However, as the Hewitt Review recognised, it is vital that social care leaders have a strong voice within ICS structures and are able to make the case that social care is a significant contributor to wider community health and wellbeing.

Action needed

- Integrated Care Partnerships (ICPs) to include appropriate representation of and engagement with representatives of care and support locally, including local authorities, providers from across sectors, people who draw on care and support, their families and carers. Mechanisms for provider input could potentially be built on models in other sectors – such as emerging VCFSE Alliances
- Integrated Care Boards (ICBs) to include local social care leaders, in line with the recommendations of the Hewitt Review, and to give time and consideration to the process of integration with social care, with due priority on agendas and in the plans for their systems

Getting the wiring right

While less often discussed, there are some practical issues that can get in the way of implementation locally. These include issues within local authorities and at national level.

For example, established IT systems that are not compatible or interoperable with other systems in the NHS, VCFSE organisations, or wider public services, can inhibit integrated and coordinated care.

Data protection regulations, while important to protect our personal information and data, if not given early consideration, can also inhibit appropriate data sharing that is beneficial to the individual and services.

The lack of data about ethnicity, for example or other protected characteristics, can limit the ability to analyse (and then address) inequalities in access to services, for example who is waiting for assessment, and the impact of charges on access. There is also a more general issue about both what gets measured and the ability to analyse and make use of available administrative data to understand the quality and outcomes of care. There are opportunities to address these issues as part of the Care Data Matters programme.

Financial systems and accounting requirements can limit the use of different incentives or fee structures, and may stop for example, multi-year business cases being approved that would support trialling and spread of innovative models.

Procurement requirements can result in VCFSE organisations and Small and Medium Sized Enterprises being excluded from the market, particularly when they do not make it easy to take social value into consideration when comparing bids. In recent decades, some local authorities moved away from giving grants to local VCFSE organisations to provide low level, preventative services, introducing burdensome tendering exercises instead, resulting in a reduction in grant funding to the VCFSE. Although some now have recognised the false economy in this and restored small grant programmes.

The experience of those who have been trying to push for change for decades is that these can be real barriers to local transformation. These are not always insurmountable but they often demand leadership and resilience and certainly require other colleagues within local authorities to share in the overall goal.

Action needed

- Local authorities to ensure that staff in key roles, including finance, human resources, digital etc support DASSs as they work to redesign and transform social care, building understanding of the outcomes and reasons for change
- Local authorities to review and update procurement and data sharing guidelines to ensure they meet the needs of social care and its partners
- Build on the Care Data Matters programme to enable a better understanding of the quality of care, outcomes achieved for people, and equitable access to care and support

Conclusions

Care and support is about enabling us to live our lives to the full, whether we live with disability, are older, or have complex health or social issues which impact our lives. This is the shared vision to which we all aspire.

We all want to live in the place we call home, with the people and things that we love, in communities where we look out for one another, doing the things that matter to us. We know the things that will need to change to get us to a place where we can deliver this for everyone, including those with the most complex needs.

While the current context is challenging, and the process of achieving our vision will take time, there are steps that can be taken now towards the change we all want to see and clear actions that will bring us closer to making a reality of this in more people's lives.

The roadmap we have set out recognises that there are things that local authorities, and Directors of Adult Social Services in particular, can do now.

However, to deliver the vision will require some more fundamental changes and significant increases in investment. We have sought to identify the enabling actions which are also needed to make faster progress.

Implementing this roadmap will look different in different places, but there are key waymarks along the path which need everyone who is involved in care and support to act – as policy makers, commissioners, providers, user led organisations, or as individuals.

We know where we want to get to. Now is the time to act; for everyone to take responsibility for those actions within their spheres of influence and make progress. By doing this we can offer hope to all of us who draw on care and support and to our families and wider communities.

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