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Towards a National Care Service:
raising national standards of care

January 2026

access

About SCIE

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The Social Care Institute for Excellence (SCIE) is an independent social care charity, collaborating and innovating with a wide range of partners and people with lived experience, to improve people's lives. Working across social care, health and related services such as housing, for adults, children and families, we contribute to the development and implementation of better care, support and safeguarding at local and national level.

As we are not-for-profit, our income goes towards improving social care, delivered through our four offers: innovative **consultancy**, expert **training**, extensive **resources** and information, and evidence-based **insights**.

Co-production with people with lived experience underpins and informs what we do, and with over twenty years' experience we bring a wealth of trusted, evidence-based expertise to work together to help transform care.

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Foreword from our Chief Executive

This Government has made a clear and public commitment to reform adult social care through the creation of a National Care Service, underpinned by national standards of care, designed to deliver greater consistency, fairness and quality of care across England. As a first step, the Government has launched an independent commission into adult social care, chaired by Baroness Casey, to inform the work required to deliver this ambition.

This renewed political attention comes at a critical moment for social care. The experience for many people who draw on care and support remains one of inconsistency, insecurity and unmet need.

In response, the Social Care Institute for Excellence, with support from The Access Group, convened a series of four policy roundtables to explore how national standards of care could form the basis for system reforms. Across October and November 2025, we brought together policymakers, commissioners, people who draw on care and support, unpaid carers, providers, and researchers to debate the principles, key opportunities and levers for change.

The roundtables highlighted the potential for using national standards of care to tackle people's frustrating experiences and poor outcomes. These include issues of equitable access to care, where local systems struggle to meet even the most basic needs, as well as the variation in care experiences and how this affects people's quality of life, their dignity and independence. Discussions about inadequate support also covered how this places intolerable pressure on unpaid carers.

Starting with a set of principles, this report describes the key insights from the roundtable discussions, including areas of consensus and unresolved tensions, and presents additional evidence for how national standards might be developed and used effectively, including their limitations. National standards of care were seen as having the potential to offer clarity about what people can expect from a National Care Service, resolving issues of quality and equity, and setting out the priorities for system change and innovation.

One purpose of the roundtable series was to develop a framework for what national standards of care could and should be – rooted not only in policy aspiration but grounded in the practical realities of frontline delivery and lived experience. Based on the roundtables and supplementary evidence, this report proposes such a framework and describes how it could be used to close the gap between our policy ambitions and people's real-life experiences. To achieve this potential, however, the framework identifies important enablers, from more effective allocation of public resources to investing in a well-trained workforce.

Our intention is for this report's insights and the proposed framework to prompt further debate and to inform the work of the Casey Commission and its recommendations for a future National Care Service.

We are especially grateful for the expertise of all the participants in the roundtable series, whose perspectives reflected the sector's diverse interests and who challenged assumptions and the status quo. We would like to extend a heartfelt thank you to our colleagues at The Access Group for their support and commitment to bringing this roundtable series to life.

Kathryn Marsden OBE
Chief Executive, Social Care Institute for Excellence

Executive summary

The ambition to introduce national standards of care reflects widespread recognition of persistent inequities in adult social care. People's access to support, the quality of care they experience, and the outcomes they achieve continue to vary significantly depending on where they live and how local systems operate.

This report's purpose is not to restate these challenges, but to clarify what national standards of care could realistically achieve, the problems they are best placed to address, and the conditions under which they are most likely to support meaningful improvement.

More specifically, national standards have the potential to bring greater coherence, visibility and accountability to established values in social care. This includes the Care Act 2014's core principles of wellbeing, prevention, partnership, accountability and choice and control, and, more recently, Social Care Future's articulation of social care's 'North Star': "We all want to live in the place we call home, with the people and things we love, in communities where we look out for each other, doing the things that matter to us".

Accordingly, the starting point for this report is that a critical challenge facing social care is not a lack of vision or values, but the absence of shared, operational expectations – ones that consistently translate these principles into people's day-to-day experiences of care and support.

Drawing on evidence from a series of policy roundtables, in conjunction with lessons from wider health and social care policy and international learning, this report sets out a proposed framework for national standards of care. This framework is intended to clarify the principles, expectations and design choices required if standards are to support meaningful and sustained improvement in social care access, outcomes and experiences.

National standards are therefore best understood as a mechanism for clarifying expectations for a future care service – anchored in lived experience. This is also where key tensions sit: between national consistency and local discretion; between standardisation and personalisation; and between assurance and learning. These tensions cannot be designed away. They need to be managed explicitly. As such, central to the framework is a core set of seven foundational principles. These principles define what is essential and non-negotiable across all care settings and for all people who draw on care and support. They provide the baseline against which quality, equity and person-centredness should be judged.

01 Adopting a rights-based definition of social care
02 Embedding co-production and lived experience
03 Outcomes and evidence metrics that reflect what matters to people, not just what is measurable for care systems or providers
04 Early intervention and integration as core system behaviours
05 Aiming for a care system that is fair and equitable to all
06 A system that is easy to understand and to navigate
07 A system that delivers high-quality care while using resources efficiently and sustainably.

It is also clear that national standards of care cannot, on their own, resolve the structural challenges facing the care sector. Yet, they can play an important role in setting system-wide expectations and shaping how statutory duties are interpreted by different actors and prioritised.

This includes reducing unwarranted variation by clarifying what people should be able to expect regardless of postcode, provider or funding route, while deliberately protecting flexibility in how outcomes are achieved locally. The emphasis is on standards that specify outcomes and experiences, rather than prescribing services, tasks or processes, so that national consistency does not become standardisation at the expense of personalisation and innovation.

The success of national standards also depends on the conditions under which they are implemented. The current care sector limitations extend to workforce skills, capability and leadership; commissioning capability and market shaping aligned to outcomes; co-production infrastructure that treats lived experience as a default system behaviour; and improved data and digital foundations. Without deliberate action to strengthen these enabling conditions, national standards risk either remaining aspirational or defaulting to narrow compliance processes. The framework therefore treats standards and system capability as interdependent, emphasising that standards must both articulate expectations and actively shape the investment, behaviours and accountability needed to deliver them.

Beyond system conditions, the framework also draws on lessons from previous approaches to national standards in health and social care, including NICE guidance and NHS Modern Service Frameworks. These experiences highlight that standards are most effective when they are embedded within commissioning, regulatory and improvement systems, supported by clear national stewardship and sustained local capability. Where standards operate in isolation from these levers, their impact on practice and outcomes has been limited.

Taken together, the framework set out in this report points to a clear call to action for government, system leaders and sector partners.

The central challenge is not defining new ambitions, but translating shared principles into consistent frontline practice. As the framework sets out, national standards will only drive meaningful change if they are designed and implemented alongside the enabling conditions required to deliver them – workforce capability, commissioning and market-shaping skills, co-production infrastructure and robust system intelligence. These are not peripheral considerations, but integral to whether standards function as levers for improvement or remain aspirational statements. While this report identifies practical ways in which standards can begin to shape these conditions, it also highlights areas where further development and testing will be needed to support sustained system reform.

The report also recognises the risks and constraints inherent in introducing national standards in a complex, resource-constrained system. Poorly designed or implemented standards risk reinforcing compliance-driven behaviour, misusing data, or constraining local innovation without strengthening delivery capacity. There are also political and economic realities to contend with, including changes in government priorities over short electoral cycles and sustained financial pressures on the care sector.

For these reasons, the framework set out here is intentionally focused on outcomes, learning and system capability, rather than prescriptive models. The 'Next steps for the framework' section sets out how SCIE is committed to taking this work forward: developing a roadmap with sector partners and people with lived experience; focusing initial standards on priority challenges in social care and areas of interface with health; supporting a shift towards prevention and early intervention; and working with government and the Casey Commission to improve clarity for the public about what good social care looks like.

About the SCIE roundtable series

Social care in England is characterised by marked variation in access and quality.

In some areas, services provide timely, personalised support that empowers people to live with choice, independence and dignity. In others, overstretched local systems struggle to meet people's basic needs, with unpaid carers often shouldering the financial, emotional, social and physical costs. Overall, local care systems are increasingly under pressure because the demand for social care outstrips available resources.

Following the launch of the Casey Commission, SCIE, supported by The Access Group, stepped forward to help explore what we mean when we talk about national standards of care and their role in shaping social care reforms.

During October and November 2025, a series of four roundtables was jointly convened to discuss the issues and to co-produce a framework that will support the consistency, personalisation and quality of social care provision across the country. Discussions were structured around a small number of core questions, and they were designed to surface areas of consensus, tension and unresolved challenges.

The roundtables were attended by 75 representatives from national and local government, national and local charities, independent care providers of varying size, care provider representative bodies, workforce representative bodies, unpaid carer representative bodies, NHS representative bodies, researchers and think tanks, as well as people with lived experience.

The first roundtable tackled the lack of a shared understanding of what national standards of care mean in practice. Entitled 'Purpose, quality improvement and personalisation', the roundtable examined whether standards should act as baseline guarantees that safeguard against poor practice, aspirational goals that drive continuous improvement, or a combination. Participants explored different ways of defining national standards in terms of behaviours, processes or outcomes, and their discussions addressed what areas of care the standards should cover, how detailed they should be and whether they should apply in the same way across different types of services.

The second roundtable examined 'Data, technology and their role in enabling better care'. Building on the premise that standards should be measurable, transparent and future-ready, participants pointed towards the fragmented care system and underdeveloped infrastructure for social care data, which often fails to capture what matters most to people. Participants discussed unresolved questions about how digital tools such as AI and real-time analytics can be used responsibly, how to guarantee digital inclusion, and how issues of consent and the ethical use of personal data should be addressed.

The third roundtable explored the potential of national standards in driving 'Integration and system alignment'. Recognising that the social care system does not operate in isolation, participants pursued how standards could be used to create a joined-up system that supports people's lives, not just service delivery, including alignment with healthcare, housing and community services. In particular, the current gaps across the health and care system were viewed as contributing to people's experiences of variable access, fragmented services and inconsistent outcomes. The roundtable examined the mechanisms, partnerships and approaches needed to ensure standards can support a more coordinated and cohesive system of care. Discussions addressed how standards might correspond with current reform efforts in the NHS and housing sectors, promote shared outcomes across public services, and strengthen collaboration between local government, the NHS and voluntary and community services.

The final roundtable covered 'Measurement, accountability and future policies'. Participants observed that existing accountability and regulation in the sector rely heavily on compliance and inspection, which can identify failings but do not always promote learning or improvement. The discussions addressed the need to balance mechanisms for assurance with flexibility for provider-led innovation. There was uncertainty about who was responsible for setting national standards of care and how they would evolve over time. However, participants stressed the importance of ensuring collective responsibility for standards so that they respond to demographic changes, emerging evidence and feedback from people who draw on care.

This report draws directly on the insights gathered from the roundtable discussions. For a comprehensive account of each roundtable, including the questions explored and the discussions which took place, please refer to the SCIE website, where you will find 'Insight papers' connected to this report.

The roundtable insights are set within the wider policy and legislative context in England. These sources have been used to test the insights against wider system evidence and to identify areas of alignment and gaps. The paper also draws selectively on international experience, where this helps illuminate design choices or trade-offs for developing national standards of care in England.

What good care services should deliver for people

Having engaged with a variety of sector interests and diverse perspectives through the roundtable series, a consensus emerged about the purpose and scope of national standards of care, particularly regarding their effectiveness in tackling existing system challenges.

In the absence of a national quality strategy in social care, something evidenced by Penny Dash's 'Review into the operational effectiveness of the Care Quality Commission', there was a strong push to define the boundaries of what national standards can and cannot achieve, starting with a coherent set of principles that reflect the values of social care.

National standards of care have the potential to bring greater coherence, visibility and accountability to an already established set of values in social care – aligning what the law intends with what people should expect from their care experiences. In other words, national standards of care should be grounded in a clear, shared understanding of what good care and support are meant to deliver for people who draw on care and support, and also for their carers. This has been best articulated through Social Care Future's 'North Star' vision for a future National Care Service: "We all want to live in the place we call home, with the people and things we love, in communities where we look out for each other, doing the things that matter to us". This understanding is not new. It is already articulated in statute, including, but not limited to, the Care Act 2014, Health and Care Act 2022, Mental Health Act 2025 and Children and Families Act 2014.

A multitude of interconnected and deep-rooted challenges have prevented the sector from delivering this 'North Star', however. Chronic workforce shortages, local authority budget gaps, unmet care needs, and geographic disparities in access and quality have left those who need social care without adequate support, while unpaid carers face significant economic and personal sacrifices.

Despite these challenges, the principles enshrined in the current statutes remain valid and are ones national standards of care should take forward. The Care Act 2014 establishes wellbeing, prevention, choice and control as the core principles for adult social care, positioning support not merely as a response to need, but as an enabler of dignity, independence, relationships and participation.

The Care Act 2014, Section 1, establishes wellbeing as the organising principle for adult social care. Section 1 places a general duty on local authorities to promote an individual's wellbeing, defined as including:

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

These principles are reinforced by the Health and Care Act 2022, which places duties on integrated care systems to pursue population health, reduce inequalities and support integration across health, social care, housing and community services. Similarly, the Children and Families Act 2014 sets out the principles of choice, coordination and continuity. Taken together, this statutory framework articulates a coherent vision of care as part of the nation's social infrastructure, focused on relational, rights-based, preventative and integrated care.

Although these principles are unevenly realised in practice, with wide variation in access, experience and outcomes across local systems, recent progress has been made. For instance, Think Local Act Personal's Making It Real framework translates these statutory duties into outcomes expressed directly through lived experience. Its co-produced 'I statements' describe what good support looks and feels like in practice, and these are presently being used as part of the regulation of social care. For example:

> “I can live the life I want and do the things that are important to me as independently as possible.”

> “I can get information and advice that helps me think about and plan my life.”

> “I feel safe and am supported to manage risks in a way that matters to me.”

> “I have people who support me, such as family, friends and people in my community.”


VISITOR
Ant Tucker
NHS Confederation


CLENTON
TLAP.


Welcome from the Chair
Kathryn Marsden OBE, Chief Executive,
Social Care Institute for Excellence

What national standards can help address and what they cannot

Given the existing care system pressures, it is important to understand the limits of what national standards of care can realistically achieve.

Social care in England faces deep-rooted challenges, including chronic underfunding, workforce shortages, provider market instability and structural fragmentation, as evidenced in the Health and Social Care Select Committee's inquiry '[Adult social care reform: The cost of inaction]'.

Standards cannot, on their own, resolve the system's inability to meet the growing demand for social care. They cannot tackle issues of sustainable funding, fair pay and progression for the workforce, or long-term investments in service capacity. Nor can they, by themselves, eliminate the fragmentation of services and poor care experiences arising from the separation of health, social care, housing and welfare systems.

However, national standards of care can play a distinctive and important role if their scope is clearly defined. They can help to:

01 support people's care preferences and choices
02 enable consistent provision of high-quality care
03 improve equity by reducing unjustified variation in people's care access, quality and experiences
04 improve accountability for access, care outcomes and care experiences.

Supporting people's care preferences and choices

Outcomes-focused standards can actively enable personalisation. By clarifying what care should achieve, rather than how it must be delivered, standards can support flexibility, innovation and individual choice. Which outcomes are measured and how they are measured are two sides of the same coin.

Concerns were expressed at the roundtables that setting out national standards could promote the standardisation of services over personal choice and control. Participants commented on the related risk of standards being overly prescriptive and focused on processes rather than outcomes. Finding a way to balance these considerations was deemed important but remains unresolved.

The Making It Real framework provides a strong, co-produced articulation of personalised outcomes, expressed through lived experience. From the roundtables, there was agreement that embedding this framework within national standards would enable:

- greater consistency in how personalisation is understood and applied
- flexibility in service models, including community-based and preventative approaches
- proportionate risk-taking in pursuit of individual goals
- recognition that maintaining stability or a chosen way of life can represent positive outcomes.

Despite the support for the Making It Real framework, there was recognition that the role of the 'I statements' would be enhanced with greater reliability of their metrics and a more consistent approach to collecting and classifying data.

Enabling consistent provision of high-quality care

A second core purpose of national standards should be to support improvement in the quality of care and to ensure that high-quality social care is consistently accessible and available across local care systems.

Historically, quality in social care has often been measured as compliance with processes, inputs or infrastructure requirements, rather than from outcomes and lived experience. Reviews of regulation and inspection, including Penny Dash's 'Review into the operational effectiveness of the Care Quality Commission' and Sir Mike Richard's 'Review of CQC's single assessment framework and its implementation' have highlighted the limitations of this approach, noting that it can distort practice towards what is easiest to measure rather than what matters most to people. As the former evidenced, to shift this tendency, greater emphasis should be given to expanding the range of outcome measures used in the sector.

Importantly, standards can also help address inequities in care access and quality. Evidence from CQC's annual report, 'The state of health care and adult social care in England 2024/25', shows that people from marginalised groups, including people with learning disabilities, autistic people and people from minoritised ethnic communities, are more likely to experience both difficulties in accessing care and poorer quality of care. By making these expectations explicit and measurable, national standards of care can support more systematic identification of inequalities and clearer accountability for addressing them.

Improving equity by reducing unwarranted variation in access, experience and outcomes

Despite a national legal framework, i.e. the Care Act 2014, people's access to care, the quality of support they receive and the outcomes they experience continue to vary widely depending on where they live, how their care is funded and which organisations are involved. The CQC's 'The state of health care and adult social care in England 2024/25' highlights significant geographic variation in:

- eligibility thresholds and assessment practice
- access to timely support, particularly at points of transition
- continuity and reliability of care
- workforce capacity and stability.

This unwarranted variation directly affects people who draw on care and support as well as their unpaid family carers. National standards could help address this by defining a consistent baseline of what people should be able to expect in their access to, and experience of, care and support.

Yet a key debate at the roundtables was whether national standards should be framed as a minimum "floor" of rights and expectations, or as a broader improvement ambition that pulls the whole system upwards. Participants supported the idea of a floor because a baseline creates clarity and enforceability that people can rely on, regardless of postcode, provider or funding route. However, participants also acknowledged the risk in a resource-constrained system that minimum standards can quickly become interpreted as “good enough”, turning the floor into a ceiling and legitimising low ambition.

The roundtables suggested an alternative framing: that national standards of care should include a rights-based baseline that is non-negotiable, while being explicitly designed to enable continuous improvement above that baseline. In practice, this means pairing any ‘minimum expectations’ with an improvement model – one with capacity for shared learning, information transparency and feedback loops – so that standards are not a static compliance threshold but a mechanism for progressively reducing inequity and continuously improving outcomes over time.

The NHS provides a relevant comparison of how national expectations can be translated into a structured improvement offer. The Government’s ‘10 Year Health Plan for England: fit for the future’ commits to the development of “Modern Service Frameworks” as part of a refreshed quality strategy, with early priorities including cardiovascular disease, mental health, frailty and dementia. This approach signals a model in which standards are set on a consistent ambition, describing how the best evidence-based interventions will deliver better care for people, alongside a clear strategy to support and oversee uptake by health and care professionals.

For social care, the lesson is to create shared ambition and expectations that support improvement while allowing local adaptation. Participants in the roundtable series consistently warned against overly prescriptive standards that could undermine personalisation and local innovation. Instead, the suggested approach was to frame standards around lived-experience outcomes (a “common currency”), with clear expectations at key cross-system touchpoints (such as hospital discharge, mental health crises and transitions to adulthood), underpinned by data interoperability and an improvement infrastructure.

International evidence reinforces this approach. In New Zealand, as shown by Standards New Zealand, national standards of care are explicitly framed as a stable national floor of rights and outcomes, designed to apply consistently across a mixed public-private system while allowing for cultural and local adaptation. These standards embed expectations for partnership working, equity and culturally responsive practice across the system, including explicit recognition of Te Tiriti o Waitangi and the role of Māori in governance, design and improvement. Beyond this, and importantly, the New Zealand approach positions standards as part of a wider improvement architecture, aligning assurance, learning and continuous review rather than treating compliance as the primary objective.

In Ireland, the Health Information and Quality Authority (HIQA) has developed national social care standards that articulate clear, rights-based expectations for people’s experiences of care. HIQA’s standards are structured around themes such as person-centredness, safeguarding, governance and responsiveness, and are supported by guidance that encourages services to demonstrate learning, reflection and improvement over time. Evidence from the Health Information and Standards impact report 2023 highlights that its effectiveness lies not in uniformity of provision, but in providing a common outcomes-focused reference point against which diverse local services can be assessed, challenged and improved.

Taking lessons from international comparators, England’s approach to care standards could adopt a model in which standards describe shared outcomes, make cross-system responsibilities explicit, and provide structured mechanisms for review and refinement, supporting collaboration as a built-in feature of how standards operate.

Improving accountability for access, care outcomes and care experiences

Accountability arrangements are a critical determinant of the impact of national standards of care. The National Audit Office in ‘The adult social care market in England’ (Figure 2) set out how adult social care is currently shaped by fragmented roles across government departments, local authorities and regulators, with no single line of sight for system performance and limited direct levers for central government to intervene in local authority delivery. This fragmentation matters because national standards are only meaningful if someone is responsible for ensuring they are realised, and if responsibilities across partners are sufficiently clear, especially where responsibility for better care outcomes is shared, such as with integrated care.

An interesting insight from the roundtables was about striking a balance between prime responsibility and “shared accountability” across care system partners, since the day-to-day oversight and delivery of the standards may need to be dispersed across a number of actors.

Successful delivery of care may depend on a combination of the regulator, commissioners, representative bodies and local leaders, but it is important not to leave the governance muddled. Allowing the tension between a compliance-driven approach and more diffuse accountability to persist could result in finger-pointing by system partners and little progress in improving accountability. Without a national strategy for improving quality in social care, as evidenced in Penny Dash’s ‘Review into the operational effectiveness of the Care Quality Commission’, accountability cannot rely on regulation alone; it must be designed as a whole-system model and facilitate collaboration.

The roundtable discussions also noted that if national standards are implemented through “shared accountability”, they will be effective only if enabled by shared capability and aligned incentives. Participants repeatedly described accountability failures at “touchpoints” (such as hospital discharge, housing-related escalation and mental health crises) as the predictable outcome of separate budgets, competing priorities and unclear expectations about who must act, when, and with what data. They argued that standards must therefore define expectations – roles, timelines, minimum information to be shared – and be accompanied by the practical system levers needed to deliver them, including joint commissioning capacity and interoperable electronic care records.

The issue of accountability is one which requires further investigative work as unresolved overarching tensions remain, not least whether national standards of care themselves lead to clearer accountability and system governance, or whether clearer accountability and system governance would lead to better national standards of care.

A proposed framework for national standards of care

This section sets out a proposed framework for national standards of care, drawing together evidence from the roundtable series, policy discourse and international learning to clarify the principles, expectations and design choices required if standards are to support meaningful and sustained improvement in social care access, outcomes and experiences.

Rather than presenting standards as a single policy instrument, this framework recognises that standards operate within a complex system shaped by legislation, funding, workforce capacity, regulation, commissioning and lived experience. The section, therefore, addresses the conditions under which standards are most likely to be effective, and the trade-offs that must be navigated in their design and use. The intention is for these standards to command the attention of social care leaders, enabling the accountability, levers for change and allocation of resources that move the dial for achieving better care.

The framework is structured around six interrelated questions:

- What principles should underpin all national standards of care?
- How and where might standards be used to drive system reform?
- How might national standards be used in practice?
- How will we know if standards are enabling the system's desired reforms?
- What will be needed to support the development and use of standards over time?
- What methods might be used to develop standards? How do we build on the existing body of evidence about good practice?

What principles should underpin all national standards of care?

National standards of care must be underpinned by a clear and shared set of foundational principles. These principles define what is essential and non-negotiable across all care settings and for all people who draw on care and support. They provide the baseline against which quality, equity and person-centredness should be judged.

These principles are not intended to be abstract. They are grounded in existing statutory duties, co-produced frameworks and regulatory expectations, and they reflect areas where there is already broad consensus across the sector about what good care and support must deliver for people, including unpaid carers.

Without a clear set of foundational principles, national standards of care risk being reduced to technical compliance, describing service activity rather than shaping a future model of care. A future National Care Service requires standards that actively pull the system towards quality, equity and personalisation, rather than simply codifying today's constrained practice. This is particularly important in a context where national policy, not least the 10-Year Health Plan, is explicitly seeking to shift public services upstream (early intervention and prevention) and outward (community-based support), and where adult social care is increasingly recognised as integral to wider public service resilience.

Seven foundational principles are presented below:

01 Adopting a rights-based definition of social care
02 Embedding co-production and lived experience
03 Outcomes and evidence metrics that reflect what matters to people, not just what is measurable for care systems or providers
04 Early intervention and integration as core system behaviours

05 Aiming for a care system that is fair and equitable to all
06 A system that is easy to understand and to navigate
07 A system that delivers high-quality care while using resources efficiently and sustainably.

Adopting a rights-based definition of social care

First, national standards must rest on a clear and legally grounded definition of who social care is for and its purpose and scope. The Care Act 2014 establishes wellbeing as the core principle for adult social care, embedding duties that go beyond safety and basic need to include dignity, autonomy, participation and early intervention. That purpose sits alongside other statutory expectations that shape real-world care pathways: the Children and Families Act 2014 frames rights and outcomes for children and young people with special educational needs and disability, with direct implications for transition into adulthood; the Health and Care Act 2022 reinforces system duties around integration and inequalities; and the Mental Health Act 2025 strengthens rights and least-restrictive practice in mental health settings.

Taken together, these frameworks suggest that national standards should articulate social care as enabling ordinary life: living with dignity, connection and control, and receiving support that is coordinated across organisational boundaries.

However, across the roundtable series, there was clear recognition that articulating care in terms of rights and entitlements risks exposing the gap between statutory ambition and the system's current capacity to deliver consistently. Participants cautioned that if rights are framed as absolute guarantees without regard to delivery realities, there is a risk of raising expectations that cannot be met in the short term, potentially undermining trust among people who already experience inconsistency and unmet, under met or wrongly met need. The Care Act 2014 provisions were seen as a cautionary tale.

At the same time, the roundtable discussions highlighted that ignoring a rights-based framing carries its own risks. Where expectations are not clearly articulated as rights, practice tends to default to discretion, negotiation and local interpretation, reinforcing geographic inequities and weakening accountability.

A way around these considerations was to propose that standards should be designed to increase the probability of good outcomes and even better, quality care. This framing allows standards to be ambitious without being detached from reality, and to act as a lever for improvement over time. rather than a benchmark that the system is set up to fail.

Embedding co-production and lived experience

National standards must treat co-production and lived experience not as themes in their own right, but as the default for prioritising, implementing and continuously improving care. The insights from the roundtable series showed that where co-production is taken seriously, it defines standards around what matters to people, the questions that are asked, the measures used, and the decisions that follow. Where co-production is absent or tokenistic, standards risk being designed around institutional convenience instead.

There is already a strong foundation for translating rights and statutory intent into lived experience language. The Making It Real framework sets out co-produced statements describing what good care and support look and feel like from the perspective of people who draw on care and support. In policy terms, its value is that it provides the practical "common currency" for standards discussed earlier: a way to specify expectations in terms people recognise (choice, relationships, feeling safe without being controlled) rather than service processes.

The development of national standards of care must use co-production to be meaningful. Roundtable participants were keen to stress the need to build directly on Making It Real rather than inventing parallel frameworks, using it to shape the language of standards, the way quality is judged, and the design of improvement programmes.

The use of co-production also has implications for the governance and performance of local care systems and services. In regards governance, national and local standard-setting bodies should include people who draw on care and support as equal partners, through co-chaired boards, citizens' panels and properly resourced roles. Regarding improving performance, co-production should be embedded in commissioning processes such as service design and evaluation, ensuring that decisions about quality cannot be taken without the voices of those most affected.

Outcomes and evidence metrics that reflect what matters to people, not just what is measurable for care systems or providers

Standards must be underpinned by outcome measures and metrics that reflect what matters to people who draw on care and support, not simply what is easiest to count.

This is not a simple task. Even in the Government's policy paper 'Adult social care priorities for local authorities: 2026 to 2027', the core set of outcomes, outputs and activity metrics, which are predominantly drawn from existing frameworks, such as 'Monthly statistics for adult social care (England)' and 'Measures from the adult social care outcomes framework, England', are not collected in real time, they reflect only a subset of people who draw on care and include metrics more related to NHS services than social care.

This underscores a challenge identified by the roundtable participants about what we currently measure. They noted that there is a disconnect between the things people say define a good life – safety, continuity, control, relationships, belonging – and the indicators currently used to track system and services performance, which focus more on episodes of care, process compliance or crude activity counts.

To shift the dial, national standards should require:

- A concise set of co-produced outcomes, aligned with Making It Real and the Social Care Future vision, which can be applied at individual, service and system level.
- A mixed-methods approach to evidence, combining quantitative indicators (e.g. visits) with qualitative stories, peer challenge and continuous feedback loops.
- Integrated, interoperable data arrangements that allow information to flow lawfully and transparently across health, care, housing and community services, while maintaining people's rights to see, correct and control their own records.

This requires bringing together the Care Act 2014's broad duties, existing datasets such as ASCOF, and the CQC's emerging use of experience data into a single, co-produced measurement spine for the National Care Service. Without such a spine, standards will struggle either to demonstrate their impact or to shift behaviour towards system learning and improvement. Finding new ways to capture relevant data in real time should be a concurrent aim, one requiring further research.

Early intervention and integration as core system behaviours

National standards must treat early intervention and integration across the health and care eco-system as core system behaviours, not aspirational add-ons. As unfulfilled aims of the Care Act 2014, the benefits to people who draw on care and support are well established. A focus on intervention and integration, however, will require articulation of shared priorities, clarity of accountabilities and alignment of resources.

Prioritising early intervention remains challenging in the current financial climate. Resources are constrained in all parts of the system, with acute care being prioritised in system response. The ‘Independent Investigation of the National Health Service in England’ found that between 2006 and 2022, the share of the NHS budget spent on hospitals increased from 47% to 58%. At the same time, the ADASS ‘2024 Autumn Survey’ found that the proportion of councils taking a positive investment strategy for preventative services dropped from 44% in 2023/24 to 29% in 2024/25. The primary reason for this being cited as financial pressures; 81% of councils are on course to overspend their adult social care budget in the current financial year. Consequently, funding for prevention is usually unavailable; rather than shift the demand curve, local authorities are left reacting to increasing demand and fewer resources.

While investment in preventative measures is challenging, it is essential to both NHS and social care sustainability. Joint accountability for national standards of care that prioritise early intervention should be able to shift the resources because they drive system efficiencies as well as better care. For example, SCIE’s ‘Supporting engagement with reablement: a practice guidance resource for reablement services’ highlights how preventative approaches can reduce long-term dependency and improve outcomes for people post-discharge, while also relieving NHS pressures. Providing individuals with access to intermediate care, rehabilitation, and reablement can reduce the need for hospital readmissions, prevent exacerbation of conditions, and allow people to live independently for longer. For example, SCIE’s ‘Intermediate care guide’ shows that 92% of people who used home-based or reablement services maintained or improved their dependency score (a measure of the help they need with activities of daily living).

The economic case is compelling. ‘Earlier action and support: The case for prevention in adult social care and beyond’ demonstrates that every £1 spent on early intervention generates an average ROI of £3.17. Investing in recovery-focused and preventative services reduces demand on acute care, promotes independence, and improves quality of life.

National standards should:

- Make early intervention a central requirement, tied explicitly to the Care Act 2014’s prevention duty and backed by dedicated funding and performance frameworks that recognise “things that do not happen” – crises avoided, deterioration delayed, independence sustained.
- Set clear expectations at cross-system touchpoints, including roles and responsibilities, response times, shared information requirements and co-produced escalation routes, so that people experience a joined-up pathway rather than a set of institutional hand-offs.
- Support aligned or pooled budgets and gain-share arrangements, so that when one part of the system invests in early intervention, others who benefit share in the gains, creating incentives for collaborative rather than siloed decision-making.

These expectations would reinforce the integration objectives of Integrated Care Systems and the CQC’s system-wide assurance role, and they would frame them explicitly in terms of people’s outcomes and experiences rather than organisational boundaries.

Aiming for a care system that is fair and equitable to all
The roundtable series consistently highlighted that fairness in a National Care Service must extend beyond reducing geographic variation to address structural and experiential inequities embedded within the system.

Participants emphasised that people's experiences of access, quality and outcomes are shaped not only by where they live, but by how the system responds to different needs, identities and circumstances. Without explicit attention to these dynamics, there is a risk that national standards improve consistency in form while leaving deeper inequities unchanged.

A recurring theme was the uneven visibility and protection of rights across different parts of the social care sector. Evidence of people's varying care outcomes during the COVID-19 pandemic, as cited in Module 6 of the UK COVID-19 Inquiry, illustrates the persistence of these inequities. Participants noted that people who are less confident, less resourced or less familiar with statutory systems are more likely to experience poorer outcomes, even where formal entitlements exist. From this perspective, equity was framed as requiring standards that actively compensate for power imbalances, for example, by strengthening transparency, providing access to advocacy, and enabling care decisions to be challenged, rather than assuming that equal rules will produce equal experiences.

National standards can play a role in tackling inequities by shaping how systems identify and respond to unequal risk, rather than focusing on rights and entitlements solely at the point of access. As described in 'The state of health care and adult social care in England 2024/25', NHS England's Core20PLUS5 approach illustrates how this can work in practice by targeting inclusion health groups through proactive, flexible pathways, such as community-based primary care hubs for people experiencing homelessness, which combine outreach, continuity and anticipatory care and have demonstrably reduced avoidable hospital admissions.

Applied to social care, this means national standards must shape how systems respond to inequities, not just define entitlements. Standards could encourage proactive identification of people who are less visible to services or more likely to experience avoidable harm, and require earlier, sustained support at key points such as at transitions or crisis escalation.

A system that is easy to understand and to navigate

Participants argued that national standards should help people understand what they can expect from a National Care Service. This would entail consolidating and clarifying people's rights and responsibilities into a coherent, recognisable framework that makes sense to people who draw on care and support, their unpaid family carers, as well as care professionals. This includes using language that is inclusive and reflects the broad array of lived experiences, rather than institutional processes or technical compliance. The aim is not to oversimplify a complex system, but to reduce the cognitive burden placed on individuals and families who are often engaging with care at points of stress or vulnerability. This echoes the call for a 'National Care Covenant' described in the Archbishop's Commission 'Care and Support Reimagined'. A system that people can understand and navigate easily also supports the fairness and equity, personalisation of care and better support for unpaid carers.

A system that delivers high-quality care while using resources efficiently and sustainably

Participants across the roundtable series were clear that quality and sustainability must be treated as interdependent, rather than competing, objectives. There was concern that prevailing notions of efficiency too often prioritise short-term cost control or administrative simplicity at the expense of the relational and preventative aspects of care that support better outcomes over time. In this context, participants cautioned that national standards should avoid reinforcing narrow interpretations of 'value for money' or seeing quality and efficiency as trade-offs.

Instead, the roundtables pointed towards a broader conception of efficiency rooted in outcomes that matter to people – such as stability, continuity of care and support to live well independently. From this perspective, sustainable use of resources is achieved not by maximising throughout, but by aligning support with people's personal goals and reducing avoidable escalation and churn within the system. An example of this is personal budgets. TLAP has previously shown in the 'National Personal Budgets Survey' that people who hold personal budgets report significantly better outcomes in terms of independence, dignity and control over their lives. Importantly, the survey outcomes underscore that simpler, less bureaucratic processes are critical: budget-holders who found the process of getting and managing a personal budget easy were nearly three times more likely to report good outcomes.

Roundtable participants also highlighted that sustainability depends on coherence across decision-making, measurement and accountability. They stressed that where standards articulate clear expectations about quality and outcomes, they can help guide resource allocation in a more transparent and evidence-informed way, supporting choices that are defensible, comparable and aligned with shared priorities, even in a constrained fiscal environment.

Mechanisms for change: how and where standards might drive system reform?

The Care Act 2014 establishes a set of duties that extend beyond individual assessment and provision, including duties relating to prevention, information and advice, market shaping and cooperation with partners. However, evidence consistently shows that these duties are unevenly realised in practice and weakly enforced, both for people who draw on care and support and unpaid carers.

ADASS's 'Time to act: a roadmap to reform care and support in England' highlighted the gap between the statutory ambitions of the Care Act and people's lived experience of care. In particular, it pointed to persistent variation in access and quality, limited progress on early intervention and prevention, and weak accountability for outcomes that sit across organisational boundaries.

National standards of care cannot, on their own, resolve these structural challenges. However, standards can play an important role in setting system-wide expectations and shaping how statutory duties are interpreted and prioritised. This evidence identifies opportunities for how standards can work as mechanisms for change.

Reducing the postcode lottery in access, quality and outcomes
Despite the introduction of national eligibility criteria under the Care Act 2014, access to care remains highly variable; the ADASS '2025 Spring Survey' found that 418,029 people are waiting for an assessment, care or direct payments to begin or a review of their care plan – a "postcode lottery" situation, with access to social care being determined by where you live.

National standards can help address this by clarifying minimum guarantees that sit alongside statutory duties – not replacing local discretion but eliminating unjustified variation in how duties are applied. This would make statutory duties more consistently visible and enforceable, rather than as aspirational targets. In practical terms, national standards could help reduce the postcode lottery by acting as a shared reference point for what people should expect, making variation easier to identify, challenge and learn from.

The New Zealand approach, as evidenced in Standards New Zealand, illustrates how articulating outcomes and experience expectations at a national level, while allowing local interpretation through guidance, can support greater consistency of intent across diverse settings. The Australian experience, following the Royal Commission into Aged Care Quality and Safety, similarly highlights that clearer expectations and oversight can help expose variation that remains hidden when responsibilities and information are fragmented. Taken together, these examples suggest that standards can help surface and challenge variation by improving transparency and comparability, supporting learning across places rather than enforcing uniform provision.

Reframing social care as essential social infrastructure

Social care is often labelled a 'Cinderella service'; treated publicly and politically as secondary to the NHS and driven by crisis decision-making. Participants argued that standards can help reframe social care as essential social infrastructure, comparable to transport or education. This reframing would enable people to live the lives they choose and to flourish.

This matters for standards design because it shifts the 'unit of value' away from services and tasks and towards participation, belonging, continuity of home and relationships – essential outcomes aligned with the Social Care Future vision.

In practice, this would mean that standards should consistently describe what good care enables in people's lives and communities, not only what services do to or for people.

Making the social contract around care more explicit

England has a strong legislative base in the Care Act 2014, but its principles are unevenly, infrequently and inconsistently implemented and enforced and often 'invisible' to the public. The result is a system where many people do not know what they can expect, what is guaranteed, and who is responsible – particularly in the self-funded market.

This is connected to a deeper 'social contract' question: since 1948, England has not fully renegotiated the shared understanding of rights and responsibilities around ageing, disability and care. Similar to the proposal of a 'National Care Covenant' described in the Archbishop's Commission 'Care and Support Reimagined', standards can serve as a social contract which clearly and simply sets out the mutual rights, roles and responsibilities of citizens, families, communities, and the state both in providing support and paying for it.

Aligning commissioning, regulation and improvement around lived experience outcomes

Roundtable participants commented on the misalignment between commissioning priorities, regulatory frameworks and improvement activity. Different parts of the system operate to different definitions of quality, creating fragmentation and conflicting incentives.

To remedy this, one option is to consolidate and strengthen existing co-production tools, such as Making it Real, into a shared 'common currency' that can align:

- personalised care (what good care means to individuals)
- commissioning (what is prioritised and purchased)
- regulation (what outcomes are assured)
- improvement (what is supported and learned).

This approach would support alignment by providing a shared reference point for what good access, quality and outcomes look like, while allowing responsibilities to be exercised differently across local systems. By expressing expectations in lived-experience terms, standards can be used consistently by people who draw on care, commissioners, providers and oversight bodies, even where delivery models vary. Evidence from the roundtable series highlighted the importance of standards being supported by guidance, learning and review, rather than operating solely as compliance tools.

Shifting from crisis response towards prevention and early intervention

Evidence from the roundtable series highlighted how adult social care in England is structurally oriented towards crisis response, despite the Care Act 2014's explicit emphasis on prevention. Participants consistently described a system in which rising demand, constrained local authority capacity and fragile provider markets combine to prioritise immediate risk management over earlier, relational support. As a result, preventative activity is often residual, undertaken where capacity allows rather than as a core expectation of how care and support should function.

National standards could begin to rebalance this pattern, where they make preventative practice more explicit, visible and contestable. Rather than defining prevention as a discrete set of services, standards could clarify what people should reasonably experience before crisis: timely access to information and advice, early assessment, continuity of support, and anticipatory review as circumstances change. Framing these expectations in lived-experience terms aligns prevention with statutory duties, while avoiding overly prescriptive definitions of delivery. In this way, standards can help shift prevention from a discretionary activity to a shared expectation against which local practice can be understood and questioned.

Prevention also depends on continuity across pathways and transitions, not on isolated interventions. Roundtable participants pointed to predictable moments of escalation, such as transitions between services, where a lack of coordination leads to avoidable crisis. National standards could support prevention by clarifying expectations around follow-up, coordination and shared responsibility at these points, without prescribing organisational form. When combined with learning and review mechanisms, rather than compliance alone, standards can help reorient the system towards earlier, more relational support while remaining grounded in local capability and context.

Investing in better system intelligence: data, technology and improved metrics

The social care system collects large volumes of data, but the information collected is what is easy to count (visits, forms, hours) rather than what makes a difference to people's lives.

The effectiveness of national standards depends on the quality of system intelligence available to support them. The Office for Statistics Regulation's findings in 'Care data matters' identified three persistent constraints in adult social care data: weak leadership and collaboration, significant gaps in what is collected, and poor accessibility, coherence, quality, timeliness and granularity of existing data.

Evidence from the roundtable series echoed these findings, highlighting how fragmented and activity-focused data limit the ability to understand variation, track progress or support improvement.

The potential for improving system intelligence is vast and unrealised. There is a role for national standards to instigate a data and digital 'spine' such that data and information can be measurable and improvement-focused. This will require advanced technical knowledge, analytic capacity and especially leadership at national level.

As discussions from the roundtable indicated, what is needed is a clearer organising framework for what information matters – signalling expectations around access, quality and outcomes, and strengthening the systematic use of both quantitative data and qualitative evidence of people's experiences to support learning and accountability.

How might national standards be used in practice?

How national standards are used in practice will determine whether they are a success or a failure. The steer from the roundtable participants is for standards to be written with explicit users in mind, clarifying what each group should be able to do differently to achieve them.

For people who draw on care and support, standards should function as a clear public statement of rights and expectations: what care and support should be offered, what choices are possible, what should happen at key touchpoints (for example, discharge, reassessment, transitions), what information should be shared (and on what consent basis), and how to challenge decisions about their care or instances of poor quality. Similarly, for unpaid carers, standards should clarify their entitlement to assessment and support, what to expect regarding involvement in decision-making and communications, and routes to advice, carers' breaks and crisis support.

For care providers and the Voluntary, Community and Social Enterprise (VCSE) sector, standards should create a shared, outcomes-focused definition of quality. According to Skills for Care's 'The state of the adult social care sector and workforce in England 2025', there are an estimated 19,000 organisations involved in providing or organising adult social care in England as at 2024/25 across 42,000 establishments. National standards of care can support providers and the VCSE sector by clarifying their responsibilities, including what quality and safety are expected to deliver good outcomes and experiences. The standards should be flexible enough, rather than prescriptive, to enable new care models and innovative technology to flourish.

For local government, standards of care should be used to create the conditions for better social care. This would entail improving commissioning and market shaping to meet the diverse care needs of local people. People must get the right support, at the right time, in the right place, and their views about where services are working or where they need to improve are essential to the process. National standards could support more effective working between commissioners and providers by clarifying shared expectations about outcomes and improvement, reducing reliance on fragmented contractual and regulatory signals. Roundtable evidence highlighted how a common reference point can help align expectations and goals, supporting more consistent and collaborative approaches to improvement across diverse local contexts.

For regulators, standards should balance the twin goals of system assurance and improving outcomes of care. Clearer expectations for care outcomes will enable earlier identification of safety risks and poor quality, enabling proportionate escalation where harms persist. With more robust data from people's experiences and outcomes, the standards can showcase examples of what good quality looks like in practice. Bringing these standards to life would reduce the existing reliance on process or proxy measures.

For central government, standards may be used to:

- set and maintain a stable national baseline for what constitutes good quality care
- ensure policy is joined up across departments, using government levers to create the national conditions for better care

- align funding decisions with standards requirements
- produce transparent national reporting on progress against priority outcomes, with metrics that are sensitive and meaningful to care outcomes and experiences.

This is consistent with the direction of travel in health policy, where national ambition is increasingly being operationalised through structured frameworks rather than exhortation alone. The Government's '10 Year Health Plan for England: fit for the future' explicitly commits to developing Modern Service Frameworks as part of a quality strategy – illustrating an approach where national expectations are linked to implementation machinery, measurement and improvement. National standards of care will require an equivalent seriousness of national stewardship if they are to be credible.

How will we know if standards are enabling the care system's desired reforms?

Evidence from public service reform and improvement research consistently shows that performance and accountability frameworks shape organisational behaviour, professional judgement and investment decisions. In relational, workforce-intensive services such as adult social care, this effect is particularly pronounced: what is measured becomes prioritised, while what is harder to evidence risks being marginalised. The Health Foundation in 'Measuring what really matters' highlighted this dynamic, noting that poorly designed metrics can incentivise task completion and risk avoidance at the expense of continuity, autonomy and relational quality.

Adult social care in England currently lacks a coherent outcomes and learning framework capable of supporting system-wide reform. While the Care Act 2014 establishes a clear outcomes-based purpose centred on wellbeing and prevention, national oversight remains fragmented across financial, regulatory and performance regimes. The King's Fund in 'Fixing social care: the six key problems and how to tackle them' observed that existing data provides limited insight into whether care and support is improving people's independence, quality of life or sense of control, making it difficult to judge progress against reform objectives. As described earlier, the core set of outcomes, outputs and activity metrics that the government uses as part of 'Adult social care priorities for local authorities: 2026 to 2027' is not focused on system-wide or transformational reforms.

A workable approach may be to define a small set of shared outcome domains that reflect lived experience (for example, autonomy, safety-with-choice, connection, continuity, and navigability), link them to a limited set of measurable indicators relevant to social care, and require structured qualitative evidence alongside quantitative data. The King's Fund in 'Building capacity and capability for improvement in adult social care' suggests this as a way to reduce variation without creating perverse incentives.

Indicators of progress

Compared to the system intelligence available to the NHS, data collection in social care is flawed and incomplete. Social care data are not collected in real time, and only a subset of people who draw on care are surveyed about their experiences retrospectively. Metrics about the use of NHS services are frequently used as proxy measures for the quality of social care. In addition, data about unpaid carers overlook people unknown to local authorities. Given the current state, what steps are needed to monitor and measure improvements in social care?

A pragmatic indicator set should start with what already exists (for example ASCOF, CQC intelligence, local authority returns) but be explicit about what is missing and needs development: timely experience measures, touchpoint reliability measures (discharge, transitions, safeguarding, reassessment), and better indicators of prevention and coordination that capture avoided harm and sustained wellbeing, rather than only service activity.

National standards provide the organising framework for creating an improved indicator set that can be used consistently and evolve over time. By anchoring indicators to shared expectations and not just regulatory compliance, this approach ensures that data drawn from different sources are interpreted against the same reference points.

Although reliant on the existing metrics with their known limitations, the Government's recent policy paper 'Adult social care priorities for local authorities: 2026 to 2027' provides a useful example of articulating priority outcomes and expectations aligned to an indicator set, Building on current practice, future improvements in data and system intelligence will enable comparisons, learning and accountability across local systems. A more comprehensive dashboard aligned with the care standards will: (1) reflect what matters to people; (2) identify and expose care inequities and variation in outcomes; and (3) increase the utility of metrics for local improvement.

Building capacity for continuous monitoring and improvement

A consistent message from the roundtable series was that national standards will only be effective if they are embedded within a system that supports continuous learning and adaptation over time. Participants expressed concern that existing monitoring arrangements tend to emphasise assurance and compliance, with limited capacity to surface insights about what's working or not, support reflection or spread improvement.

Participants argued that standards should be accompanied by an approach to monitoring that values continuous improvement over compliance and recourse. This includes being selective and intentional about what is measured, ensuring that evidence reflects lived experience as well as system performance, and creating space for honest feedback without fear of harsh consequences.

There was also strong support for standards being treated as iterative rather than fixed. Participants highlighted the need for mechanisms that allow responses to emerging evidence, demographic changes and feedback from people who draw on care and support. From this perspective, continuous monitoring is not simply about tracking performance, but about sustaining a shared commitment to improvement that remains responsive over time.

Evidence from Scotland's experience of health and social care integration further underlines the importance of iterative review and shared learning. Audit Scotland in 'Health and social care integration: update on progress' found that where outcomes frameworks were used to support dialogue and improvement rather than compliance, they were more likely to influence system behaviour.

What will be needed to support the development and use of national standards over time?

Evidence from England and internationally consistently shows that the effectiveness of standards depends less on their technical design and more on the system conditions in which they operate.

Workforce skills, capability and leadership

National standards will only be credible if they are matched by investment in the capability required to deliver them. This includes workforce capacity and skills (particularly relational practice, strengths-based approaches, and digital confidence), commissioning capability (outcomes-based commissioning, market shaping, and collaborative commissioning across partners), and co-production infrastructure (so lived experience is not episodic consultation but a sustained part of how standards are governed and improved).

Evidence from health and social care improvement studies shows that improvements become embedded when organisations invest in skills, data, leadership and time to learn. For adult social care intent on delivering the care standards, a capability-building programme will be essential. This is something discussed in The Health Foundation's '[Building the foundations for improvement]'.

Data, digital and technology infrastructure

The roundtable discussions were enthusiastic about the prospects of improving data capture and system intelligence. Without improved data infrastructure, however, national standards are likely to default to what is easiest to measure. Conversely, standards can help shape investment in:

- co-produced outcomes measures, especially aligned with Making It Real
- mixed-methods evidence, combining quantitative data with qualitative insight
- interoperable systems that support lawful and transparent information sharing across health, care, housing and community services
- clear protections for people's rights to access, understand and control their own data.

Funding and market sustainability

The ADASS '2025 Autumn Survey' provides evidence that rising demand, escalating needs, and intense financial pressures – including significant overspends and savings requirements – are forcing local authorities to prioritise crisis management over early intervention in social care. The effects of a crisis-led system are that fewer people benefit from available resources, and there are fewer opportunities for system reforms.

National standards of care cannot resolve funding adequacy or market instability. However, they can influence how scarce resources are allocated and justified by:

- making explicit the link between spending decisions and outcomes for people
- reinforcing the legitimacy of investment in prevention and continuity and the use of pooled or shared budgets across health and care
- supporting commissioning approaches that prioritise value, equity and long-term outcomes over short-term activity.

Improving system navigation through better information and advice

The Care Act 2014 Section 4 establishes a duty to provide information and advice, but evidence suggests this duty is inconsistently realised and weakly monitored. National standards can strengthen this aspect of the system by making expectations around navigation, advocacy and accessible information explicit and measurable.

For standards to be credible, navigation and advice must be treated as core components of good care, not peripheral add-ons.

This requires routine feedback from people who draw on care and support and carers on whether information, advice and navigation support are accessible, timely and useful in practice: whether people understand their rights and options, whether communication meets their needs (including reasonable adjustments), and whether routes to challenge and redress are clear without needing crisis escalation.

The Making It Real statements can be adapted into testable expectations (for example, whether people feel listened to, informed, and supported to make decisions). Embedding this into standards reduces the risk that 'information and advice' becomes a web-page duty rather than an experienced reality.

Integration of health and social care

Integration succeeds when local partners share purpose, outcomes, and practical mechanisms for joint action; it fails when accountability is diffuse, incentives conflict, and information cannot flow across organisational boundaries. National standards should therefore be explicit about:

- shared outcomes expected at place level
- roles and responsibilities at key touchpoints
- minimum expectations for information sharing and interoperable data
- how joint accountability is made visible to the public (for example, through shared dashboards and co-produced scrutiny).

This framing avoids over-claiming a specific governance architecture while still making a clear policy case. Without local leadership, aligned incentives and shared intelligence, standards will not translate into coordinated care at the points that matter most.

What methods might be used to develop national standards? How do we build on the existing body of evidence about good practice?

Evidence from health and social care reform consistently demonstrates that the way standards are developed is a critical determinant of whether they influence practice or remain aspirational. Research on complex interventions, such as the National Institute for Health and Care Research's 'Framework for the development and evaluation of complex interventions: gap analysis, workshop and consultation-informed update', highlights that improvement depends not only on the content of an intervention but on how it is developed, adapted and supported over time. Roundtable discussions reaffirmed this; in complex, relational systems such as adult social care, standards that are designed without co-production, iteration and explicit attention to implementation would be less likely to succeed.

Building on the existing body of evidence

Alongside legislation and regulatory frameworks, there is a growing body of practice-based evidence generated through sector-led improvement, innovation programmes and lived experience research.

The Local Government Association and TLAP's joint framework, 'Commissioning for better outcomes', demonstrates how bringing together statutory duties, lived experience outcomes and evidence of effective practice can support more consistent commissioning and delivery without over-specification.

National standards of care should therefore be developed by drawing together existing statutory, co-produced and regulatory frameworks into a single, coherent reference point that is intelligible to people who draw on care, practitioners, commissioners and regulators. It must be enforced through consistent commissioning oversight of quality, rather than irregular inspections from the regulator, if trust is to be rebuilt and maintained.

Lessons from previous approaches

In the development of national standards in the context of a National Care Service, lessons can be taken from both social care and the NHS.

The experience of NICE guidance in adult social care reinforces this lesson. NICE has developed a substantial body of evidence-based guidance and quality standards on people's experience of care, home care, dementia, safeguarding and end-of-life support. In principle, these provide a powerful national articulation of what good looks like. In practice, however, their impact in social care has been far more variable than in the NHS. Unlike in health care, NICE guidance is not consistently hard-wired into commissioning, funding or regulatory levers in social care. Evidence such as the National Institute for Health and Care Research's 'Rapid evaluation of the special measures for quality and challenged provider regimes: a mixed methods study' shows that improvement depends heavily on local leadership capacity, workforce stability and the availability of dedicated improvement resources. As such, in the absence of aligned incentives and system-wide support, guidance alone will struggle to drive consistent change at scale.

In the context of the NHS, the NHS National Quality Board (NQB) illustrates how national standards are most effective when supported by clear stewardship and alignment across system levers rather than treated as standalone guidance. Established to bring together organisations responsible for commissioning, regulation, improvement and workforce, the NQB's role has been to agree and sustain a shared definition of quality and to ensure that this definition is consistently reflected across policy, regulation and improvement activity.

Although primarily focused on healthcare, the experience of the NQB demonstrates that co-production, shared ownership and the systematic use of care experiences as evidence are critical to translating national quality expectations into practice. For adult social care, this suggests that the development of national standards must be accompanied by explicit stewardship arrangements and mechanisms for cross-system alignment, rather than relying on individual organisations to interpret and apply standards in isolation.

The earlier generation of National Service Frameworks (NSFs) for the NHS also offers a clear precedent for standards framed around long-term outcome ambitions, translated into service models and measurable expectations. For example, the NSF for Mental Health was explicitly presented as setting national standards, specifying how services should be developed and measured. The Department of Health and Social Care in 'National service framework: mental health' illustrated the intended structure of 'modern standards and service models' and the connection between standards, service design and performance/implementation expectations.

Applied to adult social care, the key learning is not to replicate the NSFs wholesale, but to retain the strengths of the approach: a clear long-term outcome to aim for, explicit identification of evidence-based interventions and delivery expectations, and an implementation model designed to reduce unwarranted variation while allowing local adaptation, supported by an explicit cycle of review and iteration. Within the recent 10-Year Health Plan, the NHS has begun to develop Modern Service Frameworks that employ this approach.

Where might we start?

There are current opportunities to implement national standards in a way that is both pragmatic and durable. First, recent national policy is already moving toward clearer outcomes and expectations for adult social care (including ‘Adult social care priorities for local authorities: 2026 to 2027’), which can provide a starting architecture for standards that is aligned with existing reporting and oversight rather than duplicative.

Second, the cross-cutting design tensions are now clearer: national consistency versus local flexibility; standardisation versus personalisation; enforcement versus learning; and prevention versus immediate pressure. These tensions cannot be eliminated, but they can be addressed through the design process, by defining a small rights-based baseline, protecting flexibility above the baseline, and explicitly building an improvement and learning model into standards implementation.

Third, capacity for continuous improvement must be treated as part of the standards proposition, not an optional implementation add-on. Without workforce stability, commissioning capability, interoperable data and local improvement infrastructure, standards are likely to increase administrative burden rather than improve outcomes. The opportunity therefore, is to implement standards in phases, prioritising a small number of high-impact touchpoints first, while investing in the enabling conditions needed for progressive uplift over time.

Conclusion

As the Casey Commission works towards its final report in 2028 and its thinking on national standards of care progresses, a clear starting point is purpose and scope. England already has strong foundations in the Care Act 2014's core principles and the articulation of how good care and support can enable people to live their best lives.

The challenge is not a lack of values, but the inconsistency with which those values are translated into people's day-to-day experiences of care and support. National standards are therefore best understood as a mechanism for clarifying expectations – anchored in lived experience outcomes – rather than as a prescriptive blueprint for service delivery. This is also where key tensions sit: between national consistency and local discretion; between standardisation and personalisation; and between assurance and learning. These tensions cannot be designed away. They need to be managed explicitly.

It is also clear that standards cannot resolve the structural constraints facing adult social care on their own. They cannot substitute for workforce capacity, stable provider markets, commissioning capability or the resources required to shift from crisis response toward prevention. The risk is that standards become aspirational statements that raise expectations without strengthening delivery conditions, or compliance processes that add burden without improving lives.

Instead, the roundtable consensus was that national care standards provide a shared reference point for people who draw on care and support, unpaid carers, commissioners, providers, regulators and national bodies – helping different parts of the system work to the same outcomes even where delivery models differ.

Our ability to measure progress and ensure accountability requires a stronger evidence base than is currently available. A recurring finding from the roundtable series was that monitoring often drifts toward what is easiest to count rather than what best reflects real-life experiences and their improvement. A pragmatic indicator set should build on what exists, but be explicit about what is missing and needs development, particularly measures of timeliness and experience, touchpoint reliability, and prevention and coordination. Alongside this, qualitative information about people's experiences needs to be treated as system intelligence, not anecdote: gathered consistently, analysed rigorously, and used transparently to inform decisions and improvement.

There are also opportunities and risks in data and technology. Better infrastructure and interoperability can support continuity, reduce administrative burden and enable learning, but only if data use is coherent, trustworthy and oriented toward improving people's outcomes. The weaknesses identified in system intelligence – leadership and collaboration, gaps in what is collected, and problems of accessibility, coherence, quality and timeliness – are not peripheral. They shape whether standards can be monitored meaningfully and whether improvement can be sustained.

Delivering the potential of national standards will depend as much on how they are stewarded and supported as on what they contain. Without careful design, standards risk becoming compliance tools, narrowing practice or exposing system weaknesses without enabling improvement. These risks are heightened by workforce constraints, uneven data maturity and the reality of shifting political and fiscal priorities.

This is why the framework presented in this report emphasises standards as a living, outcomes-focused mechanism for learning and improvement, not a fixed regulatory instrument. The following section describes how SCIE intends to take this forward, building on the evidence, roundtables and lived experience that shaped the framework: co-developing an implementation roadmap with partners; prioritising standards where they can best support integration, prevention and early intervention; strengthening data and system intelligence; and tackling the enabling conditions required for better access, quality and experiences over time, aligned with the Casey Commission's expected timelines.

Next steps for the framework

The following action areas are proposed to support the development and operationalisation of national standards of care in England. These recommendations are informed by the evidence in this report and by the insights generated through the roundtable series.

Taken together, they are intended to be progressed through a phased and iterative approach, rather than as a single point of implementation. Initial activity should focus on co-production and piloting with people who draw on care and support, sector partners and system leaders, to test how outcomes-focused standards operate in practice, particularly at key interfaces with health and other public services.

SCIE will support these actions by continuing to convene partners, contribute evidence and learning, and work alongside government and the Casey Commission as thinking develops, ahead of the Commission's final report expected in 2028.

Establish independent stewardship for standards

- Establish a clear stewardship function for the national care standards framework to support continuous improvement and learning across the system, in line with the core principles set out earlier in this report (see p.18).
- This stewardship role should include maintaining and iterating the framework over time, using evidence, data and lived experience to monitor progress, learn from and support improvement. It should be clearly distinct from inspection and enforcement and should not be treated as an expansion of the regulator's remit.

Improve outcomes and experience metrics

- Prioritise improving the quality and reliability of metrics about people's experiences and outcomes, making better use of existing data, shared care records and emerging technologies.
- Pilot improved outcomes and experience measures in local systems to test what is meaningful, feasible and useful for improvement, before formalising any national care outcomes framework.

Develop a data and digital spine

- Build on shared care records and advances in technology-enabled intelligence to improve continuity, personalised care and system insight across health and social care.
- Alongside improving analytic capacity, develop practical tools and approaches that support government and local authority commissioners to use data more effectively for commissioning, market shaping and improvement.

Strengthen accountability mechanisms

- Align local and national accountability frameworks around shared outcomes, with transparent reporting on progress and inequities.
- Embed shared accountability at integrated care system level, with outcome dashboards and co-production input.

Support prevention and early intervention expectations

- Embed prevention and early intervention expectations explicitly in standards, including timely access, anticipatory care and support at key transitions.
- Align incentives for prevention and early intervention with improved outcomes data and commissioning practice, so that standards reinforce upstream action rather than crisis response.

Sequence implementation in line with Casey Commission priorities and system capacity

- Sequence the development and use of national care standards in line with the Casey Commission’s emerging recommendations and timelines, ensuring progress on standards is aligned with investment in workforce, commissioning capability and digital foundations.

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