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The voice of care

The Power of Care

*the **system** behind our **society***

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Acknowledgements

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We are grateful to everyone who contributed to this report, including the care providers, care workers, people drawing on care and support, family members and sector representatives who took part in interviews and completed the survey. Their insight, experience and generosity made this report possible and have been central to shaping its analysis and recommendations.

We hope the report brings value in outlining social care as national infrastructure and look forward to working with colleagues across the sector to push the agenda of reform and improvement.

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Foreword

by Professor Martin Green OBE
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For too long, adult social care has occupied an uneasy and often diminished place in national debate. Although it touches all of us, underpins family life, supports the functioning of local communities and sustains the wider health and care system, it is still too often framed as a marginal service. Let me be unequivocal; social care impacts us all, not just a small population group or only at moments of acute vulnerability. It is essential to our communities and to our economy.

However, that fundamental misunderstanding has shaped both the national discourse and treatment of social care. It has defined how social care is valued politically, how it is funded, and how easily its importance is overlooked in wider conversations about public service reform, economic resilience and national renewal.

This trajectory must be challenged, and we have produced this report to do just that. Our central argument is something which we can all agree; adult social care must be understood not as a peripheral or residual service, but as essential national infrastructure. That it is fundamental not only to people's independence and quality of life, but equally critical to the sustainability of the NHS, the labour market and stability of family life. It is also an economic powerhouse with the means to boost local communities and the nation as a whole. These are practical claims, grounded in the everyday reality of what social care enables, prevents and sustains. As this report will show, much of the improvement and innovation is already happening. The challenge is for the system to enable this at scale.

> This report arrives at an important moment.

At Care England, we represent providers delivering care and support to hundreds of thousands of people across the country, and we see daily both the enormous value of that support and the increasing strain under which it is being delivered. We see a sector that continues to show resilience, professionalism and innovation in the face of rising demand, growing complexity of need, workforce pressures, financial constraint and persistent policy uncertainty. We also see the consequences of a national approach that has, for many years, acknowledged the importance of social care in principle, while failing to provide the long-term clarity, investment and reform discipline required to support it in practice.

The evidence brought together in this report makes clear that the pressures facing social care are neither temporary nor isolated. Demographic change, worsening healthy life expectancy, growing levels of complexity, unmet need, and continued fragility in local government finance are reshaping both the scale and nature of demand.

At the same time, the sector is expected to do ever more. It is required to support prevention, enable hospital discharge, reduce pressure on the NHS, strengthen neighbourhood health models, improve outcomes, support unpaid carers, and act as a stable source of employment and economic contribution in communities across the country.

These expectations are not unreasonable in themselves. Indeed, they reflect the breadth of social care's immense contribution. But they cannot continue to be met in a policy environment that remains too short-term, too fragmented and too hesitant at the point of implementation.

There is now growing recognition that adult social care cannot continue to sit at the margins of policy thinking, and that any serious attempt to reform public services, promote prevention, or shift care closer to home will fail unless social care is placed on a more stable and strategic footing. The work of the Casey Commission provides an opportunity to move beyond familiar diagnosis and towards a more durable settlement. But that opportunity will only be meaningful if it is accompanied by political seriousness about implementation, by a clearer public understanding of what social care is for, and by a willingness to treat reform not as a deferrable challenge, but as a national priority and economic opportunity.

> What this report demonstrates, above all, is that social care already delivers extraordinary value, often without equivalent recognition. Now is the moment this must change.

If we are serious about building a fairer, healthier and more resilient country, then we must also be serious about social care. That means recognising its full contribution, being honest about the consequences of continued inaction, and creating the policy, funding and workforce conditions in which the sector can deliver the kind of care and support that people have every right to expect.

It is our hope that this report will contribute to that shift. Not by simply restating the scale of the challenge, but by making the case for a different understanding of social care's place in national life, and showing that the amazing work the sector does can be scaled nationwide.

About this report

This report draws on a broad evidence base, including 177 survey responses (conducted through Gather) and 17 interviews from across the adult social care sector, including representatives that lead care providers, those that deliver care, and importantly, those who draw on care and support.

Care was taken to ensure that this evidence reflected a broad cross-section of perspectives across the sector, reflecting its diversity. We have gained the perspectives across homecare, older people and care homes, working-age adult services, and community and mental health services. This has enabled the report to combine lived experience, practical delivery insight and system-level understanding.

The findings presented in this report are not based on isolated anecdotes. Selected contributions from interviews are used throughout to illustrate and reinforce themes that emerged consistently across the wider evidence base. Together, the survey responses, interviews and supporting research have informed both the analysis in each chapter and the recommendations set out in the report. This evidence base draws on a wide range of perspectives across the sector and provides a credible and grounded picture of the pressures, priorities and opportunities shaping adult social care today.

Additional analysis, supporting evidence and full references are included in the appendices. These provide the wider context underpinning the report's arguments, including current system data, relevant policy history and extended interview material.

The appendices collate the wider research undertaken for the report, covering specific areas relevant to the overall argument. These include:

Annex A) Trends in scale and complexity of demand

Annex B) The interdependent relationship between social care and the NHS

Annex C) The economic case returns for investment in social care

Annex D) The policy landscape

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ALL DAY
BREAKFAST

Executive Summary

Adult social care is one of the most important yet under-recognised parts of national life. It enables people to live independently, supports families to remain in work, strengthens communities, and sustains the wider health and care system. Yet despite this, it is still too often treated as a residual service: something associated with crisis, decline or a small section of the population, rather than a system that underpins everyday life and that most people will encounter directly or indirectly at some point in their lives. There is now a growing opportunity to shift this understanding and recognise social care for the central role it already plays.

This report argues that adult social care must be understood differently. It is not only a public service, nor simply a set of supports for moments of vulnerability. It is essential national infrastructure, underpinning our social, economic and civic life. It is the support that allows people to live with dignity, maintain relationships, recover from illness, participate in work and community life, and retain as much independence and choice as possible. It is also a major employer, a driver of local economic activity, a support to family functioning, and a necessary condition for the sustainability of the NHS and wider public services. Recognising this creates a clear foundation for meaningful and lasting reform.

Drawing on 177 survey responses, 17 interviews, and a wider body of supporting evidence, this report presents a clear and consistent picture. Social care is widely valued, and there is a clear opportunity to strengthen the system so it can deliver at the scale the country now needs; but the system around it is currently too fragile, too fragmented and too short-term to deliver this contribution at the scale. Across the evidence, the same themes recur: rising complexity of need, financial pressure, workforce strain, fragmented interfaces with health and other systems, uneven accountability, and the continued tendency for family members and unpaid carers to absorb pressure when formal support is delayed or inadequate. Crucially, these are not intractable problems, but challenges that can be addressed through clearer policy direction and sustained focus.

At the same time, the report finds that the strongest examples of good care already exist. Across the country, there are examples of care that is personalised, enabling, relational, preventative and rooted in strong local leadership. The central challenge is therefore not to define what good social care looks like, but to create the policy, funding and system conditions that allow it to become standard practice rather than the exception.

Why social care matters to everyone

The report begins by showing that social care matters far beyond those who draw on support directly. It is experienced not primarily as a list of tasks, but as the practical and emotional support that makes ordinary life possible. Interviewees described care as the thing that enables confidence, routine, freedom, family life, work, recovery and participation in the community. Good care is valued not simply because it keeps people safe, but because it makes life possible on better terms.

This chapter also highlights the wider family impact of social care. When support is present and reliable, families are able to return to being partners, sons, daughters and parents, rather than default carers and coordinators. When support is absent or poorly coordinated, that burden does not disappear; it is transferred to families, often with implications for relationships, wellbeing and employment.

The report therefore argues that social care is not a service for "other people". It is part of the fabric of everyday society. Failing to support it adequately carries social and economic consequences not only for individuals, but for families, communities and the wider state. Conversely, getting it right delivers wide-reaching benefits across society and the economy.

Social care and the NHS: an interdependent system

The report then examines the relationship between adult social care and the NHS. While the two systems have distinct roles, responsibilities and accountabilities, they are deeply interdependent in practice. Social care helps prevent avoidable deterioration, reduce unnecessary hospital admission, support discharge, enable recovery and sustain independence after ill health. When it is working well, it improves outcomes for individuals while easing pressure on acute and community health services.

However, the evidence also shows that this relationship remains too fragmented. Delayed discharge, weak communication, poor information-sharing, unclear responsibilities and variable local relationships continue to create friction across the system. Transition points, in particular, are where system weaknesses are felt most clearly. In many cases, people are not delayed because community support is impossible, but because the right accommodation, decision-making, shared ownership or handover arrangements are not in place.

The report argues that better integration does not mean making social care more like the NHS. It means recognising social care as an equal partner with a distinct contribution and designing systems that allow people to move more smoothly between hospital, home, community care and longer-term support.

Social care as national infrastructure: the economic case for investment

The report next sets out the economic case for seeing social care as productive infrastructure rather than simply public expenditure. It shows that investment in social care generates returns through multiple channels: direct employment, local spending, labour market participation, reduced pressure on other public services, and stronger community resilience.

The sector employs around 1.6 million people in England and contributes approximately £78 billion to the UK economy each year. It is a major local employer in many areas, offering stable work, progression and careers across frontline, managerial, digital, finance and support roles. Providers consistently described social care not only as a source of jobs, but as part of the civic fabric of local places: linked to local suppliers, volunteering, family stability and wider community life.

The report also shows that social care supports economic participation beyond its own workforce. By reducing the need for family members to provide full-time unpaid care, it helps others remain in employment. By preventing deterioration and supporting recovery, it also contributes to lower downstream costs across the NHS and public services.

However, these returns are constrained by a system that is not sufficiently stable or investable. Uncertainty around funding, commissioning, workforce pressures and infrastructure suppresses long-term planning and investment. This is especially visible in the care estate, where many settings are no longer fit for future demand and where the mismatch between bed growth and demographic change points to a widening capacity gap.

The reality of providing care today and the shape of a stronger system

The report then turns to the everyday reality of delivering care. It finds that adult social care is currently being provided in a context of financial fragility, workforce instability, administrative burden and inconsistent coordination across the wider system. Providers described an environment of rising costs, limited headroom and growing complexity. Survey respondents were clear that social care matters deeply, but far less confident that the current system is strong enough to meet need now and in the future.

Several key pressures stand out. Financial pressure is experienced not only as underfunding, but as uncertainty: difficulty planning, investing and improving in an environment shaped by short-term decisions and fragile market conditions. Workforce pressures are experienced not simply as vacancies, but as challenges to continuity, trust, quality and professional recognition. Oversight is often experienced as fragmented and administratively burdensome, with duplication across regulatory and assurance activity. Integration remains too inconsistent, with too much dependence on local goodwill rather than dependable systems.

Across the evidence, prevention and recovery are shown to be achievable in practice, but not yet embedded consistently enough across the system.

The report argues that a stronger system would not merely alleviate these pressures in isolation. It would create an operating environment in which providers are financially sustainable, workforce development is treated as part of the quality architecture of care, oversight is proportionate and coordinated, and integration is designed around people's experience rather than institutional boundaries.

Creating the conditions for consistent, high-quality social care

The final chapter sets out a phased framework for reform. The report does not argue that social care lacks examples of good practice. It argues that the country has not yet created the conditions in which those examples can become reliable, widespread and sustainable. This creates a clear and achievable agenda for reform, grounded in existing success.

Phase 1: Creating the conditions for stability (0–12 months) focuses on stabilising the system so that providers and commissioners can plan with confidence. This includes a clear multi-year funding trajectory, fee rates that reflect the cost of care, a funded Fair Pay Agreement and wider workforce reform, reduced duplication in oversight, and national expectations for integration practice including discharge standards and communication protocols.

Specifically, we call for:

1. The Government must set out a clear multi-year funding trajectory for adult social care, including indicative funding pathways.

2. Local authorities, supported by central government, must align fee rates with the cost of care to address workforce and inflationary pressures and enable providers to build reserves and invest for the future.

3. The Government must publish a multi-year funding settlement for the Fair Pay Agreement, set at a level that reflects inflationary pressures and raises care work out of low-pay status, alongside a broader programme of workforce reform to strengthen progression, professional development and career pathways.

4. National bodies and system partners must coordinate oversight and reporting requirements to reduce duplication.

5. The Government must establish national expectations for integration practice, including discharge standards and communication protocols between health and social care.

Phase 2: Aligning how the system works (1–3 years) focuses on better alignment across funding, commissioning, workforce reform and integration. This includes cost-reflective local government settlements, longer-term outcome-focused commissioning, stronger involvement of social care providers and local government in planning and delivery, and clearer named coordination, shared responsibility and follow-through where needs cut across services.

To do so, we suggest that:

1. The Government must implement a cost-reflective funding model within local government settlements, alongside local authorities adopting longer-term, outcome-focused commissioning approaches.

2. Integrated Care Systems must involve social care providers and local government as equal partners in planning, pathway design and service delivery, alongside clearer expectations for named coordination, shared responsibility and follow-through where people's needs cut across services.

3. The Government must implement workforce reforms, including structured career pathways, expanded training provision and clearer progression frameworks, building on the Fair Pay Agreement and sector-led strategies.

Phase 3: Making good practice the norm (3–5 years) focuses on embedding reform at scale. This includes a cross-government social care settlement, sustained investment in care infrastructure, a mature workforce model with recognised professional status and clear progression, and commissioning and funding models that embed prevention, reablement and long-term outcomes as core system objectives.

To achieve this, we recommend that:

1. The Government must establish a cross-government social care settlement, aligning policy across departments to reflect the sector's role in supporting economic participation, community stability and public service sustainability.

2. The Government must sustain long-term investment in care infrastructure, including care environments, community provision and digital systems.

3. Commissioning and funding models must prioritise prevention, reablement and long-term outcomes as core system objectives.

1. Why social care matters to everyone

Adult social care underpins everyday life. It supports over 800,000 people to live independently, enables families to stay in work, strengthens communities, and sustains the wider health system[1].

> In England alone, the sector accounts for around 1.6 million jobs[2], and contributes approximately £78 billion to the UK economy each year[3].

The primary research for this report repeatedly returned to this conclusion. Providers, care givers, families and receivers of support did not describe social care primarily as a list of tasks; they described it as the practical and emotional support that makes ordinary life possible. Again and again, people defined good care not simply by the tasks delivered, but by the life it made possible: the ability to keep routines, maintain relationships, make choices, and participate in everyday life. As a receiver of care put it, "[support] gives me the confidence and the driving force to continue my day", while another said plainly, "without it I wouldn't leave the house, nor would I have much quality of life."

From supporting working-age adults with disabilities, to helping older people remain connected to their communities, social care plays a foundational role in people's lives and their independence. The sector's importance will only continue to grow, as demographic change, stagnating healthy life expectancy and wider societal pressures combine.

It is imperative therefore that the national conversation on social care needs to change. Policymakers, and the public, must begin to recognise its interdependent relationship with the functioning of wider society.

Social care is not a service for 'other people'. Most of us will encounter it directly or indirectly at some point in our lives. This could be by needing support ourselves, supporting a relative or friend, or relying on a healthcare system that depends on social care capacity to function. How the sector is treated politically will therefore be felt personally, socially and economically. This is because social care is not only encountered in moments of crisis. It shapes whether people can keep a home, maintain routines, stay in work, manage illness, recover confidence, and remain connected to family and community. One interviewee described it as the support that gives him "the freedom to live my life, basically, as much as I can."

For further context and research into the shifts in size and complexity of demand, see Annex A in the appendices.

> "Support gives me the confidence and the driving force to continue my day."

[1] https://digital.nhs.uk/data-and-information/publications/statistical/adult-social-care-activity-and-finance-report/2023-24
[2] https://www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/workforceintelligence/resources/Reports/National/The-state-of-the-adult-social-care-sector-and-workforce-in-England-2025.pdf
[3] https://www.skillsforcare.org.uk/news-and-events/news/latest-social-care-sector-and-workforce-data-published

While discussions about social care often focus on services or the system itself, its impact is deeply personal and is felt across families and communities.

The evidence gathered for this report shows that the value of social care is often felt most sharply in the reduction of fear and uncertainty. One resident described constant anxiety about falling or becoming unwell at home but said that once in a supportive care environment "all my worries have gone". Others described family members becoming less anxious, more reassured, and able to spend time together more positively once the right support was in place.

Social care also enables people to maintain independence, dignity and quality of life. For many people, access to the right support makes the difference between isolation and remaining connected to family, friends and community. By helping people live safely and independently at home, social care plays a crucial preventative role within the wider health and care system. Effective support can reduce avoidable hospital admissions, support recovery after illness, and help people remain active participants in their communities.

In this way, social care is not simply a support service for individuals. It is part of the essential social and economic infrastructure that sustains families, communities and society as a whole.

> It allows people to go back to being a partner, a son or daughter, rather than just a carer.

When support is absent, families often become the default coordinators and providers of care, absorbing pressure that the formal system has failed to meet.

The experiences of our interviewees and survey respondents illustrate the real-world impact of social care - highlighting both the value of high-quality support and the pressures facing the system today.

The following examples provide insight into what social care means in practice for the people and families whose lives it shapes every day.

Ashley Healey, a receiver of care and support from the North West, describes good support not as dependence, but as the backing that makes independence real. Supported living helps him manage daily routines, travel, see friends and plan his life, while also giving his family confidence that he can live more independently. His account is a strong example of care as enabling infrastructure, turning independence from an aspiration into something practical.

> It isn't just washing and dressing... those things and the support around those things enable me to do all the other stuff.

Another receiver of care and support provided insight into core qualities of residential support, including safety, reduced anxiety and family reassurance, confidence and freedom. As this resident described it, "back at my home, I was constantly anxious in case I had a fall or taken ill, since being here all my worries have gone."

Overall, without a step change in how social care is understood and supported, these pressures risk becoming self-reinforcing: rising need, constrained access, and increasing pressure on families and public services. In this context, failing to act on social care is not a neutral choice – it carries significant social and economic costs.

2. Social care and the NHS: An interdependent system

Adult social care and the NHS are often treated as two separate sectors, but in practice they are deeply interdependent. While their responsibilities, funding routes and accountability arrangements are not identical, they frequently overlap, and the outcomes they deliver are closely connected.

When social care is working well, it helps people remain healthy, maintain independence and manage long-term conditions, often following hospital treatment or other contact with NHS services. It also helps to prevent avoidable deterioration, reducing the likelihood that people reach crisis point and require unnecessary hospital admission. Put simply, the right support at the right time and in the right place can prevent greater need, improve outcomes for individuals and reduce pressure on the NHS.

When social care is under strain, however, preventative support becomes harder to sustain, hospital discharge is delayed, and pressure across the NHS increases. In this context, capacity in social care is not simply a matter of occupancy or workforce numbers, but of whether the system has the resources, coordination and flexibility needed to put timely, appropriate support in place.

The distinction between the two sectors is important. As one provider put it, "the NHS often operates as a 'break-fix' service", while social care supports people over the long term, often as a home and source of continuity, rather than a site of acute intervention.

Better integration does not mean making social care more like the NHS; it means building stronger coordination across two systems that do different but connected things.

A sustainable, well-resourced social care system is also essential to delivering the Government's aims to reform the wider health system, as outlined in the Neighbourhood Health Framework and the NHS 10-year plan[4]. However, to achieve these ambitions, social care needs to be recognised as core national infrastructure. When properly resourced, it not only improves people's lives and independence, but also enables the NHS to operate more effectively by ensuring people receive the right support in the most appropriate setting.

> "[The relationship] is essential, but it's not joined up enough."

The social care sector plays a vital, yet understated preventative role for the wider health system. The sector plays a critical role in supporting people with long-term conditions, preventing avoidable health deterioration and hospital admissions. For people with complex health needs, ongoing support helps them to remain stable, encourages independence at home, and reduces the likelihood of crisis escalation requiring hospital admission.

[4] https://www.gov.uk/government/publications/neighbourhood-health-framework

Several respondents described social care's preventative role in everyday terms rather than only system terms. Support with medication, routine, hydration, mobility, confidence and day-to-day decision-making helps prevent deterioration before it becomes an emergency. Social care is therefore not simply adjacent to prevention; it is part of the system's preventative function. This preventative function is becoming increasingly important in the context of demographic change, which creates a clear opportunity to strengthen the role of social care within preventative models, working alongside primary and community health services to reduce avoidable demand on the NHS.

Further evidence on this preventative role is set out in Annex B.

The operational interdependence between social care and the NHS is most visible in hospital discharge. During hospital discharge, movement between services, and the handover from assessment to ongoing support, is where weaknesses in coordination are most evident. Just as social care can help prevent avoidable admission, it is also essential to enabling people to leave hospital safely and promptly once they are medically fit. This is a significant and well-evidenced system challenge, explored further in Appendix B.

Delayed discharges have clear and significant consequences for patients and for the efficiency of the wider healthcare system. They reduce bed availability, limiting the NHS's ability to treat other patients promptly[5]. When waiting times grow, unmet need can deepen and conditions may worsen. Ultimately, by the time care is delivered, people often require more complex, intensive and costly support than would have been needed earlier.

Our interview evidence reinforces how visible this problem is on the ground. Providers described people remaining in hospital or long-stay settings not because support could not be delivered in the community, but because the right accommodation, funding package or shared decision-making process was not in place. One interviewee argued that the key barrier to discharge for some people with very complex needs was not workforce capacity but "the actual physical buildings".

In practice, this does not relate only to care home capacity. Safe discharge also depends heavily on the availability of homecare, supported living, reablement and wider community-based support, which are often just as important to enabling timely discharge and recovery.

Interviewees and survey respondents were especially clear that social care providers must not be treated as a peripheral delivery arm within these reforms. If neighbourhood health models are to work, social care needs equal status in planning and decision-making, not a token presence in NHS-led structures.

Social care also plays a critical role in shaping what happens after a period of ill health or a hospital stay. For many individuals, particularly older people and those living with complex or long-term conditions, the period following discharge is a pivotal point that determines whether they recover their independence or experience further decline[6].

Effective social care provision supports people to regain confidence, rebuild strength, and re-establish routines following illness or injury. Through services such as reablement, rehabilitation and ongoing community-based support, individuals can recover functional ability, maintain mobility, and reduce their reliance on more intensive health and care interventions over time[7]. In this way, social care is central to supporting recovery, not just maintaining stability.

[5] https://www.england.nhs.uk/long-read/urgent-and-emergency-care-plan-2025-26
[6] https://www.england.nhs.uk/wp-content/uploads/2023/09/PRN00761-intermediate-care-framework-rehabilitation-reablement-recovery-following-hospital-discharge.pdf
[7] https://www.scie.org.uk/integrated-care/intermediate-care-reablement/reablement-guide/

Where appropriate support is unavailable or delayed, the consequences can be significant. Individuals may experience avoidable deterioration, including loss of mobility, reduced ability to carry out daily activities, and increased social isolation. This can lead to a greater likelihood of readmission to hospital[8], as well as a higher level of long-term care need. The absence of timely and effective social care risks entrenching dependency rather than promoting recovery.

Susan Watson, Home Manager at Pytchley Court, described how, in her home, activities and therapeutic routines support residents' memory, mobility and confidence after illness or decline. Her account is useful because it shows secondary prevention in ordinary terms; not abstract rehabilitation, but helping people rebuild routines, maintain movement, keep choice, and avoid unnecessary deterioration after a health event.

This highlights one of social care's most under-recognised roles within the wider health and care system. Beyond preventing initial hospitalisation, it enables people to recover well, sustain independence, and avoid escalation of need over time. Strengthening this aspect of provision is essential not only for improving individual outcomes, but for reducing repeat demand on NHS services and supporting the long-term sustainability of the system.

Lived experience: Isaac's story

Isaac Samuels OBE, co-chair of the National Co-production Advisory Group and the Think Local Act Personal Board, and someone who draws on care and support, offers a powerful account of both the damage caused by fragmented systems and the life-changing impact of genuinely joined-up care.

I wasn't asking for perfect care. I was asking to be seen, heard, and taken seriously. For years, I moved through a system that was meant to support me. Mental health services, my General Practitioner (GP), hospital, social care. And at almost every turn, what I experienced wasn't cruelty. It was something quieter, and in many ways harder to name. It was indifference.

Processes carried on, appointments happened, boxes were ticked, but no one stepped back to ask how I, as a whole person, was really doing. When I told my GP I hadn't eaten properly in two weeks and was having thoughts of self-harm, I was given a leaflet about sleep hygiene.

When I reported persistent pain and unexplained weight loss three times in six months, nothing was investigated until I pushed, and by then something significant had already been missed.

When my social care assessment finally happened, it lasted twenty minutes over the phone. My need for help managing my medication was marked as "manageable". It wasn't. Looking back, what strikes me most is how often the system failed not because people were unkind, but because no one held the whole picture.

[8] https://www.england.nhs.uk/wp-content/uploads/2023/09/PRN00761-intermediate-care-framework-rehabilitation-reablement-recovery-following-hospital-discharge.pdf

My GP, mental health team, consultant, and social worker had never spoken to each other. I was discharged from hospital with eleven days of no support in place. There were moments, at least four that I can clearly identify, where a professional could have stepped in, made a referral, or raised a concern. None of them did, because no one was quite sure whose responsibility it was. My husband lived through all of this alongside me. He made calls, chased appointments, and held things together at home. No one asked how he was coping. He was never offered a carer's assessment. He was never offered anything.

And then something changed. A new GP. A different way of working. For the first time, someone took the time to understand not just my diagnoses, but my life. What mattered to me. What I was struggling with. What I was trying to hold onto.

My home. My mental and emotional wellbeing. My job. The things that made me who I am. And for the first time, someone in the system cared about those things too.

The people supporting me began to speak to each other. Decisions made sense because they were made together, with me rather than for me. I didn't have to repeat my story every time, or fight to be believed, or fall through gaps that no one owned.

Care became joined up, consistent, and human. There was real dialogue. Genuine listening, not to respond, but to understand. And there was a willingness to talk openly about positive risk, to trust me, and to act on that trust.

That experience changed my life. It is not an exaggeration to say it gave me one. For the first time in years, I felt able to live. Not just survive, but live a life with purpose, meaning, and connection. A life where I could contribute and feel like a person, not just a patient.

The difference wasn't complicated. It was human. It was someone asking what mattered to me, and then acting on the answer.

Making it real:

Before my care was joined up, I couldn't leave the house most days. I missed family weddings and birthdays for three years in a row. Not because I didn't want to be there, but because the journey, the steps, and the stress of getting there felt unmanageable, and no one had ever asked what was getting in the way.

After my care was finally coordinated, after one conversation between my social worker and my mental health worker that should have happened years earlier, everything began to shift. I started going to the things that made me feel human again. I found a job, and I kept it. I managed my health because I was trusted to do so. I took part, fully, in my own life.

That is what good care looks like in practice. Not a policy. Not a pathway. A life, with full participation in it. This is what the sector is capable of when it is allowed to work as it should. The question is not whether this kind of care is possible. I am living proof that it is.

The real question is why it remains the exception, and what it will take to make it the rule. Now I can live the life I want and do the things that are important to me as independently as possible.

Isaac's account illustrates both the human cost of fragmented care and the transformative impact of care that is coordinated, person-centred and built around what matters to the individual. It shows that when health and social care work together well, the result is not simply a smoother process, but restored independence, greater trust, and fuller participation in family, work and community life. The lesson is not that joined-up care is impossible, but that where it happens, its impact is profound.

3. Social care as national infrastructure: the economic case for investment

Investment in social care should be understood as an opportunity for long-term economic return, not a drain on public finances. There is growing evidence that investment in social care generates value through multiple channels, including supporting employment across communities, enabling labour market participation, reducing system costs and stimulating wider economic activity. These estimates suggest that

> for every £1 million invested in adult social care, between £5 million and £7 million of economic benefits may be realised within one year, rising to £22 million over two decades[9].

Taken together, this data and the wider evidence set out in Appendix C demonstrate that investment in social care delivers measurable economic return and should be recognised as a driver of growth.

Providers interviewed for this report consistently described these returns in grounded terms: jobs, careers, local spending, family stability and stronger community life.

As Russell Brown, Chief Executive of Shaw Healthcare, put it,

> “At a very simple level, we provide jobs, but more importantly, we provide careers.”

That distinction matters. The economic case for social care is not only about avoiding cost elsewhere; it is also about what the sector actively creates.

Providers also described social care as part of the civic fabric of local places: not only a source of employment and spending power, but a network of services, relationships and community assets that support wider local resilience.

The sector employs an estimated 1.6 million people. These jobs are distributed across all regions and communities and are relatively resilient to economic cycles, making social care a critical contributor to local economic activity and stability.

The provider interviews strongly reinforce this point. One interviewee described their organisation as the largest employer in a major town in the South East, where other sources of work have declined.

[9] https://onlinelibrary.wiley.com/doi/10.1002/hec.70026

They also noted that 95 percent of their frontline workforce is drawn from the immediate local area. These are not footnotes to the social care story; they are central to it. Social care is often a place-based employer and a route into skilled, long-term work in communities that need it most.

These roles are also geographically distributed across all regions, including areas with fewer alternative sources of employment, making social care a particularly important contributor to local economic resilience and 'levelling up' objectives.

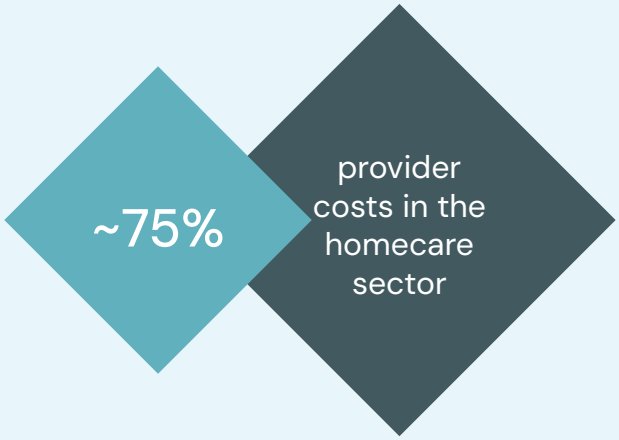
This workforce is also spread across a diverse range of service models, including home care. Skills for Care estimates that since 2018/19, the number of filled posts in domiciliary services has increased by 24%, equivalent to 143,000 additional posts[10]. This is a useful reminder that homecare is itself a major part of the sector's economic footprint and labour market value.

Investing in social care produces significant multiplier effects across local economies. These can be understood through three simplified channels:

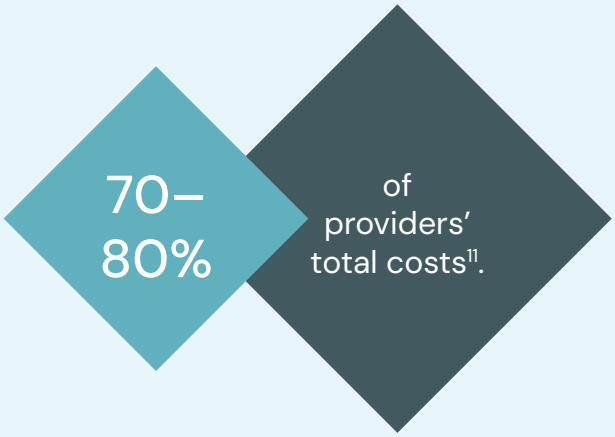
- **Direct effects:** employment, wages, and tax contributions generated by the sector
- **Indirect effects:** increased demand for goods and services across supply chains (e.g. training, equipment, facilities management)
- **Induced effects:** increased spending by care workers in local economies

Our interviews also suggest that these multiplier effects are often underestimated because the sector is still too often mischaracterised as low-skill or marginal. In practice, providers described a much broader ecosystem: apprenticeships, internal progression, finance and HR roles, digital and leadership careers, local suppliers, volunteers, students, and family members able to remain in paid employment because formal care is in place.

These effects are particularly strong in the social care sector due to its structural characteristics, which mean that investment is rapidly translated into wages and local economic activity. The sector is highly labour-intensive, estimated to account for



and sector wide employment costs account for



Nevertheless, the sector has been defined as a 'low-paying industry' by the Low Pay Commission in every report since 1998[12]. Workers in lower-paying sectors have a higher marginal propensity to consume, meaning any additional income they receive is more likely to be spent than saved or invested, compared to other industries[13].

[10] https://www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/workforceintelligence/resources/Reports/National/The-state-of-the-adult-social-care-sector-and-workforce-in-England-2025.pdf
[11] https://www.homecareassociation.org.uk/resource/homecare-association-minimum-price-exposes-england-s-homecare-funding-gap-as-new-employment-law-takes-effect.html
[12] https://assets.publishing.service.gov.uk/media/671259d59cd657734653d7e5/impact-assessment-establish-a-fair-pay-agreements-process-in-the-adult-social-care-sector.pdf
[13] https://www.bostonfed.org/home/publications/research-department-working-paper/2019/estimating-the-marginal-propensity-to-consume-using-the-distributions-income-consumption-wealth.aspx

As a result of this, and other factors outlined within Appendix C, investment in the workforce would likely generate higher economic returns at the national and local level.

Investment in social care supports wider labour market participation through two primary mechanisms. First, it enables unpaid carers to enter or remain in employment by reducing the need to provide informal care. Second, it supports individuals receiving care to maintain independence and, where possible, continue to participate in economic activity. Together, these effects positively affect labour supply and economic growth.

This was one of the clearest recurring themes in our survey and interviews. Multiple respondents described social care as what allows relatives to stop being full-time carers by default and return to being partners, parents, sons and daughters. That emotional relief is also an economic mechanism: it protects working hours, reduces the risk of family members leaving the labour market, and allows households to remain financially stable.

As explored in Chapter 2, sufficient adult social care capacity plays a crucial preventative and rehabilitative role in the wider health system. Meeting need earlier is more cost-effective than responding at the point of crisis. The evidence set out in Appendix C suggests that increased social care capacity can contribute to lower delayed discharges, fewer avoidable hospital admissions and greater overall system efficiency.

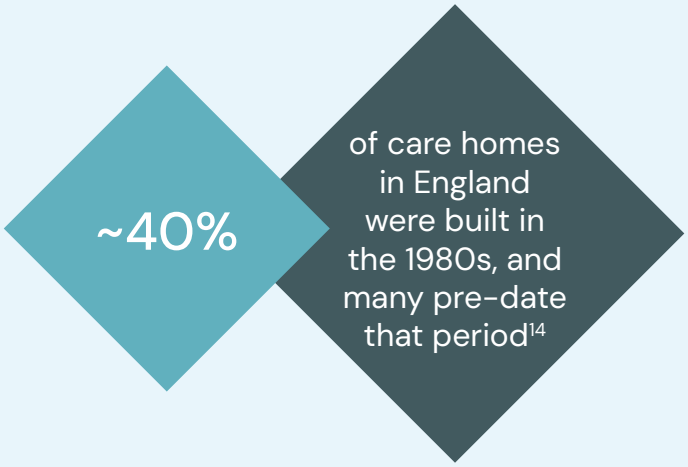
Taken together, these channels demonstrate that social care is not only a provider of essential services, but a key component of the UK's economic infrastructure. Like other forms of infrastructure, its value lies in enabling wider economic activity – supporting labour markets, sustaining local economies, and reducing downstream costs across public services.

Furthermore, a sustainable and well-functioning social care system is also essential to attracting and retaining investment within the sector. As a mixed economy of provision, adult social care relies on a combination of public funding from local authorities, and in some cases the NHS, and private self-funding from individuals to deliver services. However, uncertainty around funding, workforce pressures, and variability in commissioning approaches can act as barriers to private investment, limiting providers' ability to expand, innovate, or improve quality.

Interviewees repeatedly returned to uncertainty as a barrier in its own right. Even where providers want to invest in staffing, buildings, technology or adapted housing, weak long-term confidence in funding and commissioning suppresses ambition. This means the problem is not only low funding; it is also the absence of a stable, investable environment. As several interviewees made clear, meaningful improvement depends on investment across people, environments and systems together, rather than in any one area alone.

Creating the conditions for investment requires greater long-term funding certainty, clearer commissioning frameworks and an operating environment in which providers can plan for the future. Where these conditions are in place, investment can support service expansion, workforce development and the adoption of new models of care, including those aligned with neighbourhood health approaches. Without them, capacity constraints are likely to persist, undermining both economic and health system objectives.

Another important area is the condition and suitability of the current care estate. Investment in care infrastructure is central to modernising settings and ensuring they are fit for future demand.



Since then, regulatory standards have risen and expectations of care environments have changed significantly, meaning many older buildings are no longer well suited to modern care needs[15].

The case for investing in modern care infrastructure is strong, including from both sustainability and person-centred care perspectives, as set out in Appendix C. Government therefore needs to provide a stable policy environment that allows this opportunity for high-return investment to be realised. Most importantly, investing in modern, purpose-built care infrastructure is essential to meeting future demand and ensuring the long-term sustainability of the social care system.

Over the past decade, care home bed supply has increased by just 2.9 percent, while the population aged over 65 has grown by 20.7 percent, indicating a clear and widening supply-demand gap.

> On current trends, it is estimated that by 2050 there could be a shortage of 200,000 beds[16]. Without intervention, that gap will continue to grow.

Care homes are an important part of the sector's infrastructure, but they are not the whole of it. National adult social care finance data show that close to half of gross current expenditure on long term care continues to be spent on community based services across age groups, and that for adults aged 18–64 the largest share of spending is on supported living[17]. Investment in the social care infrastructure including the homecare market, supported living, and community provision is also essential. Framing social care as infrastructure should therefore include not only residential and nursing provision, but also the broad range of services that help people remain well and independent outside hospital and institutional settings.

[14] https://societyoflaterlifeadvisers.co.uk/write/MediaUploads/Useful%20documents/LaingBuissonCareHomesforOlderPeople33rdedition20231.pdf
[15] https://www.legislation.gov.uk/ukdsi/2014/9780111117613/regulation/
[16] https://content.knightfrank.com/research/336/documents/en/healthcare-development-opportunities-2025-12025.pdf#:~:text=shortfall%20in%20bed%20supply,are%20already%20in%20a%20deficit
[17] https://www.gov.uk/government/statistics/adult-social-care-finance-report-england-2024-to-2025/adult-social-care-finance-report-england-2024-to-2025

4. The reality of providing care today and the shape of a stronger system

Understanding adult social care today means looking beyond policy statements and system design to the day-to-day realities of providing care. For providers, the experience of delivering support is shaped by a combination of rising demand, increasing complexity, financial pressure, workforce instability, fragmented interfaces with other parts of the system, and growing administrative burden. Yet it is also shaped by an ongoing determination to keep delivering personalised, high-quality support despite these pressures.

It is important to recognise that the pressures facing adult social care are longstanding, and there has been no shortage of recommendations on how to address them. While this report does not look to revisit that history in detail, it remains critical to understanding the current position. Appendix D therefore provides a comprehensive account of the policy landscape, setting out the scale and frequency of reform efforts and examining why successive initiatives have failed to deliver sustained, system-wide change.

The evidence gathered for this report points to a sector carrying significant responsibility, often with limited headroom. Survey respondents were overwhelmingly clear that social care matters: 92.9 percent said it is essential or very important to people's quality of life. But they were far less confident in the system around it. Nearly two-thirds said the sector is not currently in a strong enough position to meet people's needs now and in the future, and more than half rated NHS and social care working together as "not great" or "poor". The picture that emerges is not of a sector lacking commitment or purpose, but of one operating in conditions that make delivery harder than it should be.

What needs to change, therefore, is not only the tone of the debate around social care, but the operating environment in which care is commissioned, delivered and improved. The pressures described by respondents were not isolated problems, but connected features of a system that too often makes good care harder to deliver than it should be. This chapter therefore brings together the lived experience of providing care today with a clear articulation of what a stronger system would look like in practice, showing how each pressure identified translates into a practical and achievable direction for reform.

Financial pressure, sustainability and the conditions for improvement

A consistent theme across our evidence is that providers are operating in an environment of persistent financial strain. Rising wage costs, inflation, energy prices, food costs, maintenance, digital requirements and wider compliance costs all affect the daily experience of running services.

What providers described was not simply pressure in the abstract, but a sense that the operating environment has become narrower, less predictable and harder to plan within.

Our survey data reinforces this strongly. Underfunding emerged as the clearest structural issue running through responses, with many respondents linking it directly to staffing pressures, reduced flexibility, limits on service development and increasing strain on families. As one respondent put it, "Good care costs money." Another stated more directly:

> "The biggest problem is funding."

These are simple lines, but they capture something important about the provider perspective: financial pressure is not experienced as a background policy issue, but as a day-to-day condition shaping what services can sustain, improve or expand.

The interview feedback adds further depth. Providers often framed the issue not just as lack of money, but as lack of certainty. The most striking evidence here concerned the consequences of instability: delayed decisions, reduced confidence to invest, and difficulty planning beyond immediate pressures. Several of the strongest examples in the thematic analysis focused on what financial fragility prevents in practice, whether that is investment in buildings, staffing, technology or service redesign.

This is why the funding question should not be framed simply as a plea for more money. It is a question of whether the system is being given the conditions required to function. Providers cannot invest in workforce development, service redesign, innovation, digital tools or the care environment if they are operating within chronic uncertainty and fee arrangements that do not reflect the real cost of care. Nor can commissioners credibly prioritise prevention, continuity and independence if the provider market remains fragile.

> A stronger social care system would directly address these constraints by creating the conditions for financial sustainability and long-term planning.

The Care Act statutory guidance is clear that local authorities should promote the efficient and effective operation of a market in services for meeting care and support needs, and should ensure a sustainable and diverse range of high-quality services for local people. Market sustainability is therefore not an optional extra, but part of what the system is supposed to deliver.

If the system expects providers to deliver personalised, preventative and integrated care, it must also create the conditions in which those expectations are realistically deliverable. Financial sustainability should therefore be understood as a precondition for continuity of care, market resilience and innovation.

Financial sustainability also matters because it shapes the range and quality of options available to people locally. A healthier market means preserving meaningful choice. The National Institute for Health and Care Excellence (NICE)'s quality standard on personal budgets is relevant here too[18]: control over care is weakened if the local market is too fragile or too narrow to offer real options. Good care therefore depends not only on the quality of individual services, but on whether the wider market is sufficiently stable, diverse and investable to support different needs and preferences across a local area.

This fragility was also visible in the survey findings: two-thirds of respondents (66 percent) did not think social care is currently in a strong enough position to meet people's needs now and in the future.

[18] https://www.nice.org.uk/guidance/qs182/chapter/quality-statement-2-empowering-people-to-manage-their-personal-budget

If policymakers continue to ask the sector to do more while preserving the instability that undermines delivery, the gap between ambition and reality will persist. If, instead, social care is treated as essential national infrastructure rather than a residual service, a more coherent route to reform becomes possible.

Workforce pressures, capability and the foundations of quality

The workforce also emerged across the evidence as both the sector's central strength and one of its greatest points of vulnerability. Survey respondents described care workers in highly positive terms: compassionate, skilled, committed and essential to good outcomes. But they also described a workforce under sustained pressure, facing low pay, emotionally demanding work, recruitment challenges and insufficient recognition. One respondent wrote:

> "It's reliant on goodwill from an amazing workforce. That goodwill will run out one day."

For providers, these pressures are not experienced simply as vacancy figures or abstract recruitment problems. They affect continuity, flexibility and the ability to build trusted relationships. Our interview feedback was especially strong on this point. Continuity of staff was repeatedly associated with whether people feel safe, understood and able to communicate openly. In practice, that means workforce instability affects not only operations but also the nature of the support people receive.

This human dimension also came through strongly in lived-experience evidence. One receiver of care described good support as requiring workers to understand not only the physical side of disability, but the mental and emotional side too. That is an important reminder that workforce pressures are not only about staffing numbers: they affect whether support remains emotionally intelligent, relational and responsive to the whole person. They also affect whether care can be genuinely shaped with people rather than simply delivered to them, through the time, continuity and trust that shared decision-making depends on.

> "Families end up being the communication conduit."

At the same time, provider evidence pushed back against narrow assumptions about care work. Several interviewees described social care as a profession with progression, training and varied career routes rather than a stopgap or low-skill role. That point matters here because it reflects how providers understand the work they are already doing. The current experience of providing care includes the challenge of maintaining professional, skilled support in a labour market and policy environment that does not always reflect that reality.

> No social care system can function well without a workforce that is large enough, stable enough and skilled enough to provide consistent, high-quality support, and the evidence presented here makes clear that current pressures are directly undermining that stability.

The challenge, however, is not simply one of numbers. A good workforce model is not simply about filling vacancies. It is about creating the conditions in which people can stay, develop and build careers in social care.

Workforce instability has direct consequences for quality. High turnover disrupts continuity, increases reliance on temporary staffing, and makes it harder for workers to build the trust and familiarity on which good care depends. For providers, this often results in greater reliance on agency staff, reflecting a short-term mitigation of a structural workforce issue.

In a stronger system, social care roles would offer more competitive pay and conditions, clearer progression pathways, and structured access to learning and development. Workforce policy would be treated not as a separate employment issue, but as part of the quality architecture of the system.

This link between workforce conditions and care quality was strongly reflected in the survey evidence. Respondents repeatedly connected staffing levels, retention, training, morale and pay with continuity, safety and the quality of relationships people experience in care. The shared message from respondents was clear: workforce conditions are not peripheral to good care; they are one of its foundations.

As one respondent observed...

> We are not machines, we are people too; we need to be compensated for the time, energy and effort we put into this job.

Another put it more directly:

> Staff are the backbone of social care, so they need to be treated well and paid properly.

A capable workforce must also be equipped to meet the growing complexity of care. As more support is delivered in community settings, and greater levels of healthcare activity are delegated to care staff, the demands placed on the workforce are increasing. In line with wider system ambitions to prevent deterioration, avoid hospital admission, and support discharge and recovery, staff need the skills and confidence to respond to needs that are more complex and less predictable than in the past. Skills for Care's workforce strategy rightly emphasises the importance of workforce planning, career development and investment in skills. A well-functioning system would align workforce development with the reality of need, rather than expecting staff to absorb growing complexity without the necessary support, training or recognition.

Oversight, regulation and the experience of system friction

Another strong theme in our evidence gathering was the complexity of regulation and oversight. Providers did not argue against accountability or scrutiny. Rather, they described an environment in which multiple bodies may request information, monitor performance or seek assurance, sometimes in ways that feel overlapping, poorly aligned or administratively burdensome.

Survey responses support this picture. Respondents referred to delays, red tape and difficult processes that consume time and management attention. While not all of this relates narrowly to formal regulation, the cumulative effect described is one of friction. For providers, this is part of the everyday experience of delivering care: not just supporting people directly, but repeatedly navigating layers of process, documentation and external scrutiny.

The challenge described by providers is not the existence of scrutiny, but the experience of fragmentation across the bodies that shape and monitor provision.

This is particularly relevant given the growing number of organisations with an interest in service quality, performance and capacity, including regulators, commissioners, local authorities and health partners.

> Good social care requires oversight that is strong, but also proportionate and coordinated, and the current experience described by providers suggests that this balance is not yet being achieved in practice.

Survey responses reinforce this picture. The wider regulatory system is often experienced not as streamlined and enabling, but as administratively burdensome, slow and fragmented. Respondents described delays, red tape and confusing processes as draining time and energy that could otherwise be directed towards direct care and improvement.

A stronger model of oversight would be clearer about who is asking for what, on what basis, and for what purpose. Information would be shared where appropriate, expectations would be more consistent across organisations, and providers would spend less time responding to overlapping or differently framed requests. That matters because unnecessary duplication consumes management capacity that could otherwise be directed towards improvement, workforce support and quality.

As one respondent put it:

> “Cut the red tape and bureaucracy. Spend money on care that matters.”

Proportionate oversight does not mean weaker accountability. It means aligning assurance activity more closely with the outcomes that matter: safe care, good experiences, service continuity and improvement over time. It also means recognising that regulation and improvement are linked. A mature system does not treat compliance as an end in itself. It uses oversight to identify risk early, support improvement and create a clearer shared understanding of quality across commissioners, regulators and providers.

Fragmentation, integration and the experience of navigating the system

Survey respondents described working across health and care as inconsistent, especially around communication, discharge and follow-up arrangements. One respondent observed that “Families end up being the communication conduit,” while another noted that coordination too often depends on individuals rather than the system itself.

This distinction was particularly clear from one interview with a receiver of care, who described day-to-day support as capable of being enabling and life-changing, but the wider system around it as restrictive, exhausting and poorly joined up. They spoke of having to piece together support across multiple routes.

Providers themselves described delays, remote decision-making, weak information-sharing and uncertainty about who owns particular decisions. The evidence also suggests that the problem often begins earlier than formal handover points alone: poor assessment, weak follow-through and unclear ownership can leave people and families navigating systems that never fully take responsibility for the whole picture.

These accounts show how fragmentation is experienced in practice: as repeated chasing, avoidable delay, unclear responsibilities and additional pressure at service level. Providers are often trying to deliver continuity for people while operating across discontinuous systems.

Care workers themselves described remote decision-making and NHS processes that felt detached from the realities of care on the ground, capturing the problem starkly in the phrase:

> They've not even met the person.

This reflects a system where decisions are too often made without direct understanding of the individual, creating gaps between assessment, planning and the lived reality of care.

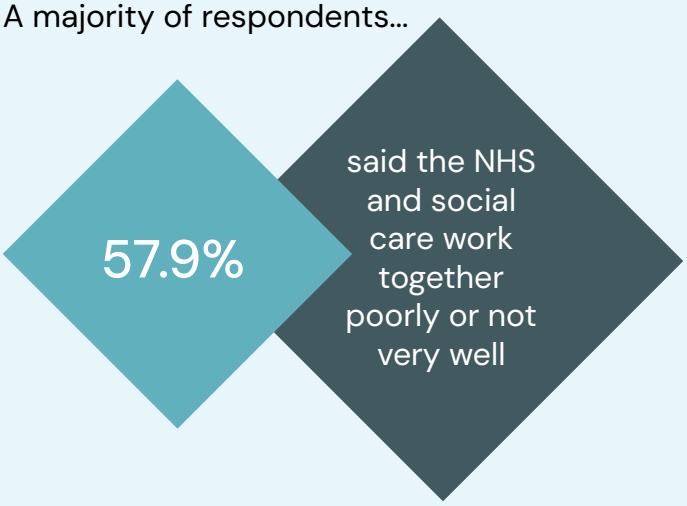
Overall, this fragmented way of working has practical consequences for the delivery of care. It can slow decision-making, create additional work for providers and families, and make already pressured services absorb risk and uncertainty generated elsewhere in the system.

> A strong social care system cannot be understood in isolation from the wider health and care system around it, and addressing these challenges requires more consistent and embedded integration across organisational boundaries.

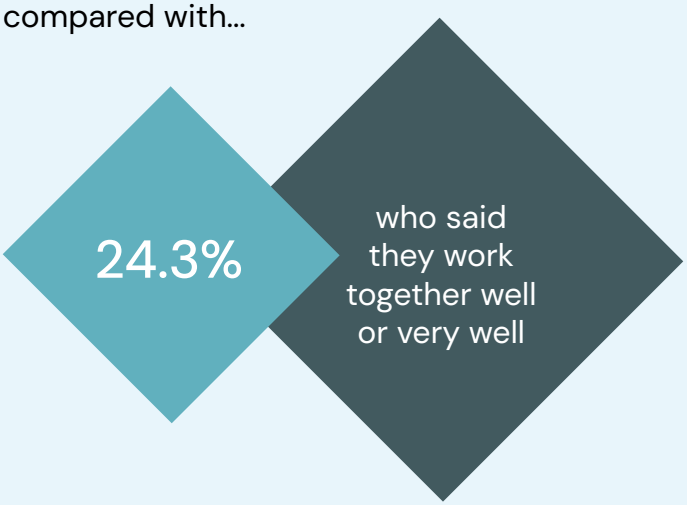
This is especially relevant in the context of current reform ambitions, which place increasing emphasis on neighbourhood working, community-based care and more joined-up local delivery. The Government's Neighbourhood Health Framework makes clear that reform depends on joint working between the NHS, local authorities and wider partners, with a greater emphasis on community-based care, prevention and more joined-up local delivery.

Yet the survey evidence suggests that this remains far from routine in practice.

A majority of respondents...



compared with...



As one resident respondent put it:

> From my experience, the NHS and social care can work well together, but it's inconsistent, and too often it depends on individuals rather than the system itself.

For social care, this means a functioning system is one in which providers and local government are not peripheral to integration, but active participants in planning and delivery. In practice, this should mean smoother pathways between hospital, primary care, community services and social care.

One care worker respondent made the point practically:

> "Hospitals are not great when communicating with care providers regarding a patient's care needs and health conditions. A standardised and thorough discharge form would be really helpful."

The problem is not that joined-up working never happens. It is that it too often depends on individuals, local goodwill or providers compensating for weak system design. Good coordination exists in places, but it is not yet something people can depend on across the system as a whole. Effective coordination therefore remains the exception rather than the norm.

Crucially, good integration is not simply a matter of more meetings or more structural complexity. It is about whether organisational boundaries become less disruptive for the people who rely on support. A stronger model would recognise that social care has a distinct contribution to make, and that neighbourhood reform will succeed only if those perspectives shape local delivery in practice. The risk in any integrated model is that social care is treated as a supporting function to NHS priorities rather than as an equal partner. What good looks like is a more balanced settlement in which social care is involved early, not added later.

Ultimately, the success of an integrated system should be judged by the experience of the individual seeking support: they should not need to understand organisational boundaries or navigate multiple entry points, but instead access care through a single route and move seamlessly to the support they need, in the right place and at the right time, regardless of who delivers it. Success should be measured by people and outcomes, not systems and processes.

The survey evidence suggests that respondents experience these pressures as connected rather than separate. Workforce strain, funding fragility, weak integration and bureaucracy appear throughout the responses as part of the same structural picture.

One of the longstanding weaknesses of social care reform is that decisions affecting the sector are too often made in isolation from one another. Immigration policy, labour market policy, NHS reform, local government finance, housing and wider economic policy all shape the capacity of social care to function well, yet they are rarely designed as part of a coherent whole.

Prevention, recovery and independence in practice

The consequences of fragmentation are especially clear when thinking about prevention, recovery and independence. A strong social care system also takes prevention seriously in practice, not just in principle. The Care Act places a duty on local authorities to provide or arrange services, facilities or resources that help prevent, reduce or delay needs for care and support. In social care, prevention is broader than crisis avoidance alone. It includes supporting independence, maintaining function, promoting recovery and helping people remain connected to everyday life.

This broader understanding was strongly reflected in the survey evidence. Respondents frequently described social care as the support that prevents deterioration, avoids unnecessary hospital use, supports recovery and helps people remain independent for longer.

Reablement is a useful example of what this looks like in practice. The Social Care Institute for Excellence (SCIE) describes reablement as helping people regain functioning, maintain life skills, rebuild confidence and promote wellbeing, while NHS England (NHSE)'s intermediate care

framework describes step-down intermediate care as short-term support after discharge to help people rehabilitate, re-able and recover. NHSE also states that implementation of this model is expected to improve independence, reduce avoidable readmissions and reduce avoidable or premature long-term care provision.

These are important points because they show that prevention is not only about stopping future demand before it emerges. It is also about enabling recovery, confidence and function after illness or hospitalisation.

One respondent noted that strong social care can help reduce readmissions and support recovery, while another warned that without it...

> "the NHS would be massively overwhelmed, even more than it is already."

> A stronger system would therefore make independence-promoting support more routine, embedding prevention, recovery and community-based support as core features of how care is delivered rather than as add-ons.

It would intervene earlier, use reablement and rehabilitation more effectively, and connect formal care with housing, local community assets and wider support networks. It would also recognise that independence is relevant across adulthood, not just in later life. Good social care does not define success only as keeping people safe; it defines success as enabling people to do the things that matter to them for as long as possible.

Taken together, the evidence presents a clear picture of what providing care looks like today. It is skilled, relational and highly consequential work, but it is being delivered in a context of financial fragility, workforce strain, administrative burden and inconsistent coordination across the wider system. Providers are not only supporting individuals; they are also absorbing uncertainty, managing complexity and compensating for weaknesses elsewhere. This helps explain why adult social care reform has so often struggled to move from aspiration to implementation.

A persistent weakness of adult social care reform has been the gap between ambition and delivery. Policy documents have often described the right goals, but without clear ownership, measurable milestones or sustained follow-through.

These features describe a social care system that is stable enough to be relied upon, flexible enough to respond to different lives and needs, and coherent enough to support high-quality care consistently.

A final point, underlying all of the others, is that reform must remain grounded in the purpose of care itself. Respondents repeatedly described social care as fundamentally human, relational and enabling. One wrote: "It is about living, not just surviving." Another said policymakers need to remember...

> "that we are dealing with humans not objects."

5. Creating the conditions for consistent, high-quality social care

The previous chapter set out both the experience of providing care today and the conditions in which the system is able to operate effectively. The evidence does not point to a system lacking capability. It points to a sector already delivering high-quality, person-centred care in many places, often in spite of the environment around it. The challenge now is to ensure that the system consistently supports that standard, rather than leaving it to chance.

Across the interviews and survey responses, a clear pattern emerges. Where care works well, it is not accidental. It is the result of stability, trusted relationships, timely decision-making and a system that enables providers to focus on what matters. These examples are not isolated successes; they are proof of what the system can deliver when the conditions are right.

As one contributor reflected, the stakes are real, noting that...

> “people actually lose their lives because we don’t intervene at the right times.”

However, the message from this report is not one of failure. It is one of opportunity. The building blocks are already in place. The task now is to bring them together so that effective, timely support is something people can rely on, wherever they are.

A phased approach provides a practical route to achieving this, moving from stability, through alignment, to a system where high-quality care is delivered consistently at scale; building social care as a recognisable national infrastructure, indispensable to government’s aims of widespread economic growth and levelling inequality.

Phase 1: Creating the conditions for stability (0–12 months)

The first phase is about creating the conditions in which the system can operate with confidence. The evidence in this report shows that providers are already delivering high-quality care, supported by a skilled and committed workforce. What is needed now is an environment that enables that work to be sustained and strengthened.

Funding is central to this. Providers described the impact of financial pressure in practical terms, shaping decisions about staffing, service development and continuity of care. As one respondent put it, *"Good care costs money."* But the issue is not simply funding levels. It is the certainty that allows organisations to plan, invest and improve over time.

Providing that certainty begins with a clear direction from government. In practical terms:

> *1) The Government must set out a clear multi-year funding trajectory for adult social care, including indicative funding pathways*

to give providers and commissioners the confidence to plan beyond immediate pressures and invest in the future of care.

At a local level, sustainability depends on whether funding reflects the reality of delivery. The evidence shows that where fee rates are aligned with the cost of care, providers are able to invest in workforce, quality and continuity. Where they are not, pressure builds across the system. Responding to this means

> *2) Local authorities, supported by central government, must align fee rates with the cost of care to address workforce and inflationary pressures and enable providers to build reserves and invest for the future*

so that providers are supported to sustain and improve services, rather than managing shortfalls.

The workforce sits at the heart of this system, and throughout this report, care workers are described as skilled, compassionate and central to good outcomes. As one contributor noted, "it's reliant on goodwill from an amazing workforce." The opportunity now is to move beyond reliance on goodwill and build a workforce model that is stable, recognised and properly supported. This requires

> *3) The Government must publish a multi-year funding settlement for the Fair Pay Agreement, set at a level that reflects inflationary pressures and raises care work out of low-pay status, alongside a broader programme of workforce reform to strengthen progression, professional development and career pathways based on sector-approved strategies developed by Skills for Care*

ensuring that care is consistently recognised and supported as a profession.

The system around providers also shapes what is possible. Where processes are streamlined and aligned, organisations are able to focus on care. Where they are not, capacity is diverted away from delivery. As one respondent put it, "cut the red tape and bureaucracy. Spend money on care that matters." Addressing this means

> *4) national bodies and system partners must coordinate oversight and reporting requirements to reduce duplication*

so that time and resource can be directed towards improvement and care itself.

Finally, improving consistency in how services work together will help ensure that people experience more seamless support. Small changes in communication and coordination can make a significant difference. Because of this,

> *5) the Government must establish national expectations for integration practice, including discharge standards and communication protocols between health and social care*

supporting a more reliable and joined-up experience of care.

Phase 2: Aligning how the system works (1–3 years)

With stronger foundations in place, the next phase focuses on ensuring that the system works in a more coherent and joined-up way. The report shows that many of the strengths already present in social care can be further realised through better alignment across funding, commissioning and integration.

Commissioning is central to this. Providers described how longer-term, outcome-focused approaches create the space for investment in quality and continuity. As one system leader observed, *"there's money there. It's just in the wrong pockets."* This highlights a clear opportunity to not simply increase resource, but to ensure that it is used in a way that supports the outcomes the system is trying to achieve.

To enable this shift, funding and commissioning must work together more effectively. This requires

> *6) the Government to implement a cost-reflective funding model within local government settlements, alongside local authorities adopting longer-term, outcome-focused commissioning approaches*

ensuring that funding supports sustainable, high-quality care over time.

Integration also becomes more consistent in this phase. While strong examples already exist, the aim is to make these the norm rather than the exception.

As one care worker noted, *"a standardised and thorough discharge form would be really helpful,"* highlighting how practical changes can improve coordination. Achieving this requires

> *7) Integrated Care Systems to involve social care providers and local government as equal partners in planning, pathway design and service delivery, alongside clearer expectations for named coordination, shared responsibility and follow-through where people's needs cut across services*

so that integration is built into the system, rather than dependent on individuals.

Workforce reform also moves from design into delivery. The evidence throughout this report is clear: workforce conditions shape care quality. This phase is about implementing the improvements already identified, ensuring they translate into practice. This means

> *8) the Government must implement workforce reforms, including structured career pathways, expanded training provision and clearer progression frameworks, building on the Fair Pay Agreement and sector-led strategies*

supporting a workforce that is stable, skilled and able to deliver consistently high-quality care.

Phase 3: Making good practice the norm (3–5 years)

The final phase focuses on ensuring that the strongest examples of care identified in this report become standard practice across the system. The evidence shows that these models already exist. The opportunity now is to ensure they are consistently supported and delivered at scale.

At this stage, the focus shifts from individual reforms to system-wide alignment. Social care plays a central role in supporting economic participation, community wellbeing and the sustainability of the NHS. As one respondent noted, without effective social care, *"the NHS would be massively overwhelmed, even more than it is already."* Recognising and supporting that role consistently is key to long-term success.

This requires a more coordinated approach across government, ensuring that decisions in areas such as housing, workforce and economic policy reflect the contribution social care makes. To achieve this,

> *9) the Government must establish a cross-government social care settlement, aligning policy across departments to reflect the sector's role in supporting economic participation, community stability and public service sustainability*

ensuring that social care is consistently recognised as essential infrastructure.

Sustaining high-quality care over time also depends on continued investment in the environments and systems that support delivery. Because of this,

> *10) the Government must sustain long-term investment in care infrastructure, including care environments, community provision and digital systems*

enabling services to evolve in line with changing needs and increasing complexity.

Finally, delivering consistently high-quality care requires a system that is designed around prevention, independence and long-term outcomes. The evidence in this report shows that social care already delivers this in many places. The task now is to make it standard practice. To embed this approach,

> *11) commissioning and funding models must prioritise prevention, reablement and long-term outcomes as core system objectives*

so that the strongest examples of care identified in this report become the everyday experience of people across the country.

A moment of opportunity

The evidence in this report highlights a system with significant existing strengths. Across the country, there are examples of care that is effective, responsive and grounded in strong relationships. These examples are not exceptions to be admired. They are foundations to be built upon.

The opportunity now is to make those foundations consistent. Where the system supports providers effectively, the results are clear: better outcomes for individuals, stronger support for families, and reduced pressure across the wider system.

As one contributor put it, *"reform should begin from a place of genuine care, compassion, and curiosity."* Those qualities already define the sector. The role of policy is to ensure that they are enabled, not constrained.

The direction is clear. The evidence is strong. The solutions are understood. The question now is not whether the system can deliver high-quality social care. It is whether it will choose to create the conditions in which it does so, consistently, confidently and at scale.

Appendices

Annex A)
Trends in scale and complexity of demand

Demographic trends shaping demand

The UK has experienced significant demographic change over recent decades, reshaping demand for adult social care and other public services. The population has grown substantially, reaching around 67 million people, an increase of more than 10 million since the early 2000s[19]. Alongside this growth, the country has become a markedly older society. Over the past fifty years, the number of people aged 65 and over has increased by around 5.2 million[20]. People aged 65 and over also now make up around one in five of the population, and this proportion is projected to rise further over coming decades[21].

An ageing population inevitably increases demand for health and care services. As people live longer, they are more likely to experience long-term conditions, frailty or disability that require support over extended periods. It is also important not to treat future demand as relating only to older people or to residential care. Working-age adults account for around half of gross current expenditure on long-term care, reflecting the scale and complexity of support provided across the system. For this age group, supported living accounted for the highest gross current expenditure, underlining that adult social care demand is shaped not only by ageing, but also by the continued importance of working-age adult services delivered in community-based settings.

At the same time, the UK is an increasingly diverse society. Different communities have distinct health profiles and care needs, shaped by cultural, socio-economic and environmental factors. These needs are not experienced equally, nor are they equally met. Health inequalities remain a persistent, and in many areas, a widening challenge, with some communities experiencing significantly poorer health outcomes than others.

[19] https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/articles/ourpopulationwherearewehowdidwegetherewherearewegoing/2020-03-27
[20] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/ageing/articles/livinglongerhowourpopulationischangingandwhyitmatters/2018-08-13
[21] https://ageing-better.org.uk/our-ageing-population-state-ageing-2025

Socio-economic disparities also play a major role in shaping health and care demand. People living in the most deprived areas of England can expect to spend up to two decades fewer in good health than those living in the least deprived areas. These inequalities contribute to the earlier onset of chronic illness, disability and poor mental health, increasing the likelihood that people will need care and support earlier in life.

Healthy life expectancy has stalled, and in some cases, fallen in recent years. This means more people are living longer but spending a greater proportion of their lives in poor health. The result is that many people require support earlier in life, and often for longer periods. Social care services are therefore increasingly supporting people with complex health conditions, multiple long-term conditions, and significant support needs.

Taken together, these demographic and health trends are fundamentally reshaping demand for social care. The system is being asked to support a growing number of people, often with increasingly complex needs, at a scale that will continue to expand.

At the same time, rising need is not always matched by access to support. Many people do not meet eligibility thresholds for publicly funded care. Current rules mean anyone with savings or assets over £23,250 is normally excluded from public funding. For residential care, the value of a person's home is also included (unless protected by specific exemptions)[22]. Even for those who receive public funding, it is common to face delays in accessing services, or receive support that does not fully meet their needs. Eligibility has become so restrictive in real terms, that only around 1 percent of people will receive publicly funded, long-term care[23].

When access to support does not keep pace, pressure is displaced onto families, communities and other public services. In this context, adult social care is not a residual service, but the system through which these pressures are most directly and visibly managed.

Rising demand

Despite this, the demand for adult social care has grown steadily over the past decade, driven by the aforementioned demographic change, worsening population health and rising complexity of need.

In response, public spending on adult social care has also risen. Between 2009/10 and 2023/24, spending on publicly funded adult social care increased by around 16 percent in real terms[24]. Local authorities in England spent £23.3 billion on adult social care in 2023/24, with total gross expenditure reaching around £29 billion in 2024/25[25]. Against a backdrop of wider financial pressures in local government, adult social care now accounts for more than 40 percent of local authority service spending[26].

Overspend on adult social care has also become a sizeable problem for local authorities. According to latest projections, councils are likely to overspend by £623 million in adult social care budgets between 2025 and 2026[27]. With pressures to make £869 million of savings for 2026 to 2027, additional strain on care providers and workforce capacity is likely.

[22] https://www.kingsfund.org.uk/insight-and-analysis/data-and-charts/key-facts-figures-adult-social-care
[23] https://www.instituteforgovernment.org.uk/sites/default/files/2025-06/adult-social-care-across-england_1.pdf
[24] https://www.instituteforgovernment.org.uk/publication/performance-tracker-2025/local-services/adult-social-care
[25] https://commonslibrary.parliament.uk/research-briefings/cbp-7903/
[26] https://ifs.org.uk/sites/default/files/2024-10/Adult-Social-Care-in-England-IFS-Green-Budget-2024-R338.pdf
[27] https://www.adass.org.uk/wp-content/uploads/2025/11/ADASS-Autumn-Survey-2025-Final.pdf

Alongside publicly funded care, a significant proportion of care is privately funded by individuals and families. Latest estimates from LaingBuisson suggest that between £10-12 billion is spent each year on privately purchased social care[28]. This reflects the larger number of people who do not meet local authority eligibility thresholds and therefore have to fund their own care.

However, these figures do not fully reflect the total amount of care provided across society. A significant proportion is delivered unpaid by family members and friends. Around 5 million people in England provide unpaid care to loved ones, often alongside paid work and other responsibilities[29]. This support is essential to sustaining the wider care system: without it, demand for formal services would be far higher. Yet growing reliance on unpaid care raises serious questions about sustainability and fairness. Many unpaid carers are forced to reduce their working hours or leave employment altogether, often at considerable financial and personal cost. This is not only emotionally significant; it has clear consequences for labour market participation and family wellbeing.

There are also limits to what unpaid care can reasonably provide. Family and friends cannot always deliver the specialist or consistent support people need, which can increase the risk of unmet need, deteriorating health, and avoidable escalation in demand for more intensive services.

At the same time, pressures which stem from the health system are increasingly feeding into social care demand. The Care Quality Commission (CQC)'s State of Care report highlights the impact of NHS backlogs and delayed discharge on demand for care services in the community[30]. Delayed discharges increase by 8 percent year-on-year, equivalent to around 3,800 additional patients every month who could not leave hospital because the right support was not available[31].

Declining healthy life expectancy is also contributing to rising need. Evidence from Age UK suggests that the number of years people spend in good health after the age of 50 is falling[32]. This means more people are living longer with health conditions that require support.

Together, these factors point to a clear trend: demand for social care is rising, becoming more complex, and affecting a growing share of the population. Yet rising demand does not automatically translate into rising access. For many people, support is delayed, reduced or unavailable altogether, leaving families to absorb growing levels of need themselves.

Increasing complexity of care needs

Alongside rising demand, the nature of care needs is also becoming more complex.

Projections suggest that by 2040, approximately 9.1 million people in the UK will be living with a major illness, compared with around 2.5 million in 2019[33]. Many people will also be living with multiple conditions simultaneously, which is referred to as multimorbidity.

Managing multiple health conditions requires coordinated support across health and care

[28] https://www.homecareassociation.org.uk/asset/F26B2E4B%2DC183%2D45E8%2DABC6274E97EE24AC
[29] https://www.england.nhs.uk/commissioning/comm-carers/carer-facts/
[30] https://www.cqc.org.uk/publications/major-report/state-care/2024-2025
[31] https://www.gov.uk/government/statistics/local-authority-capital-expenditure-and-receipts-in-england-2023-to-2024-final-outturn/local-authority-capital-expenditure-and-receipts-in-england-2023-to-2024-final-outturn
[32] https://www.ageuk.org.uk/SysSiteAssets/documents/reports-and-publications/reports-and-briefings/health--wellbeing/state-of-health-and-care/state-of-health-care-of-older-people-in-england-2025.pdf
[33] https://www.health.org.uk/reports-and-analysis/reports/health-in-2040-projected-patterns-of-illness-in-england

systems. Social care plays a critical role in helping people manage these conditions in daily life, including support with medication routines, mobility, personal care and community participation.

Certain conditions are also becoming more prevalent. For example, diagnoses of early-onset dementia have increased significantly in recent years, with around 70,000 adults estimated to be living with the condition[34].

Importantly, this is one of many prevalent conditions that conveys that social care is not only a service for older people. Many working-age adults rely on care and support to live independently, including people with physical disabilities, learning disabilities, mental health conditions and complex neurological conditions.

Providers across the sector are increasingly supporting people with highly complex needs, often requiring specialist skills, personalised care and close coordination with health services. Ultimately, this pushes up the cost of providing care and exacerbates increased demand and costs with continuously scarce funding. Despite these pressures, many providers continue to innovate to enhance independence and wellbeing.

Annex B) The interdependent relationship between social care and the NHS

Preventing hospital admissions

Social care is not just a partner of the health system, but an integral part of its preventative function. Evidence shows emergency hospital admissions among people with social care needs are potentially avoidable. A study by the National Centre for Social Research found in 2026, around one in four emergency admissions among those receiving social care were potentially avoidable. Many of these involved falls, chest infections or hydration issues that could be managed by community support[35].

This aligns with NHSE data that found there were over a million emergency admissions among older people for similar, potentially avoidable reasons, including falls and exacerbations of chronic conditions[36]. These findings illustrate the extent to which social care already helps mitigate NHS demand, and the extent to which weak capacity increases pressure on urgent and emergency care.

This preventative function is becoming increasingly important in the context of demographic change. In 2024, Age UK estimated 2 million people aged 65+ in England had unmet social care needs[37], and the International Longevity Centre UK predicts by 2040, nearly 1 in 4 people will be over 65, increasing the demand for social care[38]. As stated previously, an ageing population and a rising prevalence of multiple long-term conditions means more people require ongoing support to maintain their health and independence. Where no such support is available, these individuals have no alternative but to rely on an overstretched NHS system to meet their needs, resulting in delays, poorer outcomes, and higher costs to the system.

[34] https://www.alzheimers.org.uk/about-dementia/types-dementia/young-onset-dementia
[35] https://natcen.ac.uk/news/social-care-needs-linked-higher-risk-avoidable-hospital-admissions-study-finds
[36] https://natcen.ac.uk/publications/unmet-needs-unplanned-admissions
[37] https://www.ageuk.org.uk/latest-press/articles/2-million-older-people-now-have-some-unmet-need-for-social-care/
[38] https://ilcuk.org.uk/new-vision-social-care/

Annex C) The economic case returns for investment in social care

Investment in social care should be understood as an opportunity for long-term economic gains, not a drain on the public finances. There is growing evidence that social care investment generates economic returns through multiple channels, including supporting employment across all communities, enabling labour market participation, reducing system costs, and stimulating wider economic activity.

Economic modelling has identified a significant relationship between higher adult social care spend per recipient, broader access to care, and increased Gross Value Added. Estimates suggest that for each £1 million invested in adult social care, between £5-7 million of economic benefits may be realised within one year, with the figure rising to £22 million over two decades. An estimated additional 2 percent of GDP invested into long-term care could generate a 3-6 percent increase of GDP in short term, and a 0.2 percent increase in per capita GDP in the following period[39].

This evidence highlights social care as a driver of economic growth. For successive governments set on delivering growth, investing in social care is a critical step to take.

Social care as a major national employer

The sector employs an estimated 1.6 million people. Importantly, these jobs are distributed across all regions and communities, and are resilient to economic cycles, supporting local economies and making the sector a critical contributor to local economy activity and stability.

Evidence also suggests that low and variable pay in social care leaves many workers struggling to cover essentials, with some depleting savings to cope with everyday living costs rather than building financial resilience[40]. These characteristics mean workforce investment is likely to generate strong local and national economic returns.

However, these economic benefits are increasingly constrained by consistent workforce challenges across the sector. Adult social care continues to experience high turnover rates, alongside growing difficulties in recruitment and retention. These pressures are driven by a combination of factors, including comparatively low pay, competition from other sectors, limited progression pathways, and the increasing complexity of care needs.

Nevertheless, investment in the adult social care workforce would also generates fiscal income. If workforce pay increases as a result of investment, social care work becomes more attractive as a career. An expansion of the workforce would increase tax and national insurance contributions to the public purse. Improving job opportunities in the sector may also reduce expenditure on out-of-work benefits, while increasing overall labour market participation. The government's Fair Pay Agreement (FPA) impact assessment quantifies this. For every £1 invested in social care, £0.18 will be raised in additional productivity and tax. Investment across the workforce sector will raise £0.25 through income tax, national insurance and reduced expenditure on universal credit[41].

[39] https://onlinelibrary.wiley.com/doi/10.1002/hec.70026
[40] https://stream.co/api/media/file/Inclusion%20at%20a%20crossroads%20-%20Wagestream%2C%20Care%20England.pdf
[41] Impact assessment: Establish a Fair Pay Agreements process in the Adult Social Care sector

Unlocking labour market participation

Investment in social care supports wider labour market participation through two primary mechanisms. First, it enables unpaid carers to enter or remain in employment by reducing the need to provide informal care. Second, it supports individuals receiving care to maintain independence and, where possible, continue to participate in economic activity. Together, these effects positively affect labour supply and economic growth.

This dynamic also has a disproportionate impact on women, who are more likely to take on unpaid caring responsibilities[42], meaning that investment in formal care provision also has important implications for gender equality in the labour market.

Evidence suggests that formal care provision can increase labour market participation by reducing the need for informal care. The Health and Social Care Select Committee has estimated that the work of unpaid carers is valued approximately at £184 billion per year in the UK, representing a substantial 'hidden' contribution to the economy[43]. This figure also reflects a loss of productivity, economic participation and tax revenues. Greater formal care provision could therefore support wider labour market participation and generate wider economic benefits.

Reducing pressure on public services

As already explored, sufficient adult social care capacity plays a crucial preventative and rehabilitative role in the wider health system, offering efficiencies to the NHS, as meeting demand at the point of prevention is more cost effective than at the point of an emergency.

There is significant evidence to support this point, including figures pulled from the government's FPA impact assessment, which references numerous studies that indicate a range of savings. An estimated additional £1 spent on care home services resulted in a £0.35 reduction in hospital expenditure due to fewer admissions and shorter length of stay (although this is acknowledged to likely be an underestimate).

Increased capacity of care home beds could reduce the length of stay in hospital by 1-7 percent, and that a 1 percent increase in residential care services reduce delay discharge by 0.5 percent. Higher long-term care supply and lower prices are associated with up to 20-30 percent shorter length hospital stay for patients aged 65+ with emergency admissions due to hip fracture or stroke and were discharged to a nursing or care home[44].

These findings are consistent with the ideas explored that increased social care capacity through investment contributes to lower delayed hospital discharges, lower avoidable hospital admissions, and thus increased system efficiency. However, this relationship should not be understood only through the lens of care home capacity. Timely discharge and recovery also depend on the availability of homecare, reablement, supported living and wider community-based support, which are often just as important in enabling people to leave hospital safely and avoid deterioration after discharge.

[42] https://www.health.org.uk/reports-and-analysis/analysis/unpaid-care-the-realities-of-caring-in-the-uk
[43] Adult Social Care Reform: the cost of inaction
[44] https://assets.publishing.service.gov.uk/media/68f621191c9076042263f0a2/fair-pay-agreement-process-in-adult-social-care-impact-assessment.pdf

The current care estate

Investing in care infrastructure is central to modernising the care estate and ensuring it is fit for future demand. Currently, circa 40 percent of homes in England were built in the 1980s and before[45]. Since then, there has been a series of increased regulatory standards, but also resident expectations, which no longer makes them purpose built for modern care needs.

Instead, much of the estate is adapted housing stock. While these settings continue to play an important role in the care landscape, they can limit the ability to facilitate specialist environments for people with complex needs such as dementia, mobility limitations, or multiple long-term conditions. As demand becomes more complex, this has contributed to a widening gap between the design of existing facilities and the requirements of care delivery.

Evidence shows that many care homes are not in a financial position to invest in their infrastructure. Given that the cost of constructing a new room in a care home for older people today typically ranges from £125,000 to £150,000, and the market value per room is around £100,000, embarking on new-build projects is generally only an option for large, established groups[46]. For SMEs, which represent 80-85 percent of providers, or those most reliant on local authority funded residents (which the government estimates a quarter of care homes have more than 75 percent local authority funded residents[47]) achieving these contemporary standards are difficult without the financial headroom for long-term investment projects.

LaingBuisson evidence also shows that adult specialist care for working-age adults is predominantly delivered through supported living rather than care homes, with capital costs typically met through housing and NHS funding routes rather than care provider investment[48].

These pressures help explain why much of the estate remains outdated and why purpose-built supply has not kept pace with demand.

This is a particularly acute problem in less affluent areas. As self-funders on average pay 41 percent more[49] than local authorities pay toward care; the capacity of providers who are more likely to care for higher proportions of publicly funded residents to reinvest in modernising their care facilities is limited. This inevitably creates local variation in the quality of care estates, with some areas facing greater challenges in keeping with current standards.

The opportunity for modernisation

Social care infrastructure represents a significant, under-realised investment opportunity. Demand for care services is strong and structurally embedded within an ageing population, with increasing complexity of need, making care homes a compelling asset class[50]. Private investment has been constrained by unpredictable policy and funding decisions, creating an uncertain environment for investors[51].

So much so that despite some perceptions, private equity involvement in the care sector is as little as just 12.2 percent of older people's care homes; 10.1 percent of younger adult care homes; and around 12 percent of homecare/

[45] https://ww3.rics.org/uk/en/journals/property-journal/changing-demands-for-uk-care-homes.html
[46] https://www.careengland.org.uk/future-proofing-care/
[47] https://www.gov.uk/government/publications/care-homes-market-study-summary-of-final-report/care-homes-market-study-summary-of-final-report
[48] https://www.gov.uk/government/statistics/adult-social-care-provider-statistics-england-quarterly-update-to-february-2026/adult-social-care-provider-statistics-england-quarterly-update-to-february-2026
[49] https://www.kingsfund.org.uk/insight-and-analysis/long-reads/social-care-360-expenditure#5.-cost-of-commissioning
[50] https://www.savills.co.uk/research_articles/229130/378431-0
[51] https://www.nuffieldtrust.org.uk/news-item/social-care-and-the-budget-stabilisation-for-long-term-reform

supported living services are also private equity backed[52].

Modernisation delivers clear financial benefits at provider level. Research shows older buildings are associated with higher utility costs, with poorly insulated properties potentially losing up to a third of heat and contributing to the sector-wide energy losses of up to £100 million annually[53]. Investment in both new-build and retrofitted facilities can therefore reduce operating costs and improve sustainability. Where land supply is constrained, and material costs are increasing, retrofitting existing stock is crucial to this change.

Modernisation also enables the delivery of more specialised and higher-quality care. Purpose designed environments for specialist care services, for example dementia, has been showed to improve health outcomes. Research shows small changes in features like greater contrast in lighting and colours; noise reduction and simplified layouts can have a big impact on the wellbeing and safety of dementia patients[54].

Similarly, modernisation also supports the integration of digital technologies that enhance care delivery. Technology-enabled care can lead to better outcomes for individuals by alleviating pressure on staff[55]. These tools include remote monitoring, and preventative analysis that can prevent falls, reduce unnecessary hospitalisation, and improve workforce productivity. Without modernised estates, facilitating technological adoption is extremely difficult.

Expanding capacity for future demand

Investing in modern, purpose-built care infrastructure is essential to meeting future care demand and ensuring the sustainability of the social care system. In the past decade, care home bed supply has increased by just 2.9 percent, whilst the population aged over 65 has grown by 20.7 percent, indicating a clear and widening supply-demand gap. With this demographic shift and minimal growth in supply numbers, it is estimated that by 2050, there will be a shortage of 200,000 beds[56]. This will only continue to widen without intervention. Expanding care infrastructure also supports job creation, enabling workforce participation, and reducing healthcare costs. Modern, purpose-built facilities are particularly important in this context, as they are better equipped to deliver high-quality care more sustainably.

Annex D) The policy landscape

The pressures facing adult social care are not new, nor is there a shortage of policy recommendations about how they can be addressed. For more than two decades, governments of different political parties have recognised the need for reform. Over the last three decades, at least 22 major reviews have been commissioned, resulting in a series of white papers being published, legislation being passed, and funding reforms being proposed[57].

The broad direction of reform has been clear for some time - a system that is more preventative, person-centred and sustainable, with clearer responsibilities.

[52] https://www.homecareassociation.org.uk/resource/homecare-association-minimum-price-exposes-england-s-homecare-funding-gap-as-new-employment-law-takes-effect.html
[54] https://www.mdpi.com/2075-5309/15/3/385
[55] https://beta.digitisingsocialcare.co.uk/news/digital-adoption-hits-80-its-time-shift-our-focus-fully-digitised-future
[56] https://content.knightfrank.com/research/336/documents/en/healthcare-development-opportunities-2025-12025.pdf#:~:text=shortfall%20in%20bed%20supply,are%20already%20in%20a%20deficit
[57] https://www.kingsfund.org.uk/insight-and-analysis/data-and-charts/short-history-social-care-funding

The problem, however, has not principally been a lack of ideas. It has been the repeated failure to convert policy ambition into implementation. Reforms have too often been announced and then delayed, diluted or abandoned when confronted with fiscal pressures, political risk or the complexity of delivery[58]. This has culminated, and left the country with a system in which the need for reform is widely understood, but delivery has yet to follow.

This matters because adult social care is not a marginal public service. As acknowledged already, the sector has around 1.6 million filled posts in England. Skills for Care estimates that around 470,000 additional posts may be needed by 2040 to keep pace with demographic change[59]. Yet the sector continues to face structural pressure, including a vacancy rate of 7 percent in 2024/25[60], substantially above the wider economy. At the same time, demand for support funded by local authorities is rising, while access to publicly funded long-term care for older people has narrowed sharply over the past two decades[61].

Reform without destination

The history of adult social care reform in England is marked by a recurring pattern. Governments acknowledge that the existing system is under strain, and commission work to address it. That work typically identifies many of the same underlying issues of rising demand, complexity of need, pressure on local government finances, workforce fragility, and the lack of a clear and publicly understood funding settlement. Proposals then emerge designed to help improve fairness, clarify entitlements, strengthen prevention, and reduce the amount any individual would pay toward their care. But when reform reaches the point at which difficult decisions on money, risk-sharing and implementation have to be taken - momentum stalls almost entirely.

The problem is not a lack of clarity or consensus on what a well-functioning system should deliver. It is that the benefits of reform are consistently overshadowed by the perceived direct cost of implementation.

This continued delay in action has led to growing instability across both the health and social care sectors, with wider consequences for the country as a whole. Despite the continuous efforts of successive governments, the repeated, unfulfilled promises of reform have eroded confidence in the reform process itself from both the sector, and the public itself. This delay reinforces a policy environment in which social care is consistently recognised as a major national issue, yet too often treated as politically deferrable. The situation has become sufficiently unstable that committing to reform now carries inherent political risk for governments, not least because failure to deliver on such a high-profile issue brings significant political cost.

A clear illustration of this pattern can be seen over the last fifteen years. The Dilnot Commission reported in 2011 and proposed a cap on lifetime care costs alongside a more generous means test[62]. The coalition government then accepted the principle of a capped-cost model and subsequent reforms were incorporated into the Care Act framework.

In 2021, the Johnson government returned to the issue through Build Back Better and the People at the Heart of Care white paper, proposing a new £86,000 cap and wider reform package. In 2022 those charging reforms were

[58] https://www.instituteforgovernment.org.uk/publication/performance-tracker-2025/local-services/adult-social-care
[59] https://www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/workforceintelligence/resources/Reports/National/The-state-of-the-adult-social-care-sector-and-workforce-in-England-2025.pdf
[60] https://www.skillsforcare.org.uk/Adult-Social-Care-Workforce-Data/workforceintelligence/resources/Reports/National/The-size-and-structure-of-the-adult-social-care-sector-and-workforce-in-England-2025.pdf
[61] https://www.cqc.org.uk/publications/major-report/state-care/2024-2025
[62] https://www.kingsfund.org.uk/insight-and-analysis/briefings/dilnot-commission-report-social-care

delayed from October 2023 to October 2025, and in 2024 the government confirmed that it would not proceed with the planned charging reforms, which had been due to take effect in October 2025. In 2025, Starmer's Labour government established Baroness Casey's independent commission, once again opening a major chapter in the reform debate, albeit allowing recommendations to be implemented in a phased way over a decade.[63] That sequence is important. It shows that the core problem is not the absence of policy development. It is the inability of the system to sustain reform through to implementation.

The Care Act: a strong vision, partially realised

The Care Act 2014 remains the central statutory framework for adult social care in England. It established a clearer legal basis for care and support, with wellbeing as its guiding principle[64]. The statutory guidance is explicit that the core purpose of adult care and support is to help people achieve the outcomes that matter to them in their lives. It places prevention, information and advice, market shaping and commissioning, carers' rights, and person-centred planning at the heart of the framework. It also created a national eligibility threshold and a clearer legal duty on local authorities to meet eligible needs, subject to financial circumstances[65].

In policy terms, this was a significant achievement. The Act did not present social care simply as a residual safety-net service. It set out a broader vision of a system intended to promote independence, delay the escalation of need, support carers, improve consistency, and shape local care markets in ways that support quality and choice. The statutory guidance is also clear that local authorities should shape markets strategically and emphasise preventative services that encourage independence and wellbeing.

However, the existence of a statutory framework is not the same as the realisation of its full intent. In practice, the preventative and market-shaping ambitions of the Care Act have often been constrained by the wider financial and operational environment. Local authority adult social care expenditure reached £34.5 billion in 2024/25, reflecting sustained cost and demand pressures[66]. At the same time, CQC reports that new requests for adult social care support were 4 percent higher in 2023/24 than the previous year and 8 percent higher than in 2019/20, while the proportion of older people receiving local authority-funded long-term social care has fallen from 8.2 percent in 2003/04 to 3.6 percent in 2023/24[67].

This does not mean the Care Act has failed. It means that its wider vision has been only partially realised. The legislation provided the architecture for a more preventative, person-centred and sustainable system, but that architecture has not consistently been matched by the funding, capacity and implementation discipline needed to bring it fully to life. That distinction matters, it suggests that social care has not suffered from an absence of legislative ambition so much as from a failure to operationalise that ambition at sufficient scale and consistency. Taking action to fully implement the vision of the Care Act would be a welcomed step, relying on previous thought leadership to make progress.

[63] https://www.gov.uk/government/publications/independent-commission-into-adult-social-care-terms-of-reference/independent-commission-into-adult-social-care-terms-of-reference
[64] https://www.legislation.gov.uk/ukpga/2014/23/contents
[65] https://www.gov.uk/government/publications/care-act-2014-part-1-factsheets/care-act-factsheets
[66] https://www.gov.uk/government/statistics/adult-social-care-finance-report-england-2024-to-2025/adult-social-care-finance-report-england-2024-to-2025
[67] https://www.cqc.org.uk/publications/major-report/state-care/2024-2025

Dilnot and the question of who pays

The Dilnot Commission was one of the most important attempts to resolve the long-running question of how the costs of care should be shared. Reporting in 2011, it proposed two key changes: a cap on the lifetime care costs individuals would face, and a more generous means test[68]. The significance of those proposals was not only technical. They were an attempt to create a more intelligible and equitable settlement between personal responsibility and collective protection.

This is why Dilnot is best understood not simply as a funding mechanism, but as an attempt to redefine the social contract for care. Social care differs from the NHS in that it is heavily means-tested, and many people are expected to contribute, sometimes entirely, towards their support. Yet for most people, the boundary between individual responsibility and state responsibility is unclear until they or a family member come into direct contact with the system. Dilnot sought to reduce that uncertainty by placing a limit on exposure to care costs and setting out more clearly where the state should step in.

That question still remains unresolved. The logic of a cap survived into later governments, but although it was acknowledged, no meaningful steps were taken to implement it. The 2013 reforms translated Dilnot's principles into a proposed capped-cost model, with the Government setting the cap at £72,000, higher than the level originally proposed. The Johnson government later returned to the issue with a proposed £86,000 cap.

However, for the government to determine when the state should assume responsibility for an individual's care costs, it was agreed it must first establish what those costs are. This led to the Fair Cost of Care exercise, one of the largest data collection exercises undertaken across England, intended to define local benchmarks for the cost of care, albeit limited to older people's care homes and domiciliary care. The expectation was that local authorities would then move towards aligning average fee rates with these benchmarks. While the findings remain contested, the exercise exposed a substantial and quantified funding gap. The scale of that gap made clear the implications for public finances, and in doing so, contributed to delays in implementation.

Since then, the repeated postponement and eventual cancellation of charging reform means that the underlying problem identified by Dilnot still stands; people remain exposed to potentially very high and uncertain costs, and the public still lacks a clear, stable understanding of what the system is designed to protect them from[69].

This matters not only for fairness, but for public legitimacy. Reform is harder to sustain when the social contract itself is poorly defined.

The current social contract for care is weakly understood

The current settlement for adult social care is difficult for the public to understand and difficult for policymakers to defend. Unlike the NHS, it does not offer universal free access based on need alone. Unlike a purely private insurance model, it does involve state support, but on terms that are highly conditional and means-tested. The result is a system in which entitlements are complex, personal exposure to costs can be significant, and the point at which the state steps in is neither simple nor well understood.

This ambiguity has practical and political consequences. Practically, it creates uncertainty for individuals and families trying to plan for later life, disability, or changing needs.

[68] https://www.kingsfund.org.uk/insight-and-analysis/briefings/dilnot-commission-report-social-care
[69] https://assets.kingsfund.org.uk/f/256914/x/573d46916f/social_care_360_2023.pdf

Politically, it weakens the basis for collective action because it makes social care easier to mischaracterise as a niche or purely personal issue rather than a shared societal concern. In reality, the system depends not only on paid provision but also on very substantial informal care. The sheer number of unpaid carers underlines the extent to which care responsibilities are already distributed across families and communities.

A stronger social contract for care would do more than settle a funding formula. It would establish a clearer public understanding of what support people should be able to expect, what contribution they may reasonably be asked to make, and what risks should be collectively pooled. Without that clarity, reform remains vulnerable to misunderstanding, short-termism and political retreat.

Casey: an opportunity and a test

The Casey commission creates an opportunity to break with this cycle, but it should not be treated as an automatic turning point. The Government's terms of reference make clear that the commission is intended to work in two phases: a first phase reporting in 2026 on medium-term reform and implementation of a national care service, and a second phase reporting by 2028 on longer-term transformation[70]. The commission is explicitly tasked with starting a national conversation about what adult social care should deliver for citizens and with helping to build consensus on how to meet current and future need.

That is significant for two reasons. First, it recognises that social care reform is not only a technical exercise in system design, but also a public and political exercise in defining shared expectations. Second, it reflects an understanding that previous attempts have failed not only because the policy problem was difficult, but because consensus around implementation proved too weak. The government has itself framed the commission in these terms, arguing that earlier reform efforts were undermined by short-termism and party-political conflict.

There are reasons to think the context may now be more conducive to serious reform. The social care workforce remains under pressure, the wider health and care system is attempting a shift toward neighbourhood and community-based models, and the costs of inaction are increasingly visible across hospital discharge, unmet need, unpaid carers, and local government finances. The current government has also attached the commission to a wider reform agenda, including a stated ambition to build a national care service and improve the interface between social care and the NHS[71]. It must be noted that the development of this care service is still largely untouched, without any clear progress.

But the central risk remains familiar. If Casey produces another strong diagnosis without a durable implementation settlement behind it, it may simply join the long list of reviews that clarified the problem without securing lasting change. The commission should therefore be seen not just as an opportunity for policy development, but as a test of whether the country is now willing to act on what it has long known.

[70] https://www.gov.uk/government/publications/independent-commission-into-adult-social-care-terms-of-reference/independent-commission-into-adult-social-care-terms-of-reference
[71] https://labour.org.uk/wp-content/uploads/2019/09/12703_19-Towards-the-National-Care-Service.pdf

What needs to change

The lesson from the past two decades is not that social care lacks policy ideas. It is that reform has too often been approached as something that can be announced episodically rather than sustained politically and operationally over time. What has been missing is a sufficiently strong coalition for delivery: political commitment that survives immediate fiscal pressures, a clearer public narrative about why reform matters, and a more explicit settlement on who pays, who is protected, and what the system is for.

That is why narrative matters. If social care continues to be framed primarily as a private family issue or a residual service for a narrow group of people, reform will continue to appear politically optional. If it is instead understood as essential national infrastructure that enables people to live independently, sustains family life, supports the labour market, and underpins the functioning of the NHS, the case for a more durable settlement becomes harder to postpone. This is not simply a communications point. It is part of the political precondition for reform.

The Casey commission provides a focal point around which that broader case can be made. But the test of success will not be whether it adds to the stock of analysis on social care. That analysis already exists in abundance. The test will be whether it helps to create the political, public and institutional conditions in which reform is no longer deferred at the point of delivery. If that happens, Casey could mark the beginning of a more durable settlement. If not, it will risk becoming part of the same history this chapter has traced: policy ambition without implementation.

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