FABIAN POLICY REPORT

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The roadmap to a National Care Service

Ben Cooper and Andrew Harrop

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CONTENTS

	Summary	4
	Ten principles for a National Care Service	10
	What might it mean for me?	11
1.	Introduction	13
2.	England's adult social care emergency	15
3.	The business case for care and support	19
4.	Towards a National Care Service	23
5.	Ten building blocks: our proposals for reform	29
6.	The roadmap to a National Care Service	52
	Appendix: the roadmap block by block	56
	Endnotes	61

Summary

Plans for a National Care Service for England were first presented 13 years ago in the dying days of the last Labour government. Since then no detailed work has taken place to flesh out what the service might look like or how it should be implemented. That is the purpose of this report.

England's adult social care emergency

Since 2010 care and support in England has gone downhill fast and we now face an adult social care emergency. This winter's hospital discharge crisis was a symptom of much wider problems. Spending has fallen hugely when compared to levels of need, with poorer communities bearing the brunt. Access to care has been unfairly rationed with people not receiving the services they are entitled to and levels of support often insufficient. Widely praised principles of prevention, wellbeing, personalisation and control were written into the Care Act 2014 but have not been translated into practice.

Due to funding cuts, councils are often not paying enough to secure safe and sustainable care, let alone to invest in new facilities. In this challenging environment many providers have worked hard to maintain and improve standards. But some have demonstrated low quality care, exploitative workforce practices or unacceptable commercial behaviours. Poor pay and conditions are among the factors that have triggered a staffing crisis in the sector, with 165,000 vacancies. Unpaid family carers are bearing the brunt of the system's failures, and people receiving support are paying charges they often find punishing.

Without action things will get even worse because we have growing numbers of people in late old age and with complex lifelong disabilities. To respond to rising need, projections suggest that the care workforce will need to increase by more than half and the number of care home places by more than a quarter. Billions of pounds of extra money will be needed just to replicate today's level of provision, as inadequate as that is.

The business case for care and support

The core purpose of adult social care should be to give people the support to live the life they want, in the home they want, doing the things they want, with the people they want. But there is also a strong financial case for spending more on care and support. Most importantly, adult social care spending quantifiably increases the wellbeing of recipients. It also reduces pressures on the NHS.

Over the next decade extra formal care is needed to help address a looming shortfall in the availability of family carers. More care spending will also help tackle worsening labour shortages by boosting employment opportunities for carers and disabled people. Social care spending spreads jobs and growth around the country. Every extra £1bn in social care spending will create around 50,000 jobs distributed all over England, with the largest impacts felt in the North East and North West. Finally raising taxes to spend on adult social care will redistribute money from high-income to low- and middle-income households, and from men to women.

The position now	A National Care Service
Local authorities supposedly in charge but without the money or powers they need	National ministerial responsibility and leadership working in partnership with strong councils
Unclear entitlements that are often not realised in practice	Clear rights and entitlements and the ability to enforce them
Inconsistency in access to support and quality of care	Nationwide entitlements and geographic consistency
A fragile, fragmented and sometimes extractive 'market' of care providers	Commissioners and partners working together as part of a public service
Support only for people with limited means	Support and peace of mind for everyone
Inadequate funding and emergency cash injections	Long-term and sustainable approach to finance
Insufficient development of specialist housing and modern care homes	Long-term certainty and funding to build new facilities
Inadequately rewarded staff and a recruitment and retention crisis	National terms and conditions working towards parity with the NHS
Unaffordable fees and inability to pool risks	Improvements to affordability by reducing the scope of charging over time

Why a National Care Service?

Extra spending is not enough. Money must come with reform. Creating a National Care Service would lead to a transformation in care and support in England.

Under a National Care Service, the NHS and adult social care should remain separate though interconnected services. Local government should lead delivery, with national government only exercising new functions where this is essential. Councils would continue to work with independent providers, which would face stronger expectations and requirements. Due to the competing financial pressures facing the system, charging reform should not be the first priority for extra money. It should be progressed gradually alongside other changes.

We think the National Care Service should be guided by 10 principles:

1. **Choice and control for individuals and their families**
2. **Local and place-based**
3. **Nationally consistent**
4. **Accessible**
5. **For everyone**
6. **Preventative**
7. **Relationship-based**
8. **Rights-based**
9. **High quality and diverse**
10. **Connected**

Not everyone we spoke to likes the term 'National Care Service' but we hope these are 10 principles that people involved in care and support can unite around. If future ministers opt for a different new label that would not undermine our proposals. But we are clear that a new name is needed to mark a fresh start, signal the scale of ambition, build public support, and create the institutional identity needed to sustain and protect a reformed service for the long term.

Creating a National Care Service would lead to a transformation in care and support in England.

TEN BUILDING BLOCKS

The reform should centre on a national care guarantee, codified in a new National Care Service 'constitution'. Ten building blocks should bring this guarantee to life. Some of the changes will require legislation and we propose a National Care Service Act that revises and expands on the Care Act 2014. The Westminster government should consult with devolved governments on certain aspects of the plan that may be best delivered on a four nations basis.

BLOCK 1: STRUCTURE AND IDENTITY

1. Launch a shared national brand that encompasses the adult social care activities of national government, local authorities and independent providers
2. Strengthen national leadership by creating duties for the secretary of state to support a comprehensive national care service
3. Expand national government functions with respect to strategy, co-production, finance, public information, workforce, data and evidence
4. Use and repurpose existing organisational structures to avoid the need for new national or local bureaucracy
5. Support flexibility at local level so that councils can determine models of support, the mix of providers, and whether to pool functions with the NHS
6. Support regional and sub-regional coordination with a role for integrated care systems and city regions

BLOCK 2: WORKFORCE

1. Negotiate a fair pay agreement covering the whole adult social care workforce to include a sector minimum wage and minimum employment conditions
2. Introduce national employment terms, pay bands and minimum pension entitlements for employees of National Care Service providers to achieve parity with similar roles in the NHS over time
3. Redesign occupational roles in adult social care with the long-term ambition of more people in the sector having higher skilled or specialist jobs
4. Align adult care and NHS workforce planning and skills functions with reforms to existing national agencies, and joint responsibility between councils and the NHS locally
5. Expand regulatory requirements for training and skills and consider improvements to the design and delivery of social care qualifications
6. Introduce professional registration for the adult social care workforce on a voluntary or compulsory basis with detailed consultation before deciding which of these approaches is best for England

BLOCK 3: CO-PRODUCTION

1. Embed co-production into the development of the National Care Service using deliberative techniques involving those with lived experience to design the new system
2. Create co-production and accountability mechanisms at national level with a new co-production duty for ministers and an independent scrutiny, evidence and engagement body led by people who require support and carers
3. Require co-production in the local planning and delivery of services with new duties to involve people in decisions, set up co-production forums and fund peer-led organisations

BLOCK 4: RIGHTS

1. Clearly specify existing rights and expectations by establishing the National Care Service 'constitution' and considering whether to codify existing rights in law

2. Incorporate the UN right to independent living into domestic law by introducing entitlements to choice of accommodation and inclusion in the community

3. Improve understanding and enforcement of rights including by launching an appeals system, and requiring councils to commission peer-led advice and advocacy

BLOCK 5: UNPAID CARERS

1. Strengthen national strategy and leadership with a National Care Service carers strategy

2. Specify and promote carers' existing rights such as their right to receive money from a direct payment in certain circumstances or to choose how much care to provide

3. Require local authorities to discuss carers' wishes when a family member's support and care is being planned

4. Introduce a right to short breaks for carers to help sustain caring relationships

5. Require other public services to pass carers' details to the National Care Service including direct referral by GPs, DWP and children's services departments

BLOCK 6: ACCESS

1. Expand preventative open-access support including home adaptations and consider specifying a minimum share of National Care Service budget earmarked for prevention-focused activities

2. Require DWP and NHS referrals of people with possible support needs so that local authorities can proactively offer information, advice and assessment

3. Establish earlier and more consistent eligibility for support by improving and standardising implementation of the current law and revising it if necessary

4. Introduce packages of support that better meet needs and enhance independence to properly reflect existing law plus the UN right to independent living

5. Make the NHS and local authorities jointly responsible for meeting health and care needs after hospital discharge by building on existing joint rehabilitation activities

6. Arrange services for everyone regardless of means unless people opt-out with free arrangement of services and contract management

Reform should centre on a national care guarantee, codified in a new National Care Service 'constitution'.

BLOCK 7: MODELS OF SUPPORT

1. Develop national strategies promoting effective care models to steer the future development of support and care

2. Improve research and the gathering and application of evidence including on effective care models, delivery practice and commissioning arrangements

3. Support take-up and use of direct payments by increasing flexibility in using budgets and providing peer-led support

4. Promote joint delivery of health and care to people with significant clinical and support needs including named care coordinators and joint teams for people living at home, and better NHS services in care homes

5. Promote models of housing with care by creating a new planning use class of 'housing with care' and requiring adult care and planning departments to work together

6. Improve use of data and technology with support for technology innovations, and national data standards and collection requirements

BLOCK 8: PROVIDERS

1. Establish a stronger public service relationship with 'licensed' independent providers including stable contracts, national employment conditions and joint branding

2. Promote public sector and non-profit options by giving local authorities the flexibility to chose the right mix for their area, especially when planning new capacity

3. Strengthen local partnerships between councils and providers to collaborate on service planning, quality, costs and workforce

4. Implement the standardised pricing of services building on the current government's Fair Cost of Care initiative

5. Strengthen the financial supervision of providers with expanded national regulation for large providers and light-touch local authority oversight for small providers

BLOCK 9: AFFORDABILITY

1. Take immediate steps on charging reform, for example by making short-term care free or uprating means-testing thresholds, and implement the delayed 2022 charging reforms if they have been confirmed by the existing government

2. Consider one or more charging reforms to coincide with the National Care Service launch date as part of the new national care guarantee – eg free support for people disabled before adulthood, a reformed means-test, a universal contribution or the 'Dilnot' cap on lifetime costs.

3. Progressively introduce further charging reforms in the years that follow ideally with a pre-announced timetable

Charging reform options to consider:

- free support for people disabled by the age of 25
- a lifetime cap on care costs (the version of the policy cancelled in 2015)
- reform of the assets means test (also delayed since 2015)
- reform of the income means test (eg disregard disability benefits, higher thresholds)
- a modest universal contribution to everyone's care costs
- free support for people with very significant support and clinical needs

BLOCK 10: MONEY

1. Prioritise 'year one' stabilisation spending with the aim of tackling the workforce crisis and ensuring service continuity

2. Make a 10-year spending commitment to significantly raise expenditure in real terms every year, and commission independent advice on the amount needed

3. Phase in a national funding formula and National Care Service grant to equalise spending power between areas, with the grant either topping up or replacing locally-raised revenue (to include transitional arrangements to smooth the change over several years)

4. Support long-term investment in modern care homes, specialist housing and technology by creating a public sector National Care Service investment fund and by maintaining certainty on pricing to draw in private investment

5. Consider an increased role for social security in funding residential care so that housing and disability benefits contribute towards future increases in care home spending.

The roadmap to a National Care Service

First steps are needed immediately after the next general election to stabilise care services and to ensure that people start to see initial improvements quickly. But the process of building the National Care Service will be a long-term project that is likely to take up to a decade to complete.

Once the reform process is well underway and ministers can point to visible change, we suggest an official 'launch date' when the new brand goes live. This would probably happen during the 2028/29 financial year to accommodate the process of co-design, legislation and implementation. For example, the launch could be on 5 July 2028 – the 80th anniversary of the NHS.

There are six stages in the reform journey. The appendix provides suggestions on detailed sequencing within each of our building blocks.

- **Inherit**: recent changes to law and policy already provide important foundations
- **Stabilise**: an immediate 'rescue plan' for both health and adult social care that is also designed to begin longer-term reform, especially focused on workforce issues
- **Prepare**: co-production and consultation on details of the reforms, initial changes to practice and finance using existing laws, a National Care Service Act and associated regulations and guidance
- **Launch**: the new brand, citizens' rights and public sector responsibilities go live
- **Embed**: time and money is required to secure major improvements and introduce charging reforms
- **Evolve**: continual change to improve services informed by co-production and evidence, plus a scheduled review four years after the launch date

Ten principles for a National Care Service

1. Choice and control for individuals and their families
Personalised care and assistance, with people requiring support and their carers directing and co-producing services to lead the life they want in the home they want

2. Local and place-based
Rooted in local communities and networks of support, shaped and delivered by properly resourced, accountable local authorities

3. Nationally consistent
Equally available everywhere, with a national guarantee of support and an end to postcode lotteries in support and care

4. Accessible
Available to meet all reasonable support requirements, with people referred for assistance as needs arise

5. For everyone
Services for everyone with support needs, regardless of their means, and affordable to all

6. Preventative
Providing support to reduce future needs, with a focus on early identification, wellbeing, independence, reablement and support at home

7. Relationship-based
Trusting, caring relationships between an empowered, supported, and properly rewarded workforce and individuals, carers and their families

8. Rights-based
Clear legal entitlements, transparently communicated and explained, with support to help people access their rights

9. High quality and diverse
High and rising standards, with sufficient support available to meet people's needs, diverse models of provision, and ongoing innovation and investment

10. Connected
Support that is seamlessly integrated with housing, the NHS, DWP and other community help whenever necessary.

What might it mean for me?

David, a 30-year-old with a complex learning disability

"I live in a specialist housing scheme with my own apartment and high levels of support available day and night. It is run by a housing association licensed by the National Care Service. I pay my rent and living costs from benefits, but the care is free because I have been disabled all my life."

"I see my friends and family frequently, take part in different activities around town, and connect with people who share my interests. The National Care Service arranges my support after asking me and discussing options with my family. I know my usual carers very well. They respond to what I want and understand the support I need."

Zamila, a 50-year-old who recently lost mobility

"I have a degenerative condition and am unable to walk without assistance. After successfully applying for personal independence payment, I was contacted by the National Care Service. It offered advice on local support and how to stay independent and carried out an assessment of my needs."

"I receive a direct payment that enables me to employ a personal assistant for several hours a week. This help is free because the local authority ignores my earnings and disability benefit when assessing my means. The National Care Service and a local disabled people's organisation give me advice that makes it easy to use the budget and helps me meet my obligations as an employer."

"I live with my partner in my own home which has been adapted with assistive technology. I have been able to carry on working which is really important to me. I have peace of mind about the future, knowing a range of options for alternative housing in the future exists should I need it."

Les, an 85-year-old with frailty and co-morbidities

"I have complex physical health problems that mean I have been falling at home and don't feel confident going out on my own. My GP referred me for a National Care Service assessment which happened promptly. We discussed all the things I wanted to do in my life and the support I need to do them."

"My home has been modified and I now have a care coordinator who has helped me access the ongoing healthcare I need and arranged for a carer to help me get out of the house and see friends several times a week. Integrated digital records and a simple app means that all my needs and preferences are recorded. I don't need to repeat my story, and my family and everyone helping me all know what's going on."

"I get this help even though I have £40,000 in savings and own my home. I make an affordable weekly payment as a contribution to the support I receive. I know that if I need support for many years, the National Care Service will eventually start to pay all the costs."

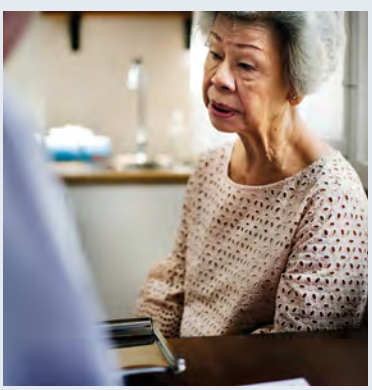
"I receive a direct payment that enables me to employ a personal assistant for several hours a week. This help is free because the local authority ignores my earnings and disability benefit when assessing my means."

June, a 95-year-old with dementia

"I live in a care home and have limited capacity to make decisions. My local council arranged my placement after offering my family a choice between several licensed National Care Service providers. A local authority adviser supported us through this process reducing stress and anxiety. The adviser is now responsible for checking the care home is continuing to meet my needs."

"The care home is a modern facility with the latest technology. It has enough well-trained staff to support me and focus on my quality of life without things ever feeling rushed."

"I have £150,000 in assets from the sale of my previous home. This means I pay fees for my accommodation and some of the costs of my care. However, the National Care Service, disability benefits and the NHS all make a weekly contribution towards the cost. My family know that if I stay in the home for several years the time will come when my support and care will be free, and I will only have to pay for the accommodation."



Maise, an unpaid carer

"I live with my dad and provide significant ongoing care. A few years ago my GP asked if I was a carer and referred both me and my dad for a National Care Service assessment."

"I now receive support from the National Care Service to help me care. At the initial assessment I made the choice to look after my dad rather than feeling forced to. My dad has a care plan that assumes I will only care for him for some of the time, following a discussion about each of our needs and preferences. I receive a direct payment to make sure I'm looking after my own needs."

"The local authority told me about my right to short breaks. I have been able to take two holidays without my dad recently, as well as receiving support once to take him away."

"I am supported by a local organisation that represents carers like me. They gave me lots of advice and help at first and I know someone is there to help if I have questions."

Penny, a homecare worker

"I am employed by a small care agency but I am part of the National Care Service team. My work has a sense of purpose and people recognise that I am part of a national public service."

"I have good pay, terms and conditions that are decided nationally after input from my trade union. I'm paid about the same as someone in the NHS doing a similar job. I get guaranteed minimum hours, decent sick pay and am paid for breaks, training and travel time."

"There are more homecare workers than in the past so I can spend more time with the people I support. I work with individuals and their families to help them stay independent in ways they want, rather than just doing fixed tasks every day. This has made my job more fulfilling."

"My work has a sense of purpose and people recognise that I am part of a national public service."

"I want to build specialist skills in supporting people with Parkinson's disease and I know I can access the training to do so, free of charge. Eventually I will be able to move into a more senior role. I have a plan to progress within social care, and I can't see myself doing anything else for work."

Trevor, a social worker in local government management

"I work with disabled people's organisations, carers' organisations and individuals receiving support to co-produce solutions and shape future services in the area."

"I have the powers and the funding I need to work with providers to deliver high-quality support and care for everyone who needs it regardless of their means. I have a positive, rather than antagonistic, relationship with providers based on long-term partnership."

"My team and I actively seek out people who may need assistance. We don't feel forced to restrict access to assessments and services when people have clear needs. We are able to refer people to open-access services and networks of support to help them live well and prevent or minimise future needs."

"I can take a long-term perspective. Working with local partners including the NHS, care providers and housing associations I have developed long-term plans to invest in new capacity, increase local recruitment and jointly provide training for care workers."

Ava, a care agency owner

"I am paid a realistic price for the complex care my team provides. This enables me to comply with National Care Service employment conditions, meet high expectations regarding quality and workforce skills, and also make a modest surplus."

"My agency is a licensed partner of the National Care Service. The team wear National Care Service logos as well as our own firm branding. We have a long-term contract and it enables us to provide flexible support to maximise the wellbeing of the people we work for."

"We collaborate with the local authority and other providers on improving practice, technology, recruitment and training. I supply data on individuals receiving support which is integrated with other information to facilitate joined-up care and inform planning and evaluation."

"I provide financial information about my business to the local authority so that it can ensure we are operationally viable and not putting profits before quality services. The company is registered in the UK and we pay all our taxes in this country."

These statements are illustrative of the change we want to see delivered by a National Care Service but do not reflect the opinions or experiences of specific individuals.

1. Introduction

This is a think tank report. It represents the views of its two authors and no one else. But it is also a response to the evidence and perspectives of hundreds of people who have contributed their ideas and steered our thinking – disabled people, older people, carers and families, people working in social care, campaigners, policy specialists and politicians. The recommendations are ours not theirs. However, they result from listening and engaging deeply with the huge diversity of experience and expertise we have encountered.

We are not detached observers. We come with our own practical experience of the health and care systems – one of us is disabled and the other has worked in the social care sector. And like almost everyone in this country, we have seen family members grapple with the complexities of care and support. We also come with our centre left politics. We believe in collective solutions convened and guaranteed by government, in solidarity between citizens and the ethic of care, in consistent, reliable standards and entitlements, and in justice and fairness between people from different walks of life. These personal experiences and political values guide our thinking.

The next steps in the process of creating a National Care Service should be for others. As the ideas in this report are taken forward, the details should be developed through collaboration and co-design, so that everyone who has a stake in adult social care is able to take part in the decisions. In fact, the first act for a future government should be to create the co-production arrangements needed to stress-test and fill-out the proposals presented here.

This report is the start of a long-term journey for the next government. We use the word 'roadmap' because building a National Care Service requires staged reform over many years across more than one parliament. Both urgent action and patient preparation will be required by a new government to get things moving. A formal 'launch' should be a symbolic moment where new entitlements, expectations and responsibilities go live. But further improvements and reforms will be needed afterwards spanning the course of a decade or more.

Thirteen wasted years

Plans for a National Care Service for England were first presented 13 years ago in the dying days of the last Labour government. In a 2010 white paper, Andy Burnham and Gordon Brown promised a new service built on six pillars:

1. Prevention and wellbeing services to keep you independent
2. Nationally consistent eligibility criteria for social care enshrined in law
3. A joined-up assessment
4. Information and advice about care and support
5. Personalised care and support, through a personal budget
6. Fair funding, with a collective, shared responsibility for paying for care and support

The Labour party recommitted to the idea at the 2017 and 2019 elections. Yet, over the course of a decade, no significant work has taken place to examine what a National Care Service should offer or how it might work in practice. That is the reason UNISON and the Labour party shadow health and social care team asked us to carry out this work.

Over those 13 years the state of adult social care has gone from bad to worse. A savage funding squeeze has dragged down both the quality and quantity of support and care available. More people who need help are going without any support, and more are receiving assistance that is totally inadequate to meet their aspirations. Family carers have been left to pick up the pieces, often at significant personal cost. And frontline social care workers struggle with low pay and unfair, insecure working conditions that have now helped trigger a severe recruitment and retention crisis.

Care and support has been allowed to reach today's point of crisis because it is a fragmented, localised system not a national responsibility.

This review is informed by our understanding of what has gone wrong since 2010, both with respect to adult social care itself and with the political debate on adult social care. We discuss the different dimensions of the social care crisis in chapter two. On the politics, we make three observations here.

First, we are convinced that care and support has been allowed to reach today's point of crisis because it is a fragmented, localised system not a national responsibility. New national leadership, national financing and national standards are an essential prerequisite for better outcomes for people locally. There needs to be a national care guarantee to ensure good, consistent services in every community. The scale of extra funding needed will only come once national politicians know they are accountable for support and care.

Second, the choice by politicians from all parties to focus on who should pay what for care has been a disastrous cul-de-sac. Striking the right balance between personal and government contributions to the funding of adult social care is an important issue. But it is just one among many vital points that need to be addressed and it is ultimately the wrong question to ask first. Otherwise, we end up debating who should pay for support that does not exist or is totally inadequate. The central task for social care reform should be to ensure that the right support is available to everyone who needs it. Achieving fair and affordable care payments can follow. An incoming government should implement whatever charging reforms are already on the table. But after that it should only consider major steps to make care more affordable gradually alongside other long-term reforms. The launch of a National Care Service should not mean immediately jumping to a position where most support is free at the point of need.

Third, it has been an error to link reform of social care to questions of revenue raising. Politicians don't debate which forms of tax should be raised every time they want to increase spending on schools, childcare, pensions or the NHS. But we have done so with adult social care, creating an unnecessary hurdle on the road to reform. This has also created the misleading impression that most of the extra money required for adult social care is needed to pay for new funding entitlements for older people with significant assets. Actually the new money is mainly needed to properly fulfil promises that the system already makes but fails to deliver, especially as the number of people requiring support continues to rise. We agree that politicians should examine the future balance of taxation in our ageing society and ask how to raise more from those with significant income or wealth. But compared to pensions or the NHS, adult social care is a tiny budget. A major increase in social care expenditure will not affect the overall balance of tax and spending or require a designated new source of revenue. For that reason, this review does not engage at all with questions of where money for support and care should come from.

2. England's adult social care emergency

England is currently experiencing a health and care crisis. Over the winter urgent NHS services were at risk of complete collapse, with millions facing unacceptably long waits for treatment and care in A&E. Thousands were stuck in wards, no longer needing to be in hospital, because the necessary care and support in the community was not available. The government introduced sticking-plaster solutions for hospital discharge that were expensive, piecemeal and focused only on the short term. There has been no comprehensive recovery plan for support in the community despite ministers' repeated promises to fix adult social care. Until such a plan is realised, the NHS will continue to face significant pressure on the healthcare it provides to us all.

But England's adult social care emergency is about much more than 'delayed discharge' and the NHS. It is about homes, communities and people: the hundreds of thousands who need practical support and care to lead a good life in a good home, and the networks of families, unpaid carers and paid care workers who want to make it happen. Adult social care directly touches 10 million people's lives each year.[1] The crisis is causing huge harm to people with lifelong and enduring disabilities, frail older people losing their independence, unpaid carers under extraordinary pressure and 1.5 million care workers who receive neither the reward nor the recognition they deserve for the vital work they do.[2]

We all lack the security of knowing care and support will be there when we or our family need it to live a good life.

Insufficient, inadequate and unfair social care means that adults who need support are unable to live where they choose, in the place they call home, with the people they love, doing the things they want in the communities that matter to them. Two-thirds of those who have used or had contact with adult social care were dissatisfied with it, according to the 2022 British Social Attitudes survey.[3]

People who do not have a care or support need, or do not know someone who does, are also affected by the social care emergency. We all lack the security of knowing care and support will be there when we or our family need it to live a good life. More than 60 per cent of adults fear the adult social care system will be unable to meet future needs that they may have or provide high-quality care and support.[4] Social care isn't about a distant minority, it is about all of us.

Paying austerity's price

England did not stumble into a social care emergency, nor was it an accident. The emergency is the consequence of deliberate policy choices. Austerity, which was forced onto local government by the coalition and Conservative governments, has pushed the social care system to the brink. Between 2010/11 and 2018/19, spending on adult social care fell by 12 per cent, after adjusting for a growing and ageing population.[5] The Local Government Association (LGA) has estimated that, over the past decade, care costs have increased by £8.5bn but revenue only by £2.4bn – resulting in a £6.1bn funding gap.[6]

These financial pressures arise partly because adult social care is funded by a local government finance system that is itself broken. The capacity of local government to raise appropriate revenue or adequately meet needs varies massively across the country. Neither the 'notional' resources earmarked for adult care nor the actual budgets set in each area bear any relationship to different levels of need or cost. It is poorer areas that tend to have the lowest resources relative to the need in their community.[7]

In the face of this inadequate funding local authorities have been forced to ration care and support by delaying assessments and narrowing eligibility. Over 110,000 more people requested social care in 2021/22 than six years earlier, but only 11,000 more actually received any support.[8] By August 2022, nearly 550,000 people were waiting for an assessment for care, a review of their needs, or for their support to commence.[9] Age UK estimate that 2.6 million people aged 50 and over in England had an unmet need for support.[10] There is also evidence of significant inequality in unmet need: the proportion of over-65s in the most deprived areas lacking support is twice as high as in the least deprived.[11]

Austerity also means that when individuals do receive care and support, it often falls short of what we should aspire to provide. Direct payments and commissioned packages of care are frequently insufficient to offer peace of mind, independence and control. Often there is only enough to provide the most basic personal care rather than to sustain wellbeing and a good life, or to take a preventative approach that limits or delays further needs. The system is often bureaucratic and formulaic, providing standardised services rather than focusing on what individuals and their families feel is needed to live well.

The number of people using direct payments has fallen every year since 2017/18, restricting opportunities for self-directed support and independent living.[12] Meanwhile people with complex, evolving health and care needs are frequently unable to access joined-up, holistic support covering practical and personal care in the home along with primary, community and intermediate healthcare. By spending public money on care and support packages that are inadequate, unsuitable and fragmented we store up problems as undermet need often results in greater demand for support in the future.

An opportunity missed

None of this was meant to happen. In 2014 the coalition government passed the Care Act, a pioneering piece of legislation which was intended to enshrine the principles of prevention, wellbeing, personalisation and control into adult social care. Neither the letter nor the spirit of the law has been realised, largely because the money has not been there – and the sector remains unreformed. The Act introduced a national threshold for eligibility that was supposed to bring more uniform national access. But in practice access to care has become ever more rationed, with local authorities each taking their own approach. The same law was meant to introduce charging reforms based on the recommendations of the 2010-2011 Dilnot commission. But implementation was shelved in 2015, reinstated in 2021 and then delayed again in 2022.

Open-access community-based services focused on prevention and wellbeing are too scarce – whether that be traditional services like home helps and befriending schemes or new models based on mutual circles of support. The same is true of

cost-effective housing-related support including aids, adaptations and warden-style support. Nor have the principles of choice, independence and control translated into a wider range of specialist housing options, leaving too many people forced to choose between institutional care or danger and isolation in an unsuitable, unmodified home. Care homes will always have a role to play for people with very high health and support needs, but there are too few alternatives such as 'housing with care' or 'supported living' schemes.

Local authorities are often paying providers too little to provide care safely and sustainably in a way that reflects people's complex personal requirements. Since 2019, £7.5bn of public money has been spent buying support for people living in care homes that have been rated 'inadequate' or 'requires improvement' by Care Quality Commission (CQC).[13] Councils often set care home fees at below cost, forcing providers to over-charge self-funding residents for the same service and risking the continuing viability of providers.[14] Home care packages are frequently priced at hourly rates significantly below the true costs incurred by providers with lawful and ethical employment practices.[15] Last year nearly two-thirds of councils reported that adult social care contracts were being handed back because funding was seen as inadequate to guarantee basic safety and care quality.[16]

Fees are inadequate to fund investment in the capacity required to meet growing demand, now and in the future. There is also no strategic planning and almost no capital funding for future facilities. For example, in 2021/22, only 0.7 per cent of local government adult social care expenditure was capital investment.[17] In this context non-profit and SME providers have struggled to develop new residential facilities or use technology to enhance care. The gap has been filled by investment firms and private equity funding which have flooded into the sector. Tactics such as debt-leveraged buyouts, splitting property ownership from operations, and the offshoring of profits have caused widespread alarm – with fears that sharp practices are undermining the quality of care as well as staff terms and conditions. [18]

The 1.5m people who work in the sector are not rewarded or valued enough, at a time when our expectations of what they will do are rising.[19] There are more vacancies in adult care than ever before: 165,000 positions are currently unfilled, up 52 per cent compared to 2020/21.[20] Recruitment and retention of staff is difficult because of low pay, poor conditions, and limited opportunities for career advancement. Around half of all care workers are on hourly pay that is within 30p of the national living wage, and a quarter are employed on zero-hour contracts.[21] Poor pay and conditions results in high staff turnover, with an estimated 400,000 people leaving their jobs in adult social care in 2021/22.[22] This prevents consistency in support and improvements in training, especially for workers who assist people with the most complex needs and disabilities. In spring 2023, the government cut £250m from a budget to improve knowledge, skills, staff wellbeing and recruitment designed to make the sector a long-term career choice.[23]

The 1.5m people who work in the sector are not rewarded or valued enough, at a time when our expectations of what they will do are rising.

Insufficient or inadequate care and assistance undermines independence and wellbeing for people who require support. But it also takes a huge toll on unpaid carers and families. More people than ever are providing unpaid care for 20 hours a week or greater.[24] Many of them struggle to balance care with work, family and other commitments. They often face significant financial pressures and experience worsening health and wellbeing. Only a small

fraction of carers receive support from local authorities and the annual number of carer's assessments has been declining. These pressures are likely to grow in the coming decades, because the number of people in a position to provide unpaid care is expected to increase much less quickly than the number who will require support.[25]

Finally, adult social care is not free at the point of need and has fees that many find punishing. Some people who have significant income or assets are ineligible for any state funding except for disability benefits and NHS nursing care. Few in this position even receive help from their local authority to arrange their care. Some who are financially secure may be able to afford support on a week-by-week basis, but if they need care for many years they still risk losing a huge share of their wealth. This is the problem that Andrew Dilnot's proposals were intended to resolve, though the government has repeatedly delayed their implementation. His plan included a cap on lifetime liabilities and reform to the adult social care assets means-test. Both these measures would result in the government paying a share of the costs of care for more people. However many already receive support that is only part funded by local authorities. They often face fees that are unfair and unaffordable even if they were disabled at birth. People with lifelong support needs face an unavoidable tax on their disability and the means-testing rules leave many with very low living standards once they have paid for care.

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Without action, things can only get worse

There is no quick fix for our social care emergency. Unless we take significant and sustained action over many years things will get worse for all of us. More people will go without the support and care they need. The recruitment and retention challenges will grow still harder. Providers will be unable to deliver acceptable standards of care. More people will become unpaid carers, or provide more hours of unpaid care, without the assistance they need.

According to LSE projections commissioned by the government, between 2023 and 2033 the number of people requiring support will rise by 28 per cent among over-65s and 15 per cent among those of working age.[26] These numbers assume that eligibility rules remain unchanged, so do not include any expansion of provision to cover people whose needs are not being met today. Similar Health Foundation projections suggest that the care workforce will need to expand by 55 per cent between 2018/19 and 2030/31 to keep up. Bringing so many extra workers into the sector will almost certainly require a major improvement in pay and working conditions – especially as the latest data suggests the workforce actually shrunk in the most recent year.[27] Significant investment in infrastructure will also be needed. Many existing care facilities are outdated and unfit for purpose: they need to be replaced or comprehensively refurbished. In addition, the LSE projections suggest that the number of people needing residential care (or equivalent specialist housing) will rise by 27 per cent between now and 2033.[28] Our ageing population and the growing number of people with complex long-term disability necessitates action now.

Today the taxpayer is spending around £20bn each year on a system in England that does not work for anyone.[29] More funding will be needed in the future, but pouring more money into a broken system is not the solution. Fundamental change must come with it, to properly serve everyone who needs care and support, and the carers they rely on. Without both reform and investment, we will never meet the ambition of an adult social care system that gives everyone the support, care and choice they need to thrive and live well.

3. The business case for care and support

The core purpose of adult social care should be to give people the support to live the life they want, in the home they want, doing the things they want, with the people they want. People involved in adult social care increasingly have a shared view about what support and care is there to achieve. It is summed up by the vision statement of the Social Care Future movement: "We all want to live in the place we call home with the people and things that we love, in communities where we look out for one another, doing the things that matter to us".[30]

The case for spending more money on care and support is first and foremost to better realise this ambition. But the rationale for spending more can also be expressed in financial terms. This chapter presents the 'business case' for spending more public money on support and care under the auspices of a new National Care Service.

Improving the lives of people who need support

The most obvious and most important reason to invest in adult social care is to improve the lives of those who need support. Today, hundreds of thousands of people experience lower wellbeing and independence, and more personal risk and harm, because of a lack of adult social care. The number will be even higher in the future unless spending on care and support increases. Even if spending on social care brought no other benefit, supporting people to live better lives would be reason enough.

More than 15 years ago, the Wanless Social Care Review hosted by the King's Fund calculated the welfare and wellbeing benefits of increased spending on care and support for older people using an analysis designed to replicate NICE's methodology for evaluating whether healthcare interventions are cost effective.[31] Whereas NICE's method measured effectiveness in terms of the money required to achieve an extra year of improved health, the Wanless review examined the cost of an extra year of support for older people to undertake essential activities of life. The review used a cautious threshold of cost effectiveness (at the lower end of the NICE benchmark) and showed there was a financial case for expanding the provision of older people's support by 20 per cent. This was at a time when there was much more social care provision for older people than today, relative to population need – and the assessment did not address the benefits for disabled people of working age.

Similar empirical studies now would be likely to demonstrate that the welfare case for allocating new spending would be as strong or stronger for adult social care as the NHS.

Reducing pressure on the NHS

Spending on adult social care is essential to contain pressures on the NHS. Studies have found that higher social care expenditure and greater availability of nursing and residential care are associated with fewer hospital readmissions, reduced length of stay and reduced expenditure on secondary healthcare.[32] One leading researcher found that spending £1 extra on care homes for older people is associated with 35p less in hospital expenditure, and that more home care among the over-75s is associated with fewer GP appointments.[33]

The Institute for Fiscal Studies assessed the impact of the cuts to older people's adult social care between 2009/10 and 2017/18. It found that a 31 per cent fall in spending per capita was associated with an 18 per cent increase in A&E admissions among the over-65s, and a 12.5 per cent increase in A&E readmissions within seven

days. Each £100 cut from adult social care spending was linked to an increase in A&E spending of £1.50.[34]

There is also clear evidence that 'delayed discharge' from hospital is in part due to inadequate social care. Last winter NHS England found there were on average 14,000 patients in hospital who didn't need to be there, of whom 24 per cent were waiting for home care and 16 per cent waiting for a care home placement.[35] Academic studies have found that more delayed discharges are associated with lower adult social care spending and fewer care home places.[36]

It is important to recognise that savings that may accrue to the NHS and other public services do not come close to cancelling out new adult social care spending pound for pound. But this evidence does show how spending on social care brings benefits to the broader public service ecosystem, and therefore helps make a business case in terms of cost effectiveness and prevention for the public sector as a whole.

Responding to the carer shortfall

Urgent action is needed to prevent a huge gap opening up between supply and demand for unpaid care. The LSE has developed projections that assume there will be no change in the proportion of different segments of the population who give and receive care (looking at care of older people only). These figures suggest that by 2035 there will be demand for 8 million unpaid carers but only 6 million will be available. This is because the number of people in late old age is set to increase much faster than the number in the age groups most likely to offer care. This alarming potential shortfall can be plugged in three ways:

- Either a larger percentage in each age group will choose to provide care
- And/or more paid services will become available (relative to the support needs of the population)
- And/or overall levels of care and support will decline further (relative to the support needs of the population)

The third of these outcomes is unacceptable given the dire position we start from today. The first two routes need to be progressed side by side. We will certainly need more paid care for the growing number of people who will not have a partner, son or daughter in a position to become a carer. For everyone else, we need to create conditions in which more family members are willing and able to provide care. This can be achieved by making it easier to combine caring with other responsibilities, for example by expanding flexible working and carers' leave for working carers. But the provision of formal care is also an important way to support the supply of unpaid care. Numerous studies show that offering more paid support increases the total amount of care available. Some evidence finds that extra paid care leads to fewer informal carers but not a full substitution (eg care by women living in the same household).[37]

> The potential shortfall in unpaid carers over the next decade is a critical and under-discussed public policy challenge.

Some finds that more paid care results in the number of informal carers remaining roughly constant (eg care by people living outside the household).[38] One study found that an expansion of paid care in Scotland actually led to more women aged over 45 providing unpaid care.[39] The researcher suggested that this might be because paid services made caring for a relative in the home viable, as opposed to a care home.

The potential shortfall in unpaid carers over the next decade is a critical and under-discussed public policy challenge. For it to be addressed, the supply of paid care needs to rise relative to population need – both to fill the gap where no carers are available and to provide the conditions that will enable more people to care.

Increasing unpaid carers' employment

The UK is facing significant labour market shortages and caring for older and disabled people is one reason why people of working-age become economically inactive. If there is to be a rise in the numbers providing unpaid care in the decade ahead we need to help more carers to work. Otherwise our labour supply challenges will grow even worse.

Research shows that working-age carers providing more than 10 hours of care a week are significantly more likely to be in work if the person they care for receives paid-for support services (1.6 times as likely for women, 1.7 times as likely for men).[40] Providing funded care and support to people with working-age carers will therefore increase employment participation. Modelling by the LSE with 2015 data examined the impact of providing paid care to older people currently without local authority assistance who receive care from working-age carers (providing more than 10 hours of care a week and not living with the cared for person). They used cautious assumptions, and our analysis of the results shows that providing paid services is modelled to increase the employment rate for this group of carers by 8.7 per cent. Each extra job would cost around £30,000 in adult social care spending (2015 prices). [41]

The 2021 census found that more than 2.1m people aged 18 to 64 provide 10 or more hours of care each week. If the results from the LSE study hold good across this whole group, providing all their loved-ones with paid services could raise employment by 180,000 people.[42] These effects could be even greater in a decade's time on the assumption that there is a significant increase in the number of carers of working-age. Such an increase in the employment rate

for carers would also have knock-on benefits to GDP and tax revenues.

Increasing disabled people's employment

A similar argument relating to labour market participation applies to employment for disabled people of working age. With the right care and support some disabled people who are unable to work at present will be able to sustain employment, while others will increase their working hours or move into better-paid jobs. There is very little evidence that quantifies the potential labour market impacts of providing better support to disabled people. One unpublished study commissioned by Leonard Cheshire suggested that improvements in adult social care that increased disabled people's employment opportunities could lead to an increase in GDP of £6bn and in income tax receipts of £1bn. [43] Much more evidence is needed to clarify the extent of the business case for adult social care with respect to the disability employment gap.

Creating jobs and growth everywhere

Increasing spending on adult social care will help level up England by boosting employment everywhere, including in some of the places that need new jobs most. Adult social care already provides around 5 per cent of all jobs in the UK and increasing spending on care creates more jobs pound-for-pound than any other area of public spending.[44] As these are jobs focused on care and personal relationships they are hard to automate and produce few carbon emissions. In both senses of the word, social care jobs are sustainable.

Using data from an economic analysis commissioned by Skills for Care, we estimate that in 2016 an increase in adult care spending of £1bn would have created 34,000 social care jobs, a further 12,000 jobs in supply chains and 5,000 as a result of wages being spent in the rest of the economy.[45] Drawing on this research and official statistics we have estimated the regional impact of spending £1bn extra in 2021/22 based on the current distribution of local government adult social care spending and long-term care recipients. Table 1 shows that such a spending increase would have a significant impact on regional rebalancing. Furthermore, since pay and conditions in social care are lower in more deprived communities, a National Care Service that

TABLE 1: Regional impacts of spending an extra £1bn on adult social care paid for by raising taxes (estimate for 2021/22, England)[46]

Region	Net fiscal gain (adult care expenditure less tax revenue)	Extra jobs in social care sector & supply chain	Extra jobs for every 100,000 workers in area
North East	£13M	2,500	20
North West	£34M	5,800	17
Yorkshire and the Humber	£19M	3,700	14
East Midlands	£13M	3,300	14
West Midlands	£17M	3,900	14
East of England	£7M	4,000	13
London	-£98M	5,500	12
South East	-£21M	5,400	12
South West	£15M	3,600	13
England	-	38,000	14

Fabian Society estimates – see endnote

improves both is likely to bring the largest benefits to those places.[47] Higher wages will inject much needed spending into local economies, increase tax payments, and lower social security payments.

Table 1 shows how higher spending on adult social care will transfer money from the richest parts of the country to communities right across England. In figure 1 we show how it will also transfer revenue from households with high incomes to those with low and middle incomes.

A reformed and better resourced adult social care system will close gender inequalities.

Tackling gender inequality

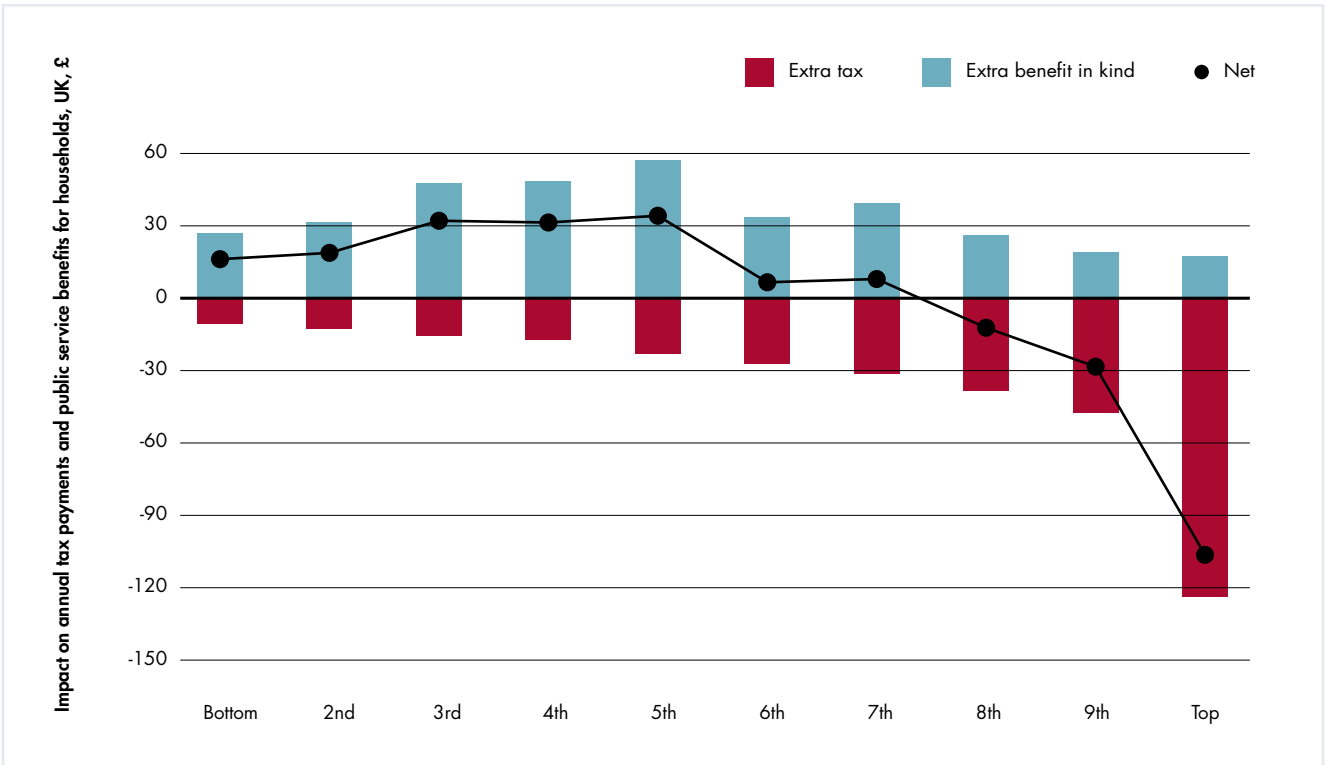
Women make up 57 per cent of people who rely on long-term care, 60 per cent of unpaid carers providing 20 or more hours of care per week, and 82 per cent of the care workforce.[48] A reformed and better resourced adult social care system will close gender inequalities by improving the remuneration and working lives of over one million women; offering adequate, personalised assistance to women with support needs; and providing women carers with more support, flexibility and employment opportunities.

Spending money raised from taxes on adult social care represents a major 'wallet' to 'purse' transfer. To illustrate the point, we calculated the effect of a hypothetical scenario where £1bn extra is spent on adult care by increasing income tax rates:

- Men would pay £720m extra in income tax and women £280m.[49]
- Women requiring care and support would benefit from £570m of this spending and men from £430m.[50]
- Remuneration for women working in adult social care would rise by £480m while for men the figure would be £110m.[51]

Increasing spending on adult social care will therefore make an important contribution to gender equality.

FIGURE 1: Distributional impact of spending an extra £1bn on adult social care funded by raising taxes (equivalised household income deciles, 2020/21 UK)[52]



4. Towards a National Care Service

Why a National Care Service?

Adult social care needs more money. But more money is not enough: it also needs comprehensive reform. Our proposals for a National Care Service for England are a response to the scale of the challenges facing adult social care. The ideas presented in this report would amount to the most significant and comprehensive set of changes to care and support in a lifetime. Creating a National Care Service would be a 'reset' moment, reflecting the reality that fixing social care cannot be achieved by minor tinkering, isolated policy changes or even a big cheque book. If any area of public policy needs an end to 'sticking plaster' solutions it is adult social care.

The National Care Service will provide a focal point for the millions of people who come into contact with the care system each year. It will signify the level of ambition that adult social care has lacked for the last 13 years, it will bring clear new entitlements to citizens, and it will provide support to everyone who needs assistance regardless of their means. It will position social care as a comprehensive and shared public service, there to deliver security and peace of mind for all of us.

> Fixing social care cannot be achieved by minor tinkering, isolated policy changes or even a big cheque book.

Over the next few years, the process of establishing the new service will create a clear and public direction of travel and the organising framework for national and local leadership, reforms to policy and practice and sustained investment. The roadmap to the National Care Service will unite policy makers, people who need support, carers, providers, commissioners and the wider public.

Under a National Care Service local authorities will remain in control, working with people and providers in their communities. But there will also be enhanced national rights, responsibilities and powers because adult social care faces national challenges. They affect Carlisle as well as Crawley, Hull as well as Hackney. From fair social care funding to the regulation of large providers, a greater role for central government is needed. And in the case of the workforce, everyone working in adult social care should be entitled to better pay, terms and conditions regardless of where they live or who they work for. This is the only way to solve the national recruitment crisis and give social care workers the reward and respect they deserve.

National co-ordination is needed to make local control and personal choice real rather than words on a page. If we only spend more money, we will end up with an inconsistent, inefficient system that does not deliver good quality care

to all. A National Care Service is our best chance of eliminating gaps in support and delivering consistent, high-quality, and innovative services that people can shape for themselves.

The National Care Service will enhance scrutiny and transparency. For too long, adult social care has been poorly understood, low profile, and unaccountable to the disabled people, older people and carers who depend on it. This has allowed national government to underfund councils delivering support and care, without being adequately challenged or judged. A National Care Service will strengthen the ability of people to influence the development of social care and to hold both national and local government to account. In the future politicians will not be able to dodge responsibility for the hundreds of thousands of people the system is failing today.

Ultimately a National Care Service is necessary to deliver on the vision of everyone receiving the support they need to live the life they wish, in the home of their choice, doing the things they want to do in the local community. It signifies comprehensive change through collective action to guarantee care and support to everyone who needs it.

TABLE 2: The position now compared with the possibilities offered by A National Care Service

The position now	**A National Care Service**
Local authorities supposedly in charge but without the money or powers they need	National ministerial responsibility and leadership working in partnership with strong councils
Unclear entitlements that are often not realised in practice	Clear rights and entitlements and the ability to enforce them
Inconsistency in access to support and quality of care	Nationwide entitlements and geographic consistency
A fragile, fragmented and sometimes extractive 'market' of care providers	Commissioners and partners working together as part of a public service
Support only for people with limited means	Support and peace of mind for everyone
Inadequate funding and emergency cash injections	Long-term and sustainable approach to finance
Insufficient development of specialist housing and modern care homes	Long-term certainty and funding to build new facilities
Inadequately rewarded staff and a recruitment and retention crisis	National terms and conditions working towards parity with the NHS
Unaffordable fees and inability to pool risks	Improvements to affordability by reducing the scope of charging over time

What's in a name?

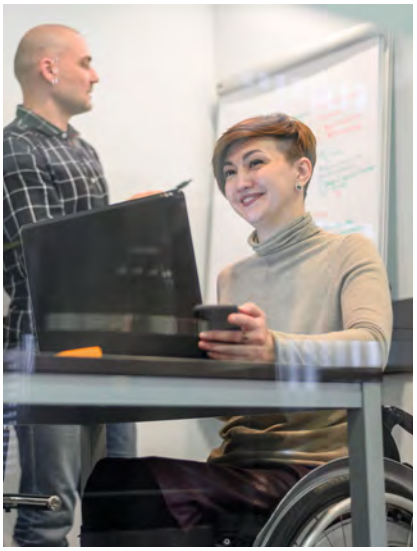
The term National Care Service was coined by the last Labour government as a way of committing to a nationwide system of adult social care that would share the values of the NHS. Labour ministers wanted a service that would be there for everyone, with national consistency on entitlements, funding, standards and workforce. They also hoped to create an institutional brand which would give rise to the same deep, long-term affiliation that people in this country have to public healthcare.

The Labour party in England has recommitted to this concept at subsequent general elections. The idea has also been taken up in Scotland by the SNP government and is being explored by the Welsh Labour government. But a National Care Service can mean different things to different people. The SNP's plan is one of top-down centralisation and sweeping structural change. This brings no clear benefit to people who rely on support and care and has been rightly criticised. By contrast our version of a National Care Service starts with people and communities, seeking to keep structural change to a minimum.

Not everyone we have spoken to likes the phrase National Care Service. Some worry that the term automatically implies national government taking over from local authorities, as is happening in Scotland. Others fear a forced merger with the NHS, where care and support in the community becomes subservient to managing healthcare capacity and the medical model of disability is entrenched. Or they see the concept of a 'national service' to be at odds with moves towards highly personalised, self-directed support.

The whole point of the term National Care Service is to conjure a parallel with the NHS. Establishing a strong connection in the public's imagination with a cherished and enduring national institution is a worthy goal. But by using the same terminology we recognise there is a risk of over-emphasising what the two systems should share and underplaying their essential differences. We agree with those who told us that a new adult social care system should be locally led, controlled by the people who require support, diverse in the services that it offers, and focused on helping people achieve independent, fulfilled lives rather than narrowly meeting clinical or personal care needs. All of this implies something quite different from the NHS.

There are even some people who don't want the word 'care' to feature in a new label. That seems a shame because caring relationships and the ethic of care should be fundamental to a future service. The recent Archbishops' Commission on Reimagining Care reminded us of the importance of mutuality, interdependence and care within communities and families.[53] These values don't need to be in conflict with disabled people's aspirations for personal control and independence. More to the point, alternatives to 'care' such as 'independent living' do not have wide public recognition or political salience (which is one of the main problems with the current term 'social care'). If we want improvements to care and support to last, we need to bring politicians and the public with us in the language that is used.



We understand the concerns some have voiced with the term National Care Service. If politicians opt for a different new label that would not undermine our proposals. But we are clear that a new name is needed and that the 'brand' of adult social care should change. With transformation required on so many fronts, sufficient and sustained reform will only happen with a clean break that clearly signals the scale of ambition. And the reforms will only endure over time, through future changes of government, if they are enshrined in a cherished institutional identity that resonates with the public.

We need reforms that establish a national care guarantee for everyone who requires support today or who may do at some point in the future. The public service that delivers this guarantee could be called the national care network or partnership or something else entirely. But for the purposes of this report we have stuck with the term National Care Service. It already has wide currency, and it embodies the idea of the new national guarantee that we know is required.

The dilemmas we have grappled with

In carrying out this project we heard from hundreds of people and organisations and we have inevitably had to juggle with competing perspectives and points of view. Before proceeding to our proposals we want to give a flavour of the choices we've made and the dilemmas we have grappled with.

The relationship between adult social care and the NHS: a minority of those we heard from said that adult social care and the NHS should merge or become so closely integrated they are almost indistinguishable. In proposing this approach they were thinking about people with very complex health and support needs, often

close to the end of life, for whom the divide between health and social care is arbitrary and harmful. For people with complex needs, the fault line between NHS and local government services makes for worse outcomes and inefficiency (although problems of fragmentation exist within both the NHS and local government too). Some also want integration between the two services as a fast, simple way to deliver social care free at the point of need.

The alternative view is that there is a fundamental difference between clinical care and practical support aimed at increasing wellbeing and independence in the community. People who take this position say that integration with the NHS implies a medical model of disability, and gives the false impression that everyone who uses community care and support has substantial healthcare needs. It also suggests that adult social care is there simply to serve the demands of healthcare capacity. More integration with the NHS, it is argued, could result in less coordination with housing and other community-based services. The social work profession clearly wishes to maintain its independent identity and councils argue that local democracy plays a key role in shaping services and meeting needs.

Overall we support the view that adult social care and healthcare are different and should not be fully integrated. We do not back the creation of a single national health and care service, although if services wish to merge locally, or at the level of city region, no one should stand in their way. Having said that, there are many people with social care needs who should receive joined-up support that makes little or no distinction between health and social care. In particular, securing better outcomes for frail older people close to the end of life demands better services from healthcare and social care, and closer coordination between the two.

Even without formal integration, there are some functions that should sit across health and care. Population level needs assessment and strategic planning are already joint responsibilities. We think workforce planning, education and employment conditions should also be closely aligned.

More nationwide rights, standards and functions are needed for local government to fulfil its adult social care mission. We need a national care guarantee.

The boundary between health and care should continue to remain under review. To an outsider there is little difference between reablement services that fall under social care care and home-based intermediate healthcare; nor between social care for someone with severe dementia and NHS-funded continuing care for people whose support is deemed to be primarily required to meet health needs. Later we suggest that care and support in the weeks after hospital discharge should always be a joint responsibility between local government and the NHS.

National versus local: Our own instincts are localist and the next Labour government is likely to embrace a strong commitment to devolution in England. We do not support the emerging Scottish model of a top-down National Care Service without local democratic involvement and accountability. Councils should remain in charge. But our firm view is also that more nationwide rights, standards and functions are needed for local government to fulfil its adult social care mission. We need a national care guarantee.

In our discussions with people in local government we found acceptance of an expanded role for national leadership and coordination, as long as councils remain at the heart of adult social care in communities. We spoke to senior councillors from all political parties and to local government officers, and everyone agreed that more national functions are needed.

In particular, a new national funding model is the only way to achieve parity of spending power for councils, in a way that reflects geographic variations in needs and costs. This inevitably means a national grant and largely separating out adult care funding from the rest of local government finance. Although this point is about the public sector's internal 'plumbing', it is probably the single largest institutional change we propose in this report.

We also conclude that a stronger national framework is needed with respect to entitlements, workforce, pricing, provider regulation and investment. A national approach to workforce is the only way to improve rewards, skills and career progression. Shaping, regulating and growing the provider landscape needs to be a shared responsibility with local, regional and national dimensions. Much of this goes with the grain of current and recent policies including initiatives to determine fair costs for providers, measure outcomes using a national framework and empower CQC to assess local authority performance.

People requiring support and their carers should be entitled to more consistency and a clearer national offer. Those with similar needs should receive broadly similar levels of support across the country. In particular, it is wrong that individuals who receive support in one part of England should risk losing it if they move across a local authority boundary.

Competing spending priorities: An incoming government in 2024 will face significant financial constraints and have many expenditure priorities. But very significant spending increases for adult social care are essential and inevitable.

The number of disabled and older people requiring support is set to rise sharply

over the next decade, so billions of pounds extra will be needed just to replicate today's level of provision as inadequate as that is. Beyond that there is a difficult four-way choice on how to spend every additional public pound that might become available:

1. Funding existing support adequately to secure sufficient, properly rewarded and well-trained staff, modern facilities and financially viable providers

2. Extending support to more people and responding to unmet need by unwinding the covert rationing of care, broadening and standardising eligibility, and expanding open-access preventative services

3. Increasing the amount of support people receive so that care services or direct payments are sufficient in scale to enable individuals and their carers to access the support they need to lead a good life

4. Making support more affordable by reforming charging. As discussed in the introduction, this is an important issue but no more so than the other challenges facing adult social care.

Given the financial constraints that will face an incoming government, it is very unlikely that there will be a big one-off jump in adult social care spending on a scale that will address the current pressures facing the care system at once. Any 'year one' budget increase will need to focus simply on securing the continuing viability of the system, largely by addressing the immediate workforce crisis. To address all four of the priorities in this list, as well as responding to rising need, will require significant annual spending rises over many years.

This is especially true if the system is to specify people's rights and expectations more clearly, which we think is important for improving outcomes, providing peace-of-mind and changing organisational culture. Services framed in terms of clearly explained rights and entitlements are likely to see greater spending pressure than less transparent systems where administrators have more scope to covertly restrict access.

The diversity of needs and different forms of support: Any agenda for adult social care reform must grapple with the huge diversity in the people who may require support, and in the range of possible solutions that could meet their needs. There is obviously a massive difference between an 18-year-old disabled from birth who is just starting adulthood and a 95-year-old with frailty, illness and disability in the closing years of life. Principles such as prevention, wellbeing, independence and control apply equally to both of them (the alternative is age discrimination). But the contexts are not the same. In the case of the young adult, their support should often interact with the education and employment systems while for the older person the critical issue is a seamless connection with the NHS.

Support also needs to reflect the different needs and preferences of men and women, of people from different racial and religious backgrounds, and of people who are LGBTQ+. And, to add to this complexity, carers also come with a very wide range of circumstances and needs so deserve their own tailored not cookie-cutter support.

Today the adult social care system uses two arbitrary categories, 'working age disabled' and 'older people'. But within each of these groups there is extraordinary diversity relating to health conditions and disabilities, support needs and personal preferences. One critical issue is the degree to which people have the capacity or desire to fully make decisions for themselves – or whether they need assistance to make choices or require others to act in their best interests. Given the rising numbers with dementia and severe learning disabilities, this is partly a formal question of mental capacity. But it is also about outlook, preference and experience of the system. Some people want to actively direct their support while others seek the peace-of-mind that comes when trusted professionals presenting good solutions.

This variety and complexity calls for a wide range of specialist skills in the adult social care workforce. Dedicated care workers and personal assistants are the backbone of support and care and frequently have wide and deep skillsets despite their low pay and lack of professional status. The sector also depends on the expertise and professional standards of regulated social workers, nurses, occupational therapists and registered managers of care services. They bring interlocking specialist skills that are essential for supporting diverse needs and aspirations. For example, adult social workers assess and work with people with complex needs and have particular responsibilities regarding safeguarding people from harm and protection of liberty.

The support and assistance people may wish to access varies hugely. To start, many people want a direct payment so that they or someone they trust can take responsibility for purchasing the support they receive. This option needs to better promoted and supported, and the rules relaxed so payments can be used more flexibly. Then when it comes to commissioned services, there is a wide array of options and in the future they should be wider still. In particular, social care should always offer more than brief moments of personal care designed simply to keep people safe. Good options are needed to help people live life to the full, whatever their age or the barriers they face. As already discussed, people with ongoing clinical and support needs should receive seamless services that wrap their health and social care together. These days adult social care commissioners also place significant emphasis on short-term interventions to achieve specific goals such

as rehabilitation or independent living, as well as immediate emergency responses. Modifying homes also plays a critical part in helping people to stay independent and prevent accidents.

There is strong and widespread support for the 'home first' principle that seeks to avoid the need for people to enter institutional care. This is an important aim both for enhancing health and quality of life and for saving money for the taxpayer. But it is not a solution for everyone. Care homes and other forms of residential accommodation are a good choice for people with very high needs and acute risk of isolation: institutions can be communities and unsuitable homes can be prisons.

Increasingly commissioners, providers and people requiring support are seeking to bridge this divide by embracing specialist housing options. For older people, housing with care and integrated retirement communities offer much more support than traditional sheltered housing. For working-age disabled people supported living schemes, and innovations such as 'shared lives' programmes, are increasingly preferred to large residential facilities. The National Care Service must have funding and commissioning arrangements designed to support all these housing options.

In developing plans for a National Care Service, this huge diversity in both personal requirements and service models must be accommodated. The new service therefore needs to provide a flexible framework that allows for local and personal choice, innovation and experimentation. But at the same time, it will need to push provision in new directions, when older, less effective models seem entrenched. The task is to create arrangements that support diversity and experimentation, while also introducing strategic leadership that has a clear, well-evidenced view on what forms of provision are effective and the tools to promote their adoption.

Independent providers and a national public service: The wide diversity in people's needs and in potential solutions implies a wide range of providers. A successful National Care Service is therefore likely to be a network of thousands of different providers, and of tens of thousands of directly-employed personal assistants. Together they can bring the diversity, experimentation and personal control we want to see.

There is in any case no prospect of a quick transition from today's landscape of mainly independent provision to public only delivery. In many places there is already too little capacity, so the last thing we need is for a new National Care Service to reject potential partners who are willing and able to deliver good quality care.

On the other hand, some independent providers display unacceptable and exploitative behaviour with respect to the quality of care they offer, the treatment of their workers and their commercial practices. The relationship between the public sector and independent providers must therefore change. A new settlement is required that aligns adult social care with other public services that use partners from outside the public sector. Elsewhere, independent delivery is subject to stable contracts, franchises or licences which give public commissioners significant control over what providers offer and the way they run – whether they are refuse services, schools or franchised bus operators. Often this goes hand-in-hand with the ability to insource services if contractors are not delivering good value or meeting acceptable standards.

There is a balance to strike. A National Care Service should recognise the contribution independent providers can make but also change the nature of their relationship with the state. Instead of spot purchasing individual packages of support, long-term public service licences are needed with robust requirements regarding the quality of care, ethical workforce practice and financial standards. The new service should specify what people can expect, regardless of who delivers the support. Locally, the idea of care 'markets' should be replaced with networks of collaboration. Councils and providers should work together to innovate and raise standards, identify needs and plan future provision, and recruit and train the local workforce. Nationally, minimum standards should exist for everyone providing services funded or arranged by local government under the banner of the National Care Service. All licensed providers would offer workforce terms and conditions underpinned by a national framework and large providers would operate under an expanded regime of national financial regulation and enforcement.

As part of these changes, non-profit care organisations should be able to play a larger role in the delivery of services – whether they be housing associations, charities, employee mutuals, or cooperatives controlled by people drawing on services. There are already thousands of non-profit care providers that at their best achieve high service and workforce standards, by combining a strong public service ethos with their own distinctive values and capacity to experiment and respond to diverse needs. We need more of them.

Public provision should also play an important and expanding role in the future alongside independent providers. Increasing the role of public delivery makes sense particularly when it is in the context of integration with other public sector provision (such as joint NHS and home care teams); where it is the most effective way to quickly build new capacity; or if independent providers need to be taken over on grounds of quality or commercial viability. Local decisions not national rules should determine the right balance, so that councils having the power to in-source provision where they conclude it is in their residents' interests.

5. Ten building blocks: our proposals for reform

The National Care Service for England should be a new national partnership that offers care and support to every adult who needs assistance, as a result of health needs or disability, to live independently and maintain a good quality of life. It will help people to live the life they choose in the home they choose, and it will work alongside family carers, local networks of support and other public services.

The service should be developed to bring to life the ten principles we set out at the beginning of this report. To achieve this we need a national care guarantee codified in a National Care Service 'constitution' that specifies what people can expect wherever they live in England.

This guarantee should cover:

- Access to assistance for everyone who requires it, as early as they need it
- High quality, personalised support sufficient to meet people's needs and aspirations
- Affordable services whatever your financial circumstances
- Support and choice for unpaid carers
- Reward and recognition for the care workforce

Building a National Care Service that brings this guarantee to life will require significant reforms to policy and practice, and significant increases in public funding. Without both, there can be no certainty that everyone will receive the care and support they need to live well.

In this chapter we set out in detail proposals for 10 building blocks that will together construct the National Care Service.

In chapter six we examine options for the implementation of the building blocks and the sequencing of reform – including proposals for a National Care Service Act and a formal launch date for the new service.

BLOCK 1: STRUCTURE AND IDENTITY

The National Care Service should be an England-wide network of distinct and diverse organisations that share a common identity. It will be a partnership bringing together national government, local government, more than 10,000 providers and over one million individual members of the adult social care workforce.

Together they should operate under the common name of the National Care Service. They will share goals, standards and requirements, working as partners to deliver a national care guarantee. There will be a shared national brand, acting as a trusted and easily understood label for care and support in England, which will appear alongside local or institutional identities (following the example of schools, GP surgeries or franchised bus companies today). Individuals and families will therefore have an end-to-end relationship with the National Care Service, from accessing a national website to their relationships with individual care professionals.

The service will be both local and national, with local government at its heart. New national functions and guarantees will create the conditions for improving, expanding and standardising the care and support that councils offer locally. The National Care Service will not be a copy of the NHS and it will not be a merger with the NHS. It will serve and reflect England's diverse regions and localities with decisions always made at the most local level possible, rooted in local democracy and co-produced by the individuals using services, their families and empowered employees.

Elected councils will be in charge of everything that does not need to happen on a national scale. In general, national decision-makers will decide what the service should achieve, but local authorities, individual providers and people themselves will decide how it is achieved. Investment in councils' adult social care commissioning teams is needed, following more than a decade of cuts that have hampered capacity to monitor delivery of care contracts and hold providers to account.

The Department of Health and Social Care and related arms-length bodies will create a strong national framework for care and support. The key changes that will make care a 'national' service will be enhanced nationwide rights, consistent funding, fair pricing arrangements, uniform employment standards and strategic leadership to promote innovation and reform. There will be a new workforce settlement, with national standards on pay, terms and conditions agreed with commissioners, providers and trade unions. There will also be a new deal with independent providers, with fair pricing for services in exchange for stronger public service requirements.

The service should be established in legislation by a National Care Service Act that revises and expands on the Care Act 2014, which will remain a key statutory foundation for adult social care in England. The National Care Service should 'go live' on a specific launch date, when new standards and entitlements come into force. For example this could be 5 July 2028, the 80th anniversary of the NHS which would give around three and a half years' run in to the launch. However, if selected, this date would be just one milestone in an ongoing process of reform (see chapter six: roadmap).

Proposals

1.1 Launch a shared national brand. A shared public-facing brand should be developed to cover all citizen interactions with care and support that are funded or organised by local authorities in England. This name and brand should encompass all the activities of central government, local government and providers that touch people engaging with services. It should be unveiled on a formal launch date when new citizen rights come into force.

1.2 Strengthen national leadership. The new National Care Service Act should create duties for the Secretary of State for Health and Social Care to lead and facilitate care and support in England. At present ministers have almost no statutory requirements with respect to adult social care. In the eyes of the law almost all responsibilities sit with local authorities.

Possible duties for the secretary of state

The law should place high-level duties on the secretary of state that mirror responsibilities relating to the health service that date back to the 1940s (they are currently specified in the NHS Act 2006 as revised by subsequent legislation). These national duties could cover:

- Promoting the establishment of a comprehensive care service in England
- Advancing the wellbeing, independence and autonomy of people with support needs
- Promoting the provision of support to everyone with needs
- Promoting the provision of support to unpaid carers
- Encouraging interventions to reduce or delay needs
- Advancing citizen rights and a National Care Service 'constitution'
- Involving people with direct experience of care and support in decisions
- Directly providing nationwide information and promoting good information, advice and advocacy locally
- Supporting the improvement of services and the use of research and evidence
- Ensuring adequate and consistent funding
- Developing a sufficient, appropriately skilled and fairly rewarded workforce
- Ensuring sufficient provision that is high quality and diverse
- Reducing inequalities in experiences of care and support
- Publication of strategies on issues relating to these duties – eg unpaid carers, workforce
- Reporting annually to parliament on care and support in England.

1.3 Expand national government functions. New duties for the secretary of state should be discharged by creating expanded national functions within the Department of Health and Social Care. These expanded central government functions should consist of:

- **Leadership, strategy and transformation** – achieved through national strategies, guidance to local authorities, a national outcomes framework and input into CQC's assessment strategy.
- **Co-production and involvement** – national arrangements for involving in decisions people who require support and carers; and central support and guidance for local authorities and providers on co-production.
- **Finance** – responsibility for meeting the financial requirements of the service; arrangements for capital investment; fair financial allocations to local authorities; fair pricing for providers.
- **National communications and information** – national digital information services, integrated with local authority digital and telephone information and advice.
- **Workforce** – workforce and skills planning; a national framework for terms, conditions and occupational grades; social partnership arrangements.
- **Data and digital** – data strategy and standards; data reporting requirements.
- **Research, evidence and innovation** – supporting new service models and evidence-based practice.
- **Reserve powers to intervene** – intervention in case of failure (a power included in 2022 legislation).

As part of these functions, the National Care Service Act should require that strategies and implementation plans are developed on key issues. These might cover topics such as coproduction; carers; workforce and skills; future models of support; local government commissioning capacity; and investment. A new law should also require that appropriate partnerships for engagement, consultation and negotiation are established.

1.4 Use and repurpose existing organisational structures. The creation of a National Care Service should not be accompanied by the development of significant new national or local bureaucracy.

Local responsibilities should be discharged by local authorities (working with integrated care systems, health and wellbeing boards and other local partnerships). We reject the Scottish model of establishing separate local care boards reporting to ministers. National functions should be largely carried out by existing agencies:

- **Executive functions** should be delivered in-house by the Department of Health and Social Care within an expanded adult social care division reporting direct to ministers. This is especially important during the development and roll-out of the new service when hands-on political leadership will be essential (once the system is mature there may be a case for an arms-length body like NHS England). The position of Director General for Social Care should be upgraded into a high-profile role of chief executive of the National Care Service.
- **Partnership structures** should be established to provide the national level machinery for engagement, consultation and negotiation on issues including the shape of future services, funding, workforce conditions and provider costs. This should include a formal co-production forum with people requiring support and carers; social partnership arrangements for agreeing pay and conditions; and consultative mechanisms with providers. The social care national partnership which was established in 2022 by social care trade unions, employer bodies and the LGA could be officially recognised by government and evolve into one element of these new structures.
- **Regulation**. CQC should continue to be responsible for regulating and driving up standards. As well as provider regulation, this would include the agency's new responsibilities for reviewing and assessing the performance of local authorities' adult social care functions. This will be a critical part of the feedback loop designed to ensure that the National Care Service achieves consistent outcomes and continually improves. CQC assessments should include thematic reviews that cover a locality's provision across the NHS and social care. Enhanced financial regulation of large providers should either remain a CQC responsibility, or pass to the DHSC or another existing regulator (see block 8: providers).
- **Workforce planning and skills**. A national agency should be responsible for adult social care workforce planning and education. This should either be a standalone body for care (developing from Skills for Care, a publicly funded charity) or a joint health and care body that also includes the role of Health Education England (which has recently lost its independence and is being absorbed into NHS England). This workforce body would be tasked with developing a national people and skills plan, maintaining workforce and skills projections, and advising on the appraisal and design of occupational roles in social care.

- **Independent scrutiny, evidence and engagement body.** We suggest a small independent commission be established to provide challenge, scrutiny and evidence, led by people with practical experience of receiving and delivering care and support. Possible models to follow include the climate change committee and the children's commissioner for England (see block 3: co-production).

1.5 Support flexibility at local level. Local authorities' legal responsibilities should remain similar to those they have under the Care Act, albeit with more national standardisation on entitlements, workforce conditions and provider relationships. They should have significant flexibility to commission the models of support that are right for their community; determine the balance between in-house and independent provision; and pool functions with the NHS if they wish. They would be expected to take account of national strategies and statutory guidance. The national outcomes framework and national financial benchmarking would be used by CQC to assess their performance and recommend improvement. All of this requires additional support and investment from national government to support the capacity of commissioning teams to deliver. Local authorities would be expected to address underperformance by working with peers, but the secretary of state will continue to have the power to intervene in exceptional circumstances.

1.6 Support regional and sub-regional coordination. Integrated care systems are now responsible for assessing population health and care needs over wide areas that frequently cover more than one local authority. Local authorities may wish to pool some of their functions with neighbouring areas to operate on the same boundaries, or to pool functions with NHS integrated care boards. This should be for them to decide.

Integrated care partnerships and boards should each include board members with expertise in adult social care given the impact their decisions will have on National Care Service provision. They should also be required to demonstrate how they are engaging with people who require support and their carers.

As the National Care Service and the new ICS model both develop, city regions should be able to bid to take over some national social care functions, as part of a package of health and care devolution. Their plans should be co-designed with people receiving support, carers, providers and the health and care workforce (see block 3: co-production).

England or beyond?

This report is about the creation of a National Care Service for England. Almost all relevant adult social care legislation applies to England only and England has been the remit of our study.

However, there may be some functions best delivered on a GB or UK-wide basis. Dialogue with devolved governments and stakeholder consultation should consider the case for a three or four-nation approach with respect to:

- Incorporating international rights into domestic law
- Financial supervision of large providers
- A fair pay agreement for the whole adult social care workforce
- Interactions between charging reforms and social security (which is a Westminster responsibility)
- Cross-border arrangements regarding entitlements and delivery of services.

BLOCK 2: WORKFORCE

A new workforce settlement should be the first priority in creating a National Care Service. This is the most urgent building block for reform because immediate action is needed to secure the continuing viability of care and support at a time when there are 165,000 vacancies in the sector.[54] On coming into office a new government should announce a health and care recovery plan focused on recruitment and retention, before moving onto long-term workforce reforms.

Significant improvements in the employment conditions of adult social care workers are required to retain staff, fill existing vacancies, and grow the social care workforce in line with rising need. It is estimated that demand for adult social care workers will rise from 1.2 million FTE posts in 2021 to 1.8 million in 2030 because of increasing requirements for support.[55]

A new workforce settlement should be the first priority in creating a National Care Service.

Better jobs are also needed to deliver better care and meet people's aspirations for good lives and independence. Adult social care occupations and training standards should be reimagined to recognise and develop caring skills, expand opportunities for specialisation and build career pathways. All of this should take place in partnership with the NHS to create close alignment and two-way transitions between the health and care workforces.

We propose national minimum employment terms and conditions, applicable to everyone who works in adult social care (even if they do not deliver a service arranged by or paid for by government). This would take the form of a sector-wide fair pay agreement which would specify minimum pay and entitlements to sick pay, breaks, sleep-in pay etc.

Further requirements should apply to employers who deliver services as part of the National Care Service. Here there should be NHS-style occupational roles and pay bands, updated annually using national social partnership arrangements to progressively improve pay and working conditions. Providers would be free to go beyond these minimum terms. Their workers will be visibly part of the National Care Service team, securing public recognition and respect, just as those who work for the NHS do.

A more robust approach to skills is also needed. As things stand, 54 per cent of staff in the sector providing direct care are without a relevant social care qualification and of these a sizeable minority have not participated in recent training. At present the basic expectation is that new care workers should achieve a (non-accredited) care certificate as part of their induction. However, 32 per cent of those who started in the sector since this standard was introduced have not taken part in any care certificate learning and only 43 per cent have achieved a certificate. Participation in social care apprenticeships has also plummeted since the redesign of apprenticeships and the introduction of the apprentice levy, falling by almost two thirds between 2016/17 and 2020/21.[56] The government is taking only baby steps to address these problems, for example by converting the care certificate into an accredited and transferable level 2 qualification. In 2022 it announced £500m to fund training and workforce development but then halved this amount in 2023.

Proposals

2.1 Negotiate a fair pay agreement covering the whole adult social care workforce. The workforce should be subject to minimum terms and conditions negotiated between national representatives of workers, employers and public sector commissioners. New fair pay agreement legislation contained in an Employment Rights Act should determine the process for reaching agreement. Before this law comes into force, an initial agreement should be negotiated on a non-statutory basis.

As a minimum the fair pay agreement should include:

- An adult social care sector minimum wage. The agreement should seek to match or exceed the lowest NHS pay point (£11.45 per hour in 2023/24) as soon as possible.
- Minimum employment conditions including rules on guaranteed regular hours, transparent and clear pay slips, paid travel time and breaks, minimum mileage rates for domiciliary care workers, sleep-in pay, minimum sick pay, minimum holidays, and paid training time.
- Minimum induction and training standards (with a requirement for induction training that results in a care certificate).
- Standards for the adoption of new technology, with appropriate training and without detriment to working conditions.
- Arrangements to facilitate union recognition by individual employers and provide union support for individuals, including union access to all workers in the sector.

In advance of the full agreement, an initial sectoral minimum wage should be agreed by government, local authorities, providers and trade unions on a non-statutory basis and announced within months. Ideally this should at least match the real living wage (£10.90 per hour in 2023).

The fair pay agreement could also include sector-wide benefits to better recognise and reward care workers, such as Engage Britain's proposal for a 'green badge' system of free parking for home care workers (similar to the blue badge for disabled people).

The fair pay agreement would apply to everyone working in a CQC regulated care service irrespective of whether the provider is commissioned by the National Care Service. Participation could become a condition of registration and CQC inspections could then assess providers' compliance with the agreement's minimum terms. Personal assistants funded by direct payments and workers delivering non-CQC regulated services (eg home help or daytime activities) could be subject to the sector minimum wage and at least some of the agreed terms and conditions. The exact detail should be subject to consultation to ensure sufficient flexibility.

2.2 Introduce national employment terms, pay bands and minimum pension entitlements for employees of National Care Service providers. Providers of services funded or arranged by the National Care Service should be required to meet or exceed a national framework of employment conditions and occupational grading and progression, as part of their contracts with local authorities. The overall aim would be to achieve broad parity with similar roles in the NHS, modelled on the

Agenda for Change system of NHS pay-scales.

The new framework would include minimum requirements for employment terms and conditions, pay bands for different occupational roles, uplifts in high-cost areas and new pension entitlements. The fair pay agreement would continue alongside this framework to provide protection to people working for providers outside the National Care Service (such as luxury private-only care homes).

Everyone covered by these terms and conditions would be designated as a National Care Service worker, creating shared identity and public recognition. All such workers would be able to wear a common badge or logo (with individual providers also free to stipulate their own requirements for branding, dress code or uniform).

The framework would include everyone working in social care who is not covered by local government or NHS terms and conditions. This would include those in support roles, such as cleaners and cooks in care homes, to ensure everyone is part of the same team. It would also include registered managers and deputy managers and health professionals working in adult social care.

The new framework should be determined through national social partnership arrangements involving commissioners, providers, trade unions and the government. Its implementation would sit alongside wider reforms in models of care (block 7), the relationship between commissioners and providers (block 8) and training and skills expectations (below) to align better pay with improved practice and quality of care. Ideally the new terms and conditions would be in place for the official launch of the National Care Service. Annual enhancements should then either be negotiated through collective bargaining or based on recommendations by an independent National Care Service pay review body.

The framework should be less prescriptive than Agenda for Change, recognising that regulated adult social care is delivered by over 10,000 diverse employers. For example providers should be free to go beyond minimum requirements to position themselves as attractive local employers.

Initially the framework would be optional for personal assistants employed directly by people requiring support (although advice should be available to help people using direct payments adopt the standards if they wish). Over time, national co-production and social partnership arrangements with representatives of disabled people and personal assistants should be used to develop improved arrangements for employing publicly-funded PAs.

Under the new framework the pay and benefits of people working in adult social care should be progressively aligned to NHS employees with broadly similar responsibilities and skills.

Under the new framework the pay and benefits of people working in adult social care should be progressively aligned to NHS employees with broadly similar responsibilities and skills. This would include health professionals working in social care such as nurses and occupational therapists. Such alignment will support two-way transitions between the NHS and adult social care as a routine part of people's career pathways.

The new framework should include minimum pension entitlements, because the remuneration gap between the NHS and independent social care providers is much higher after pensions are accounted for. New minimum pension entitlements should be negotiated for care workers in the independent sector with the aim of working towards parity with NHS and local government employees. Strong pension entitlements could support retention, by making social care an attractive long-term job on a par with working for the NHS or the best private sector companies. Options to consider include first, a minimum employer pension contribution into an auto-enrolment pension – for example the Living Pension standard; second, a new National Care Service pension scheme – eg a collective pension scheme modelled on the Royal Mail pension plan; and third, membership of the local government pension scheme.

2.3 Redesign occupational roles in adult social care. As part of the new national employment framework, occupational roles should be defined, harmonised and redesigned through a consistent job appraisal and skills specification process, building on the government's recently launched care workforce pathway for adult social care.[57]

The aim should be to develop role specifications that better reflect and reward the complexity, responsibility and autonomy of existing jobs in adult social care. The specification of occupational roles and individual job evaluations would take account of the delegated clinical tasks carried out by some social care workers, the skills required to empower and work with individuals and their families, and the expanding role of technology in delivering support and care. The framework should also cover jobs in the social care sector that support those who directly provide care and support, for example cooks, cleaners and facilities staff who make an essential contribution to adult social care teams.

The long-term ambition should be for more people in the adult social care workforce to occupy senior or specialist positions, with advanced training and higher pay. This could include having more health professionals in the sector

such as occupational therapists and nurses (providing their focus is on wellbeing, independence and personalised support, not just clinical care). Achieving this ambition will be a journey over decades however, as there is neither the money nor the supply of skilled workers to rapidly transform the occupational profile of the adult care workforce. The initial priority should be to fairly reward the existing workforce, with an eye to recruitment and retention, by creating parity with similar roles in the NHS.

2.4 Align adult care and NHS workforce planning and skills functions. Activity on adult social care workforce planning, occupational roles, skills and training should be undertaken jointly or in close coordination with the NHS.

Nationally, a statutory arms-length body should be responsible for workforce and skills functions by building on and absorbing the work of Skills for Care (an independent charity grant-funded by the government). The body would be tasked with developing a national people and skills plan, maintaining workforce and skills projections and advising on the appraisal and design of occupational roles in adult social care.

This could be a standalone body for adult social care, working in close partnership with the NHS. Alternatively, a joint workforce planning and skills body for health and social care could be created that would merge Skills for Care and Health Education England (which has lost its independence and is now part of NHS England). A joint body could ensure that workforce planning covered both sectors (for example, by ensuring sufficient training places for nurses and allied health professionals for both the NHS and social care); help align occupational roles and skills specifications between the sectors; facilitate career transitions; and support long-term moves to develop more specialist and senior roles in adult social care. On the other hand, having two separate bodies working in partnership might reduce the risk of social care being overlooked, given that any successor to Health Education England would focus extensively on the NHS, clinical roles and university education.

Locally, workforce planning and the delivery of people and skills strategies for adult social care and the NHS should take place on a joint basis between integrated care boards and local authorities. These activities should not be carried out by ICBs alone which are predominately focused on the NHS. Integrated care partnerships should oversee the work as part of their responsibilities for developing integrated care strategies. As part of this approach we propose:

- **Workforce planning:** local areas should be required to have a clear understanding of their future needs for health and social care workers, and a plan for supporting employers with recruitment and retention. This should include local sector-wide recruitment and education initiatives.

- **Training:** Local areas should develop arrangements for supporting the joint planning and delivery of training and continuing professional development covering all NHS and adult social care providers. This should include a specific responsibility to support the training and professional development of health professionals in social care settings and directly employed personal assistants.

- **Safe staffing:** Local areas should be expected to have plans to prevent unsafe staffing levels across all health and care providers – especially in serious emergencies (such as a flu outbreak). This could include contingency arrangements for employers to support each other and developing in-house employment agencies or 'people banks' to offer cover to all local providers.

2.5 Expand regulatory requirements for training and skills. Training and skills requirements within adult social care should be expanded to promote more training and accredited skills at all levels. A big shift in learning and skills in adult social care is only likely to be achieved through increased regulation. Achieving a care certificate when first caring with a registered provider should shift from being an expectation to a requirement. Providers should also be expected to provide training and continuing professional development to support advanced care competencies, digital skills, skills in supporting specific complex needs (eg people with dementia or with different communication requirements) and occupational specialisation. The detail of new requirements should be co-designed with people requiring support, care workers, commissioners, providers and training and qualification suppliers. Any new obligations could be implemented through more detailed specification of training and skills standards in CCQ regulation and guidance. Enhanced expectations for individual workers could also be introduced in time as part of professional registration arrangements (see below).

The design, marketing, delivery and funding of adult social care qualifications should also be kept under review. Training needs to be attractive and relevant to workers and employers for higher take-up and completion to be achievable. Accreditation of existing skills and modular learning should be prioritised to ensure that tougher standards do not impact on recruitment and retention. The use of standardised, externally assessed training will give care workers and providers trust in qualifications, avoiding the need for employees to re-do training each time they move employers because the latter lack confidence in training provided. Specific local, regional and national budgets to support training in the sector could be considered (eg city region initiatives to address recruitment and

retention challenges). However the default should be for employers to fund training and qualifications that are regulatory requirements and essential for the job. This could be achieved in part by converting the apprenticeship levy into a broader training levy that would contribute towards the cost of both apprenticeships and accredited, modular learning.

2.6 Introduce professional registration for the adult social care workforce on a voluntary or compulsory basis. An adult social care workforce register should be introduced on either a voluntary or compulsory basis. The two options to consider are:

- A voluntary and free national register of verified training and qualification achievements, occupational experience and DBS status that would be transferable between employers. This reflects and builds on recent government plans to develop a skills passport for the sector. This should smooth transitions between employers (learning from the emerging NHS staff passport).

- A compulsory register for all workers providing CQC regulated care and support. The initial purpose would be to bar people from the sector where serious conduct concerns are raised. Later the scheme could include requirements for qualifications or continuing professional development. Registration would be optional for directly employed personal assistants and people providing support not regulated by CQC.

There is broad support in the sector for the voluntary option, but different views about whether this should be a precursor to compulsory registration. The government has said it will explore the latter and we recommend detailed consultation before a decision is made. Scotland, Wales and Northern Ireland have all chosen the compulsory route and policymakers in England should examine their models closely, as a route to enhancing safety and quality, as well as increasing professional status and respect. However, several experts we spoke to said that ministers needed to clarify what 'problem' professional registration is intended to solve before adopting the compulsory option, so as to be clear that the benefits outweigh the costs and administrative burdens.

BLOCK 3: CO-PRODUCTION

The launch of a National Care Service creates the opportunity to embed the principle of co-production and accountability at the heart of adult social care. In developing the new service, at every stage, change and reform should be co-produced by those who need support and care to lead good lives.

Once the National Care Service is up and running, people's diverse needs and preferences should require that decisions are made as close to them as possible, with solutions genuinely co-created by those using services, their families, and empowered employees.

At local authority and national level, the National Care Service must be shaped by and held accountable by those who are affected by the decisions it makes.

What is co-production?

'People who use services and carers working with professionals in equal partnerships towards shared goals'
– Social Care Institute for Excellence

'Co-production' is when an individual influences the support and services received, or when groups of people get together to influence the way that services are designed, commissioned and delivered.
– Care Act statutory guidance

Proposals

3.1 Embed co-production into the development of the National Care Service. From the moment a new government is elected the National Care Service should be planned, implemented and further developed on the basis of co-production with people requiring support, carers and families (as well as with people working in social care at every level).

Incoming ministers should look to use deliberative techniques for developing policy, legislation and implementation. One successful model is the recent Engage Britain project which developed eight proposals for the care sector using a series of deliberative workshops. Citizens' juries and assemblies have also been used with considerable success in other areas of policy and in countries across the world.[58] More ambitiously, a new government could convene a 'People's Commission' to replicate the 'Royal Commission' that developed solution for adult social care 25 years ago. At least half of the membership of any such body should have lived experience of care and support.

3.2 Create co-production and accountability mechanisms at national level. Arrangements are needed to permanently entrench co-production at the national level:

- Create a duty for ministers to involve and seek agreement from people drawing on support, carers and families in carrying out their national social care functions. This could include a requirement that non-executive board appointments to all bodies with functions relating to adult social care include people who require support and/or carers.

- Establish an independent office for scrutiny, evidence and engagement with similar remit and powers as the Children's Commissioner for England. This independent office should be led

by people who draw on support and by carers; and should make arrangements for widely involving people in its work. It would be tasked with shaping the future direction of the National Care Service and so would have a more strategic, forward-looking and independent role than Healthwatch England (which is a committee of the Care Quality Commission). Individual complaints would continue to be handled by the local government and social care ombudsman.

- Following the initial implementation of the National Care Service from within the Department of Health and Social Care, consider transferring some or all of the department's adult social care functions to an arms-length executive body led by a board where the majority of members have personal experience of care and support.

3.3 Require co-production in the local planning and delivery of services: co-production is becoming increasingly accepted in the culture and practice of local social care, but further measures are needed to strengthen the principle:

- Revise legislation and guidance to require local authorities to involve people and seek their agreement across the whole spectrum of their adult social care functions. An end-to-end approach should stretch from co-production in local needs assessment, planning and shaping the provider landscape right through to day-by-day decisions about how support is co-designed and co-delivered with individuals. This goes well beyond current co-production responsibilities which mainly focus on assessment and care planning.

- Require local authorities to convene local co-production forums to involve people requiring support and carers in decisions and provide funding for peer-led organisations such as disabled people's organisations and carers' forums to enable them to participate in decisions and hold local authorities to account.

- Require integrated care partnerships and boards to co-produce decisions with people with support needs, carers and families and to put in place co-production arrangements to achieve this (either through guidance and direction or by revising the Health and Care Act 2022).

BLOCK 4: RIGHTS

Creating the National Care Service is a huge opportunity for the expansion and clarification of people's rights and expectations regarding care and support. A clear set of national entitlements, along with the tools to explain and enforce them, will establish citizenship rights as a core principle of a new national care guarantee. This will mark a significant departure from today's position where rights are opaque and implicit (because they are derived from local authority duties) and as a result support is covertly rationed.

We want to see rights and service expectations brought together in a citizen-facing National Care Service 'constitution' that presents a national care guarantee. The document should be co-produced with people who use support and their families and should restate more explicitly entitlements that already exist today but are often not realised – and set out how National Care Service partners can be held to account. Going further, there should be a new legal right to independent living that will help guarantee everyone the support they need to live a good life, in a place they choose, with the relationships and community they want.

Finally, more assistance is needed to help people understand and exercise their rights – as well as an accessible appeal process so people can challenge incorrect decisions.

There should be a new legal right to independent living that will help guarantee everyone the support they need to live a good life, in a place they choose.

The NHS constitution for England

The NHS constitution was first developed by the last Labour government in 2009 following a recommendation by Lord Darzi's 2008 NHS next stage review. It was developed following consultation but without an inclusive co-design process.

The constitution must be reviewed every 10 years and all NHS bodies are required have regard to it in all their actions. The constitution set out:

- Seven principles that guide the NHS
- NHS values
- Patients and the public: your rights and the NHS pledges to you
- Staff: your rights and NHS pledges to you
- Staff: your responsibilities

Proposals

4.1 Clearly specify existing rights and expectations. A new government should consider two approaches to the better specification of existing rights and service requirements. A non-legislative route should be progressed immediately, via the creation of a National Care Service 'constitution'. Going further there is a legislative option which would entail re-casting

opaque existing entitlements as clear legal rights. Politicians should therefore consider one or both of:

- **A co-produced National Care Service 'constitution'**. Modelled on the NHS constitution, this would be an accessible public-facing document setting out minimum rights, entitlements and service expectations for people requiring support and their carers. This would include entitlements derived from social care legislation and human rights law as well as non-statutory service commitments that would together comprise the national care guaranee. National and local government would be required to apply its standards.

- **Specify citizens' existing rights in law.** The Care Act could be revised so that it includes a statement of binding rights for people that would exactly mirror the duties that public bodies are already required to undertake (eg the right to an assessment or to receive support to meet eligible needs). At the moment people can challenge councils' actions but it is a long, unclear process.

4.2 Incorporate the UN right to independent living into domestic law. We support proposals to incorporate key elements of the UN convention on the rights of persons with disabilities into domestic law. In particular the Care Act should be revised to incorporate Article 19 of the convention – ie the right to live independently and be included in the community. This would entail introducing two new rights into domestic law (with corresponding duties on local and national government):

- **A right for disabled people to 'have the opportunity to choose their place of residence, and where and with whom they live'**. Introducing this right would mean that local authorities could not require someone to live in residential accommodation against their wishes on grounds of cost or convenience (or indeed deny someone a residential option on this basis either). This should help entrench the 'home first' ethos and the principle of independent living. This right would not negate provisions on detention under the Mental Health Act, or deprivation of liberty under the recently amended Mental Capacity Act, as each already embody human rights protections.

- **A right to assistance to 'support living and inclusion in the community, and to prevent isolation or segregation from the community'.** This would establish in law that local authorities cannot just meet personal care needs but must deliver care plans that support inclusion and prevent isolation. This would apply to adults of all ages and is a more explicit and robust requirement than the existing duty for local authorities to promote people's wellbeing. It has budgetary implications, especially for the commissioning of support for older people.

The Westminster government should consult with other UK nations on whether this right should be introduced in England only or on a four nations basis.

We also support the whole of the UN Convention on the Rights of Persons with Disabilities being incorporated into domestic legislation, as part of a broader project to introduce social, economic and cultural human rights into UK law. Any new human rights legislation covering issues such as the right to food, housing and healthcare should include specific provisions for disabled people based on the convention on the rights of persons with disabilities. This would create citizen rights and public duties drawing on the convention's articles and would apply to all public bodies. This topic is beyond the remit of a report on adult social care.

Article 19 – Living independently and being included in the community

"States Parties to the present Convention recognize the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community, including by ensuring that:

a. Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement;

b. Persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community;

c. Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs."

UN Convention on the Rights of Persons with Disabilities

4.3 Improve understanding and enforcement of rights. Significant action is needed to ensure people are able to understand, make use of and enforce their entitlements. Building on the clearer specification of rights that we have already proposed, the following measures to support people to use their rights should be introduced:

- **Improved provision of information, advice and advocacy**, with robust CQC assessment of how local authorities are discharging their existing duties (including requirements relating to accessible communications).

- **An appeals system** that quickly and fairly resolves disputes regarding eligibility and funding of care packages. This is already provided for in the Care Act but has never been implemented.

- **A new duty to commission peer-led support** from organisations led by people requiring support, to provide accessible advice, advocacy and support in using direct payments and employing personal assistants.

BLOCK 5: UNPAID CARERS

The National Care Service must always work in a way that recognises that the majority of support and care for people who require assistance is provided by unpaid family carers.

The service should assist and empower carers to be able to support and look after their loved ones, without this being at the expense of their own wellbeing or financial security. Carers should have a strong voice and their interests should be represented right at the heart of the National Care Service.

The National Care Service should fully assess people's support needs irrespective of whether they have an informal carer – as is required by the Care Act. Local authorities should then be required to discuss people's wishes and preferences about how much care they provide to a family member, and which needs they meet, so their decisions are sustainable and positive. As part of this, a carer's right to time away from their caring role should be better specified and realised.

In some countries including Germany, it is common for family carers to receive social care budgets as an alternative to formal care. In England direct payments can be used to pay family carers who do not live with the person requiring support, and in exceptional cases can be paid to a carer living in the same home if this is the best way to meet someone's needs. Few carers are aware of these provisions and they should be much better promoted. However, at this stage we do not support the general use of payments for carers who live in the same home as the person requiring support. This is a pragmatic judgement based on cost. We think the first priority should be to give carers real choice about how much they care by providing adequate formal care when it is needed, rather than expanding payments to carers outside of the social security system.

Broader changes are also needed to improve carers' financial security, health and wellbeing. While beyond the scope of the National Care Service, policy changes to improve life for carers should be progressed through a cross-government carer's strategy.

> The service should assist and empower carers to be able to support and look after their loved ones, without this being at the expense of their own wellbeing or financial security.

Proposals

5.1 Strengthen national strategy and leadership. The National Care Service Act we propose should require DHSC to produce a National Care Service carers strategy, co-produced with carers. This should then inform national guidance, the outcomes framework and CQC's approach to assessing providers and local authorities. One option would be to specify a benchmark or minimum level of National Care Service expenditure that ministers expect to be spent on support for carers.

5.2 Specify and promote carers' existing rights. Our proposal for a National Care Service 'constitution' should include an explicit statement of the entitlements and options already available to carers, some of which are not widely known or understood. In particular it should state that:

- **Choice:** Carers are not under an obligation to provide care and can choose how much care they provide (and local authorities must adjust support arrangements accordingly).

- **Payments:** Carers who do not live with the person receiving care can be paid to provide support using a direct payment (and all carers can be paid to arrange and manage care).

Consideration could also be given to specifying these rights explicitly in primary legislation, as with other citizen rights derived from local authority adult social care duties.

5.3 Require local authorities to discuss carers' wishes. A change in the law could improve clarity and understanding about a carer's right to choose whether, how, and how much they provide care. The Care Act says that councils must provide support except where needs are being met by a carer. It does not state that a carer is free

to choose what needs they will meet. The statutory guidance goes a little further and says a carer's willingness to meet needs must be recorded. Even this doesn't stipulate that choices and options should be explored with carers or that carers can change their wishes at any time. We think there is a case for an explicit duty for local authorities to discuss a carer's wishes when planning care packages. At the very least the statutory guidance should be revised on this point.

5.4 Introduce a right to short breaks for carers. Short breaks or respite care should already be widely available under the current funding and duties of local authorities (either as a way of meeting the needs of people requiring support, or to advance the wellbeing of carers). In practice very few respite breaks are recorded in the official statistics and carers' organisations have told us that awareness and take-up of short breaks is very low.[59] Sometimes carers have to battle to obtain time away from caring, even if it is crucial for their health and wellbeing or the sustainability of their caring role.

A new legal right to short breaks would help to drive change. It could be part of the wider right for carers to be able to make choices. For example the law could state that carers can express preferences about whether they can meet a loved one's needs for a particular period of time (not just on an ongoing basis).

5.5 Require other public services to pass carers' details to the National Care Service. 2.4 million people in England provide unpaid care for more than 20 hours per week but only around 400,000 receive support from local authorities.[60] Under our proposals for the National Care Service local authorities should come into contact with more carers as a consequence of improved access for people requiring support (see block 6: access). However the government should also make separate plans for the direct referral of carers to the National Care Service. This will increase access to carer's assessments and carer's support packages. In particular GPs, the DWP and children's services departments preparing a child's education, health and care plan should be required to automatically transfer data about carer status to local authorities (subject to data consent and security arrangements) so that the National Care Service can then contact carers who may need support.

A new legal right to short breaks would help to drive change.

A cross-government carers strategy

Beyond proposals for the National Care Service, a broad-ranging strategy for improving the lives of carers should be developed on a cross-government basis. Many of the possible elements are beyond the scope of this review. Ideas for consideration include:

- Improved support and recognition for carers within the NHS.
- An automatic right to flexible work at recruitment and from day one of employment.
- Paid leave for carers (going further than the week of unpaid leave the government is introducing).
- Higher carer's allowance (following developments in Scotland) and Universal Credit carer's payments.
- Paying carers half their former earnings for a year if they give up work to care (a recent proposal by the Fabian Society).[61]
- Making 'caring for a disabled or older person' a protected characteristic under the Equality Act.

BLOCK 6: ACCESS

The National Care Service should be designed to provide support that is accessible, consistent and for everyone, guaranteeing peace of mind and assistance to all who need it. Improved access to support must be one of the key changes people see with the creation of the National Care Service.

Eligibility should be determined on a nationally consistent, common-sense basis with more people entitled to help, at an earlier stage than today. Practices that delay or divert people from assessments should be stamped out. Packages of support also need to be sufficient to meet people's needs holistically, including participation in society.

Services should be made available rapidly when people have urgent needs, whether that is following a hospital stay or when at home. The NHS and the National Care Service should have joint responsibility for the hospital discharge process and the first six weeks of support after leaving hospital care.

Open-access community-based support, activities and home modifications that are focused on prevention, inclusion and wellbeing should be much more widely available. This will improve quality of life and prevent or delay more substantial support being needed. The National Care Service should offer information and open-access support to all adults receiving disability benefits.

Finally, support should be available to everyone with needs regardless of their means. The distinction between publicly financed clients and 'self-funders' should end with the National Care Service meeting the needs of everyone who wants support.

At a time when needs are already rising because of demographic change, these proposals have significant budgetary implications. Improving access to support and increasing the amount of support that some people receive will require an appreciable rise in spending compared to

today. As we saw in chapter three this extra spending is likely to result in an increase in labour market participation and tax revenues and in some savings to other public services particularly the NHS. However these financial benefits will not be enough to offset the extra spending. Ministers will need to consider what pace of change is affordable to deliver on the promise of expanded access to care and support.

Proposals

6.1 Expand preventive open-access support including home adaptations. Every community should have a good range of openly available wellbeing-related services and activities, that can be accessed regardless of whether people have been assessed as eligible for formal support. This is a core responsibility under the Care Act but has been severely underfunded, with the exception of housing-related adaptations and interventions. Councils should embrace new models that focus on utilising and building on the assets that neighbourhoods, families and individuals bring, as well as facilitating support from other public services, charities and businesses.

The National Care Service should progressively increase funding for home modifications including disability facility grants which provide major adaptations on a means-tested basis. It should also improve the marketing and delivery of this financial support to stimulate demand and improve efficient delivery.

The shift to early intervention can be achieved through national guidance and strategies, the national outcomes framework, and CQC assessment of local authorities. The share of National Care Service budgets spent on preventative activities should also be reported and monitored and ministers could consider specifying an expected minimum percentage of spending – ie top-slicing adult social care budgets for prevention. Areas should also be held accountable for the impact of their prevention-focused spending on the wellbeing and health outcomes of people with potential support needs using the outcomes framework.

6.2 Require DWP and NHS referrals of people with possible support needs. Public services should be required to work together to identify people who have existing or emerging support needs. GPs should be expected to identify people who may have support needs and pass their details to the National Care Service (with appropriate arrangements for data consent and protection). The DWP should be required to do the same with people receiving disability benefits benefits in England.

As part of the National Care Service, local authorities should be required to develop an 'early help' service that proactively contacts people identified as having potential needs by DWP and the NHS. This service should offer people information about open-access support in the community and personalised advice on how to effectively spend disability benefits to maintain independence.[62] It should also screen people to identify those who are likely to have eligible needs for care and support and refer them to a full assessment. Eventually this service could be offered to all age groups but it is likely to be of particular benefit to older people as they acquire support needs, so could initially be targeted at people over the age of 70.

6.3 Establish earlier and more consistent eligibility for support. The process for determining eligibility for support should remain a local function. We do not believe there is appetite for a rigid national eligibility system, given widespread concerns about the operation of disability benefit assessments. A national assessment would also be detached from broader local conversations about options for support and care planning.

Having said that, under the National Care Service, local authorities should be expected to conduct nationally consistent assessments that result in more people being found eligible than today. We hope it will be possible to secure earlier, more consistent access to support using the existing Care Act regulations on eligibility. A common-sense reading of the current law suggests that far more people should be eligible for support than is now the case.

In addition to more money, policy interventions are needed to prevent gatekeeping and delays prior to assessments and to secure fair, consistent decisions. These could include CQC assessments of local authority practice; using the national outcomes framework to monitor and benchmark key measures (eg requests for assessment, waiting times, numbers of assessments, decision outcomes); revising statutory guidance; developing a national decision-making tool; introducing professional practice standards for decision makers and adult social care leaders. These measures should be tested for a reasonable period and then reviewed. If they fail, then consideration could be given to changing the eligibility regulations themselves (eg to reduce the scope for subjectivity in decisions).

Local determinations of eligibility should trigger a national entitlement to support from the National Care Service. Assessments should be transferable between local authorities creating a right to support in any place in England where someone chooses to live. Local authorities would be required to accept eligibility determinations for incoming residents to provide people peace of mind when planning to move home.

6.4 Introduce packages of support that better meet needs and enhance independence. Under the National Care Service, care planning and resource allocation should provide many people with more support than they get today. The Care Act and its statutory guidance

are designed to achieve person-centred support that promotes wellbeing. But a big shift is required to make care and support plans more ambitious and their associated personal budgets more realistic:

- The Care Act and its related guidance on care and support plans should be properly applied. This requires increasing local authority budgets as well as appropriate national direction via government strategy, the outcomes framework and CQC assessment of local practice.

- The new right to independent living that we propose should result in local authorities reconsidering the sufficiency of their care and support plans (especially to ensure they promote inclusion and prevent isolation). This right will also prevent councils from insisting on a particular form of accommodation on grounds of cost (see block 4: rights).

- Our proposal for a national framework for the fair pricing of care should frequently result in higher personal budgets (see block 8: providers). This is already the intention behind the current government's fair costs of care initiative. Realistic resource allocation should apply to all forms of commissioned provision and to direct payments.

In determining care and support plans and resource allocation local authorities should still be able to balance the needs of different residents and take account of their own financial constraints. Councils should be able to choose between the cheaper of two similar ways to appropriately meet someone's needs, as long as they involve the individual in the decision and promote the new right of appeal.

6.5 Make the NHS and local authorities jointly responsible for meeting health and care needs after hospital discharge. The NHS and the National Care Service should have joint legal and financial responsibility for assessing and meeting health and support needs for six weeks after someone is discharged from hospital. This builds on the widespread practice of jointly commissioning and delivering intermediate care and rehabilitation, as well as government guidance on hospital discharge issued in 2022.[63] The requirement should cover all support provided to people discharged from hospital to their own home or a care home (whether or not the support is focused on rehabilitation). Local authorities should be exclusively responsible for the resumption of ongoing care that was already in place before the hospital admission. All new support should be free during the six week period following discharge (as is already the case with intermediate care). By creating clarity and shared responsibility, this proposal will help reduce delayed hospital discharge.

6.6 Arrange services for everyone regardless of means. The National Care Service should be designed to assist everyone who has support or care needs irrespective of their financial position. This will end the current distinction between people who are publicly funded and self-funded.

Local authorities should carry out assessment and care planning functions for anyone in their community who may have support needs, and then provide or arrange assistance for them. This will provide confidence and peace of mind to individuals and families who, without assistance, frequently lack the knowledge, experience or market power to select and put in place good support at a fair price. This care planning function should also encompass prevention-focused interventions, home modifications and technology.

Under this reform people receiving care and support outside of care homes would become protected by the provisions of the Human Rights Act and would be able to hold providers to account for breaching their fundamental freedoms – replicating the existing protections for those who are publicly funded or who live in care homes.

Our proposal builds on the government's delayed plan for implementing the Dilnot reforms. This already requires local authorities to assess eligibility and determine a (notional) personal budget to use in calculating when the limited liability cap is reached. Support is however only to be arranged if requested and associated management fees can be charged. Our alternative assumes that everyone with assessed needs will be offered commissioned services or a direct payment unless they actively opt out. They may need to pay for the provision but help to arrange the service should be free.

This approach will offer better value for the taxpayer than the government's 2022 plans. These would have incurred the cost of assessment and resource allocation for people who are currently self-funders. But much of that money would be wasted since many of those receiving an assessment would never reach the Dilnot cap and benefit from public support. Our alternative would add a little to the costs by introducing free care management as well as assessment. But it would provide a real benefit immediately, not a hypothetical future gain, because local authorities would manage everyone's support arrangements from the start.

- **Home care.** For care in the home there is in fact little difference between this plan and the envisaged post-Dilnot landscape. Under the government's reforms, most people who need support at home will be entitled to some financial help from local authorities and will be covered by the public system. This is because the revised means-test would offer support to people with up to £100,000 of capital excluding their home (see block 9: affordability).

- **Care homes.** There is a greater difference between this proposal and the government's plan when it comes to care home residents. We recommend that local authorities should help almost everyone to choose a care home, secure a fair price, and manage the contract. This would apply even to residents who were not immediately eligible for financial assistance because they have significant assets.

As with the government's plan, our proposal would create capacity and workforce demands for local government. More skilled workers would be required to assess and support an expanding caseload, albeit aided by improved technology and more efficient working practices. Training for social workers and other roles with the skills needed for these tasks would need to feature in local and national workforce and skills plans.

People who would have once been self-funders would still have choice over providers, including between care agencies, care homes and directly employing staff. If they wanted to spend more than a local authority would normally approve (eg on premium residential facilities or extra hours of assistance) a local authority could still arrange the service on their behalf if desired. All services arranged by councils would fall under National Care Service contracts, bringing the large majority of individuals and providers under the new service's umbrella. A small minority might choose luxury private-only provision along the lines of private healthcare or education.

People will be able to direct and control their support as much as they wish, including by employing personal assistants using direct payments.

BLOCK 7: MODELS OF SUPPORT

The National Care Service should enable personalised and joined-up support with individuals and families in control.

Our proposals are designed to create the enabling conditions for empowered individuals, families and employees to design and co-produce personally tailored solutions to help people live the life they choose, in the places they choose, maximising wellbeing, health and independence. Thousands of people involved in adult social care already share a vision for these models of support. The National Care Service will enable them to deliver it.

The support available under the new service will include long-term assistance for those who need it, time-limited interventions designed to increase independence and capability, and open-access preventative services. Secure funding including access to investment will allow people requiring support, commissioners and providers to work together to develop new approaches. Innovation, experimentation, and a learning culture will see the wide diffusion of new models of support and new enabling technologies, with the government having a key role in supporting the evaluation, communication and adoption of effective new practice.

People will be able to direct and control their support as much as they wish, including by employing personal assistants using direct payments. Skilled professionals tasked with providing peace of mind will also be there to plan and coordinate support based on people's unique and changing circumstances and preferences, and independent peer-to-peer organisations will be available to provide advocacy and support in making decisions.

Support from the National Care Service will often be fully integrated with housing or with community and primary healthcare, with institutional boundaries and silos largely invisible to individuals and families. Joined-up support and services will meet requirements spanning health, care, practical support and housing-related needs, often with a single individual co-ordinating everything. Support will be designed so that people can live safely, remain resilient and regain capabilities both to maximise their wellbeing and reduce need for emergency or acute NHS services.

Proposals

7.1 Develop national strategies promoting effective care models. National guidance and strategies, the outcomes framework and CQC assessment should all push local commissioners to shift the balance of services over time. All of these should be co-designed with individuals requiring support, the adult social care workforce and providers. In this way national strategic leadership can steer and support local choices on innovation and new forms of provision. This would be analogous to the role played in healthcare by the NHS long-term plan today or by the national service frameworks produced by the last Labour government. Examples of models to promote include: more joint health and care teams for people in the home with high needs; increased use of direct payments; new models of housing with care; and open-access preventative support focused on personal and community assets.

7.2 Improve research and the gathering and application of evidence: The government's national responsibilities should include supporting research, evidence and the take-up of innovation, working closely with NICE and the CQC as well as independent partners such as the Social Care Institute for Excellence, Think Local Act Personal and IMPACT. Evidence to support new models of care and specific practices should be developed and promoted. This role should also include developing and promoting evidence on better planning and commissioning. For example, the government should evaluate commissioning practice that rewards providers for achiev-

ing outcomes rather than undertaking specified tasks. This can create broader autonomy for providers and individual practitioners to work with individuals and families to maximise wellbeing and respond to preference.

7.3 Support take-up and use of direct payments. National guidance should promote the take-up of direct payments and discourage unnecessary restrictions on their use. The growth of direct payments has stalled in recent years. We were told that this is partly because local authorities do not always provide sufficient flexibility or support in how direct payments can be used. It is also because budgets are not being set at a realistic level, with people questioning whether they can secure independence and personalised support with the money they are offered. This challenge can start to be addressed as part of the 'fair cost of care' process by increasing personal budgets as well as provider prices.

Peer-led organisations should also be funded to support people to use direct payments. This must include guiding people on how to be lawful and ethical employers of personal assistants. Cooperative models should be encouraged to create the infrastructure to jointly employ personal assistants.

7.4 Promote joint delivery of health and care to people with significant clinical and support needs. While we think adult social care and the NHS should remain separate services, specific care pathways or forms of support should be jointly commissioned and provided (where this is not already happening).

We have already proposed that healthcare and social care should be a joint legal and financial responsibility in the six weeks following discharge from hospital, building on existing practice with respect to intermediate care and rehabilitation. In addition, local areas should routinely have a joint approach to commissioning health and care support for people with high support and clinical needs living at home, and primary and community healthcare for care home residents.

When it comes to integration, joining up support for individuals with complex needs is the priority, not area-wide whole-system mergers. People with significant support and clinical needs should receive care from a joint team with a named care coordinator and there should be data sharing and communication between everyone involved. Commissioners could also explore outcome-focused commissioning where a single provider is tasked with delivering good health and wellbeing over time for an individual with complex needs.

This will require the NHS to step up. It will not be possible to achieve better outcomes for people with high support needs unless the NHS commits more resources to community healthcare, intermediate healthcare, primary care in care homes and hospital at home provision. As part of this there needs to be more NHS commissioning of short-stay beds for rehabilitation.

7.5 Promote models of housing with care. A major expansion of housing with care and supported living schemes is a high priority. The UK has far less specialist housing for older people than many comparable countries, and what is available often does not provide sufficient support to prevent care home admissions when people's needs grow more complex.[64] Similarly, more independent living schemes for younger disabled people are needed as part of the 'home first' philosophy to avoid the need for residential accommodation if possible. We also need more capacity simply to accommodate the growing levels of need that will arise during the next decade.

Local government adult social care and planning departments should take joint responsibility for assessing, planning and delivering new supported housing requirements (as well as traditional care home provision). They should encourage providers to make their own investments in new capacity, and facilitate access to a National Care Service capital investment fund (see block 10: money). We envisage this fund being particularly important for supporting public sector and non-profit development at scale.

To ease planning constraints, the government should also consider a new planning use class of 'housing with care', so that local planning authorities would be required to identify and deliver an adequate number of housing with care and independent living units to meet population needs.

7.6 Improve use of data and technology. The creation of the National Care Service is an opportunity for a huge step forward in the use of technology and data in adult social care. The sector's practice is far behind other public services, although significant advances have been made since the start of the pandemic. Leaders in the sector are working together to improve the design and application of technology, for example through the technology enabled care action alliance. The government's health and social care data strategy also sets out a vision for using data to improve people's experiences of support as well as planning, commissioning and strategy functions.[65] The key elements of the strategy with respect to adult care are: improving access to information for adult social care providers; integration of health and social care data; and expanding the use of data from care technologies. The Health and Care Act 2022 also creates new powers for the government to require providers to supply data.

The National Care Service should aim to secure ambitious technology solutions that support people to lead fulfilling, independent and connected lives. This should be based on a clear account of what technology can do, and what people should expect – developed through co-production with those who need support. Locally and

nationally the National Care Service should partner with and shape the independent living technology market and promote the application of mainstream technologies in care and support contexts, with the aim of achieving more holistic and personalised care, tackling isolation and loneliness, and reducing safety risks.

Progress can be advanced by supporting research and development networks to share innovation and best practice – with government bodies, technology companies, social care providers, carers and people requiring support all involved. Many technology solutions are cheap and prices continually fall. But where money is a barrier to adoption, commissioners and providers should be able to access grants or loans from our proposed National Care Service investment fund (especially when there is a clear invest-to-save case).

To bring the potential of technology-enabled care to life people requiring support, carers and social care workers need support to use technologies, including help with digital skills, access to fast, reliable internet and technology-specific assistance relating to adoption, maintenance and speedy troubleshooting. Robust data security and appropriate consent arrangements are also essential to maintain trust, especially in the case of data about people at risk.

The National Care Service will be able to promote a standard national approach to data that can support improvements in the quality of data and intelligence for evaluation, planning and commissioning. Individual, provider and commissioner level data should be brought together to provide a comprehensive picture covering issues including levels of need, activity and outcomes, and information about providers and workforce. Building on current developments, the National Care Service will be able to specify consistent, flexible nationwide data collection standards, supported by real time electronic record-keeping.

Examples of technology-enabled care:

- Apps to support behaviour or lifestyle changes
- Case management and assessment tools to reduce cost and improve decisions
- Digital communications and apps to maximise social connections
- Coordination and information sharing between everyone providing an individual care and support
- Digital tools to manage direct payments
- Integrated care record with data from all providers
- Local or national analysis using anonymised individual data for evaluation and service improvement
- Location detection to maximise liberty for people with impaired cognition
- Movement sensors to detect falls or health emergencies
- Prediction of risk and proactive intervention using personal and population data
- Remote appointments with practitioners
- Remote health and diagnostic monitoring
- Workforce planning and rostering tools

BLOCK 8: PROVIDERS

The National Care Service will bring together more than 10,000 care providers under a common umbrella and a common brand, with shared goals and standards. There will be a wide diversity of provision, organised through stable partnerships, with a level playing field between high-quality public, non-profit and private provision.

Independent providers will have stable contracts to deliver National Care Service provision as licensees discharging a public service. Instead of commissioning individual packages of care, local authorities will pay providers for ongoing capacity, or better still to achieve specified outcomes. For providers there will be a fairer, more certain financial relationship but also significant new requirements regarding workforce practices, collaborative working, branding, and high financial standards to ensure public money is spent on better social care outcomes. Licensed independent providers

Independent providers will have stable contracts to deliver National Care Service provision as licensees discharging a public service.

will mainly deliver National Care Service provision because local authorities will be commissioning services for almost everyone requiring support (the old distinction between publicly funded and self-funding clients will no longer apply).

Rather than a competitive, and at times antagonistic, relationship providers and commissioners will work together on the basis of collaboration, with long-term relationships and a high degree of coordination. Providers will not compete on price but work together to improve quality and value, so the terminology of the care 'market' will no longer be relevant.

Over time local authority commissioners will be able to choose to shift the balance between private, non-profit and public sector provision if they wish.

Proposals

8.1 Establish stronger public service relationships with 'licensed' independent providers. Providers who are commissioned to deliver care and support by local authorities should become licensed partners of the National Care Service. This would involve ongoing, stable financial relationships rather than spot purchasing of places, drawing on models used in other public services – eg bus franchises, academy schools and GP surgeries. For example, Transport for London uses private delivery partners but tightly stipulates the service provided. Academy schools are independent charities but have detailed funding agreements specifying how they must act.

As local authorities will arrange support for people regardless of their means (unless they opt out) most providers can expect to see the large majority of their clients placed with them by councils. The old distinction between local authority and self-funding clients will therefore largely disappear for providers licensed under the National Care Service. Services will be jointly branded, so that individuals and families can easily identify when they are receiving support as part of the National Care Service. Individual providers will also be able to maintain their own branding to signal their organisational identity, values and reputation.

All licensed providers will be required to meet high care standards; employ people in compliance with National Care Service terms and conditions; collaborate with other providers locally; allow trade unions access to employees; be subject to freedom of information and Human Rights Act requirements; and comply with financial transparency and conduct requirements that prevent profiteering. This would build on practice that already exists in many places such as the living wage standard and UNISON's ethical care charter. Commissioners will retain the ability to terminate relationships with providers, if there are clear quality, transparency and probity concerns.

8.4 Promote public sector and non-profit options. Local authorities should be free to make choices about what balance of provision should be provided by public bodies, non-profit organisations and private businesses. In particular, commissioners should be able to prioritise the development of new capacity in the non-profit and/or public sectors, while also continuing to work with existing for-profit providers. This would mean that as the supply of local care and support services expands over time, the balance between types of provider might shift.

Commissioners should be able to exercise a preference for commissioning non-profit, mutual or peer-led provision where they are clear this will deliver good outcomes for individuals and broader social value. Non-profit providers frequently deliver high quality services that are well integrated into wider networks of support. Specialist non-profit providers are also well placed to meet specific needs, for example for people from particular religious groups or who are LGBTQ+.

Councils should also have flexibility about when to deliver a service through the public sector – either in-house or by commissioning another public body, such as an NHS provider or joint health and care provider. Commissioners will often wish to expand public delivery in order to:

- Develop integrated health and care teams – eg for emergency responses, hospital discharge, people with high clinical and support needs living at home.
- Quickly develop new provision to reflect rising need.
- Reduce the overall cost of delivering and arranging a service.
- Test new service models to influence the local provider landscape.
- Take over a service following financial failure or unacceptable quality.
- Develop in-house capacity and expertise to be positioned to manage future services as needed.

Statutory guidance (and if necessary legislation) should be reviewed to ensure that the existing duty to promote diversity and choice in provision does not prevent commissioners from opting for public sector and/or non-profit providers. Any review should establish that decisions to take services in-house cannot be unreasonably challenged; and consider how best to support greater diversity of ownership structures, including more non-profits, cooperatives and mutuals, and publicly owned social enterprises.

Future ministers should also consider whether local authorities should have stronger powers to act as a 'provider of last resort' in the event of business failure or a service being de-registered by CQC on grounds of quality or safety. At present councils have a temporary duty to meet

needs if a provider fails. Local authorities could also be given a power to permanently take over the operation of a care facility or the employment of relevant staff.

8.3 Strengthen local partnerships. Local partnership bodies should be established in every area bringing providers, commissioners and workforce representatives together to coordinate on issues such as new models of support, quality and innovation; projecting demand and planning places; fair standardised prices; and workforce issues including numbers, training, recruitment and retention. This will be long-term planning of local capacity and mix of provision, with commissioners and providers working together, alongside representatives of people requiring support and carers.

Under the National Care Service, local authorities will fund or arrange most care and support as an integrated public service. In this context the language of the care 'market' may come to seem outdated, since the aim of what is today called 'market shaping' will be to secure choice and flexibility using providers funded and arranged by local government. Once these commissioning reforms are bedded in, ministers should consider how existing 'market shaping' duties might evolve to reflect the new landscape where providers and commissioners collaborate in long-term partnerships; and where most services are commissioned by councils or purchased using publicly funded direct payments. This could entail revising section 5 of the Care Act ('promoting diversity and quality in provision of services') or associated statutory guidance.

8.4 Implement the standardised pricing of services. As part of the National Care Service there should be a national framework for determining fair provider prices using national, local and provider level data on costs. This would build on the government's fair cost of care exercise and the Homecare Association's minimum price for homecare. Prices should reflect the cost of efficiently providing services in a locality, including return on investment and a modest surplus. Providers and commissioners should be consulted on the pricing framework and annual updates, and decisions should be robust and evidence-based. As things stand there is wide divergence between the government and the sector's view on the degree of underpricing in the system and this will need to be resolved.[66] The government should also guarantee that the system will remain in place over many years so that providers can rely on it to make investment decisions (see block 10: money).

Nationally, DHSC should annually update a framework for calculating prices to take account of changing nationwide cost inputs. In particular, annual increases in payroll costs under our proposed National Care Service terms and conditions will need to be accounted for. The process of updating the price framework therefore needs to be aligned with national pay setting procedures and the allocation of funding to local authorities. External scrutiny of the process should be provided by the National Audit Office or the Labour party's proposed Office for Value for Money.

Locally, commissioners should be required to develop their own local versions of the pricing framework, by applying data on local cost variations in a reasonable and transparent fashion. This will mean providers will not need to compete on price and will be able to focus on improving quality and collaborative working. A process for providers to challenge decisions should be established – eg a mechanism for triggering compulsory reconsideration or conciliation between commissioners and providers.

Price setting need to take account of the complexity of people's needs, and what this may imply about skills requirements or staffing levels. For example, these days most care home residents have very high needs and require much more support than 10 or 20 years ago. Some types of adult social care service are sufficiently uniform that they can have a standardised local price. However, many services or packages of support are unique and should be priced on a case-by-case basis, using suitable data on payroll and premises costs.

8.5 Strengthen the financial supervision of providers. Independent providers of public services should be held to high standards regarding financial transparency, probity and value for money. For many years the business practices of some large for-profit care providers have been a source of disquiet – with leveraged debt financing, offshore corporate structures, tax avoidance and excess profits. There are also concerns that providers are not viable and could collapse in a disorderly manner without safe arrangements for continuity of care.

Today the CQC has a responsibility to monitor the financial viability of large providers. The purpose of this regime is not to intervene to prevent failure but to warn local authorities so they can prepare to meet people's needs should an operator collapse. This narrow remit contrasts with the Regulator of Social Housing which supervises social housing providers broadly with respect to financial viability and value for money and has significant intervention powers.

As part of a National Care Service, new requirements on financial conduct should be introduced. This is not just to address current concerns but also because we propose higher and more predictable fees for providers. In exchange for this the taxpayer needs confidence regarding the appropriate use of public money. Stronger financial supervision should sit alongside a framework for fair pricing.

This more managed approach to provider finances would make the adult care sector look more like social housing or regulated and franchised utilities. Detailed consultation will be required to develop a new regime learning from these sectors and overseas experience.

The system should cover financial viability, value for money, conduct and transparency. The consultation should include questions on where providers are domiciled for tax purposes, corporate structures, debt financing, tax avoidance schemes and excess profits.

- **Large providers.** We recommend that enhanced financial regulation be introduced for the large strategic providers currently included in the existing CQC market oversight regime (ie around 50 providers at present). People we spoke to had different views on who should be responsible for this regulation, with options including CQC, the DHSC or another institution. The right answer will probably depend on how extensive the regulation turns out to be: an evolution of existing requirements would suggest the CCQ (meaning that a single regulator would be responsible for quality and financial practice); a more complex regime might require a specialist financial regulator. Regardless, some additional resource and staffing will be required to ensure that the regulator can set, monitor and enforce financial standards properly.

- **Local providers.** Local authorities should be responsible for the financial supervision of smaller providers, with a light touch set of requirements focused on financial viability, value for money and financial conduct. In carrying out this function they should take a proportionate, risk-based approach. Their financial supervision powers should operate alongside their responsibility for setting fair local prices, with the aim of striking a balance which, in the case of well-run services, achieves financial viability without excess profits. The government or CQC should issue guidance on how to discharge this role consistently and proportionately.

BLOCK 9: AFFORDABILITY

There is an understandable and widely held desire to reduce charging for adult social care at the point of need. Whether people are disabled for their whole lives or have long-term needs in old age, no one chooses to have social care costs. In principle there is a strong argument for the costs of support and care being shared across society through taxation, as with other public services.

But charging reform is only one of several potential priorities for extra spending and any reforms need to be balanced against competing pressures and introduced in the context of the government's overall financial position. That means for the foreseeable future, there will be a mix of adult care services that are free of charge, and services that require a financial contribution.

But support must always be affordable for people given their circumstances. Finance must never be a barrier to accessing the help they need to live independently and well. Reforms should be progressively introduced to improve affordability and the pooling of risk over time.

The approach the next government takes to charging will in part depend on the legacy it inherits. The Dilnot charging reforms are currently scheduled for implementation in 2025/26 and their cost forms part of the financial baseline that ministers will inherit. If the planned timetable is confirmed future ministers should see the reforms through. If they have been abandoned or delayed again a new government may wish to consider whether other charging reforms are higher priorities by conducting a short, sharp review and co-design process. A lengthy external commission should be avoided.

Support must always be affordable for people given their circumstances.

Proposals

9.1 Take immediate steps. If implementation of the Dilnot charging reforms is underway, an incoming government should continue with the package, based on whatever timescale and funding has been announced. The two key elements of the reforms are changes to the assets means-test and the new limited liability cap. We also propose some immediate reforms to the charging system which would be low-cost and make it work more effectively:

- Make all short-term support and care free, especially during the first six weeks after hospital discharge (this removes ambiguity since most of this support is free now).

- Annually uprate thresholds in existing means-testing rules (ie capital rules, minimum income guarantee, personal expenses allowance).

- Reform the disability facilities grant means-test (following the government's commitment to consult on this issue).

9.2 Consider one or more charging reforms to coincide with the National Care Service launch date. The National Care Services is a new 'offer' to the public and from its launch it should ideally include a new offer on charging, as part of the national care guarantee. In particular, as a new service for everyone regardless of means, it should seek to offer most people at least some financial support. We therefore think future ministers should consider one or more of the following options (depending on whether the first two below have been inherited from the existing government):

- **Reform the asset means test** as proposed by the existing government – ie public support available to people with assets of up to £100,000 (excluding the value of the home when the individual or their partner lives there).

- **Introducing a lifetime cap on care costs.** Ideally payments towards the cap should include both local authority and personal contributions as provided for in the Care Act. Under the government's 2022 version of the reform only private payments were to count, which meant that people with assets just over the cap could eventually pay almost their entire wealth in care fees.

- **Introduce a universal contribution** to adult care costs so everyone with support needs receives some financial help. This would bind former self-funders into the new public system and create a financial incentive that would induce take-up among people currently not receiving any support. Options could include a weekly cash contribution (of say £25 to £50), a percentage contribution to the cost, or a weekly charge cap (as with home care in Wales).[67]

- **Reform the income means test.** Options include exempting disability benefits from home care charges (replacing complex rules exempting 'disability related costs'); and/or increasing the 'minimum income guarantee' (especially for people aged under 65) and 'personal expenses allowance'.

- **Expand the scope of free support.** In our view this should start with people who have disabilities acquired at birth or early in life. For example, care could be free for people requiring support by the age of 25 (as proposed by the coalition government). Charges would be made for daily living costs in residential accommodation.

At the launch of the National Care Service we hope it might be possible to introduce one or two of these measures.

9.3 Progressively introduce further charging reforms in the years that follow. Over time, ministers should then consider further charging reforms. Ideally they should develop a timetable of further charging changes so that people will know that the affordability of support will improve over time.

Improvements to affordability could be achieved by continuing in the directions already outlined above. The value of our proposed universal contribution could be increased. The lifetime liability cap could be reduced over time or frozen in cash terms. Or the scope of free services could be expanded up the age range.

Another option for extending the scope of free services was proposed by the 2014 Barker commission.[68] This is to make all support free for people assessed to have the very highest needs. This would in effect relax the conditions for NHS continuing care by providing free services to more people with very high medical and care needs. In exchange, daily living charges for continuing healthcare in care homes could be introduced for new beneficiaries.

There is one widely discussed reform that we do not support. This is to introduce free 'personal care', which was proposed by the 1999 Royal Commission on Long Term Care and is available in Scotland. Making a distinction between meeting 'personal care' needs and needs relating to wellbeing and social inclusion contradicts the direction of adult social care policy for well over a decade including the Care Act 2014. In fact, experience in Scottish care homes suggests that 'free personal care' ends up being an arbitrary financial contribution that may well be insufficient to meet even personal care needs. We think it would be more straightforward to offer a defined government contribution towards meeting any care and support need in order to maximise people's control and choice.

BLOCK 10: MONEY

Setting up the National Care Service as a brand and a set of institutional arrangements will require very little new money. The main costs would be a public-facing website and a modest expansion in the number of officials working on adult social care in the Department for Health and Social Care and arms-length bodies.

On the other hand delivering on people's aspirations for what a National Care Service should achieve will require a very substantial increase in public funding over many years. This is not mainly to finance new laws or policies but to adequately discharge existing responsibilities that are grossly underfunded today – and have been for some time. Some of this money is bound to be provided by ministers from any political party to avert dangerous service failures. But the creation of a National Care Service is intended to trigger extra resources to better realise existing responsibilities.

A number of the individual policy changes we propose also require new money – though it is important to emphasise that this accounts for a small fraction of the future funding requirements for adult social care. These new entitlements and responsibilities should be introduced progressively, as overall resources allow. They should be fully and explicitly funded in rising local government spending allocations.

Setting up the National Care Service as a brand and a set of institutional arrangements will require very little new money.

Ideally an incoming government would approve a significant one-off increase in adult social care spending to make up for years of underfunding. However, given the financial pressures a new administration will face we don't think it is realistic to expect a short-term jump in spending on the scale that is needed. Instead, we propose a long-term approach to funding with a 10-year plan for large, sustained real-terms spending increases. This will provide the certainty to plan, build institutional capacity and invest.

What we have in mind is a steady and enduring increase in spending not an instant sugar rush. However, we know that when new ministers come into office an immediate spending rise may well be needed to prevent services from collapsing. This will mainly be focused on arresting the current workforce crisis. There may also need to be a one-off jump in spending when the National Care Service goes live to fund new legal entitlements. We suggest this could happen in 2028/29.

The creation of the National Care Service should also lead to sweeping changes to the way money is allocated for care and support. This would entail reforming the distribution of funding to local authorities and the creation of a capital investment fund. Although reforms to local government finance are technical changes relating to the internal plumbing of the public sector, they are among the most far-reaching steps required to create a fair and consistent National Care Service.

Proposals

10.1 Prioritise 'year one' stabilisation spending. An incoming government should plan to immediately raise spending to secure service continuity. This should primarily focus on resolving the workforce recruitment and retention crisis by improving minimum pay from April 2025 (see block 2: workforce). When making this commitment ministers should be clear that any extra spending is only a beginning and is not sufficient to address the financial pressures facing the sector.

10.2 Make a 10-year spending commitment. The prime minister and chancellor of the exchequer should make a long-term promise to increase real terms funding for adult social care by a significant percentage each year. The exact spending figure should be informed by an independent assessment of cost pressures in adult social care commissioned from the Office for Budget Responsibility, the new Office for Value for Money proposed by the Labour party, or from the independent National Care Service scrutiny body we propose in this report.

The long-term spending pathway the government commits to should take account of the amount of money needed to adequately discharge existing responsibilities – ie responding to rising demand; providing earlier, more consistent access to care; ensuring packages of support are sufficient to meet needs; and achieving sustainable workforce pay and provider viability.

It should also account for the costs of any new policies adopted as part of the National Care Service reforms – ie charging reforms, new entitlements, alignment of social care and NHS pay and conditions over time. There will be a particular need to increase spending in the financial year new National Care Service entitlements and responsibilities are unveiled (which might be 2028/29).

10.3 Phase in a national funding formula and National Care Service grant. Under the National Care Service, local authorities should receive funding through a new national grant. Funding allocations should be based on population need and the cost of adequately delivering care locally, to be established using a national needs-based formula. Local authorities would be free to supplement this budget or to pool it with other public service budgets (to deliver integrated support including with the NHS).

Details of the new system should be co-designed with local government in the context of wider reforms to local and devolved financial powers. A formula to determine 'spending power' should be based on principles and methodologies informing the current government's delayed Fair Funding Review or the last Labour administration's pre-2006 local government finance system and use up-to-date, neighbourhood level data. The new formula would be likely to significantly improve the relative financial position of councils with high population need and/or low revenue raising capacity.

The 'spending power' formula should then be used to allocate:

- EITHER a 'top-up' grant that would pay the difference between assessed financial need and an assumed local revenue contribution from council tax and locally retained business rates. This new grant would absorb existing grants for adult care and support.

- OR a freestanding 'designated' grant to cover the whole of an area's spending requirement (or all but the income assumed from a council tax social care precept). This standalone allocation would follow the model of NHS funding or the designated schools grant.

Most people we spoke to preferred the 'designated' model. This is because today there is a large mismatch between 'assumed' local revenue and the amounts councils raise in practice. This means that the 'top-up' option would not actually deliver parity in spending power for the foreseeable future. The 'designated' option would however require wider reform of local government finance because adult social care is such a large proportion of overall council spending. In particular it would be necessary to renationalise most or all of business rates revenue to secure sufficient resources to

fund this larger version of the grant.[69]

Either of these changes to local government grants will need to be introduced with transitional arrangements to support areas that are currently 'overspending' compared to their calculated spending need. Year one grants should be based on existing levels of spending, to be followed by gradual convergence over a number of years to formula-determined spending allocations. This process would use 'ceilings' and 'floors' for each area's yearly percentage budget increase. High overall national funding increases will make this process faster to implement without areas that are 'losing' (compared to the national average) facing real-terms cuts. Financial inequalities could therefore be closed sooner than has been the case with other public services over the last decade.

10.4 Support long-term investment. Long-term policies are needed to increase capital investment in adult social care (and in housing with care). Otherwise investment is only likely to come from large for-profit providers with access to private equity or other speculative, high-risk capital. Measures are needed to generate a large increase in adult social care capacity, while also ensuring that a wide diversity of providers can invest at scale. To achieve this the care system will need to draw on a broad range of sources of capital including bank finance, pension funds and public investment. We propose two approaches:

- **Long-term certainty on pricing.** Providing predictability regarding the future pricing of care services will permit a significant increase in private investment through bank lending and patient capital (eg pension funds). Earlier we proposed a nationwide framework for determining fair prices based on evidence of costs (block 8: providers). This should include an allocation for costs of capital. In developing the pricing framework the government should make a 10-year commitment that prices will rise annually to at least reflect changes in minimum pay in the sector. By tying their own hands in this way, ministers will be able to induce a lift-off in private investment in the sector.

- **A National Care Service investment fund.** Additionally, a public investment fund should be established to support providers and local authorities to develop new capacity. The purpose of the fund would be to ensure that public, non-profit and SME providers have a level-playing field when it comes to developing future capacity. Work is needed to scope out the detail of the fund – for example the balance between grants and loans and how public investment might leverage in private finance. We suggest there should be separate programmes to cover care homes, housing with care and technology investments. The fund might cover building new capacity, modernising or replacing old facilities, and the adoption of technology. Investments could be targeted to places where there is insufficient capacity at present, or where commercial investment prospects are lower, especially areas with high needs and low property prices. Conditions should apply including a permanent commitment to operate as a National Care Service provider (or transfer the facility to an alternative provider).

The government should also expand funding for home modifications to increase investment in adapting people's homes and the installation of assistive technologies.

10.5 Consider an increased role for social security in funding residential care. As an optional addition to these financial reforms, ministers should consider expanding the role of social security in paying for residential care. At present people with low incomes living in residential accommodation cannot access means-tested housing benefits for the rent component of care home fees. Nor are people who receive public support for care home fees entitled to disability benefits.

A public investment fund should be established to support providers and local authorities to develop new capacity.

We suggest that housing and disability benefits should be payable to people in care homes, with this money then being offset by lower local authority payments. This would result in a reduction of over £2bn in the costs currently incurred by local authorities.[70] In the parlance of Whitehall, this is a shift from departmental to annually managed expenditure ('DEL' to 'AME'). The policy would be revenue neutral at the point of implementation. It should be supported for four reasons:

- To create financial neutrality between care homes and specialist housing (with housing and disability benefits available regardless of tenure).

- To reduce the amount that needs to be allocated through spending formulas and local government grants, and reduce the wider impact of adult social care on local government finance.

- To act as a demand-led, buoyant and predictable source of funding in the future (benefit spending rises automatically each year in line with growing eligibility and uprating rules).

- To achieve fairness and consistency in social security payments for people in care homes in England, Scotland and Wales (as things stand, different national charging rules lead to variations in disability benefit entitlement).

6. The roadmap to a National Care Service

Plans for a National Care Service will take time to deliver in full. First steps will be needed immediately after a general election to stabilise care services and ensure that people start to see initial improvements quickly. But the process of building the National Care Service will be a long-term project that might last up to a decade. The changes will need to be delivered against the backdrop of a system in crisis and each step on the road must support short-term repair as well as long-term reform.

Once the journey is well underway and ministers can point to visible change, there should be an official 'launch' for the National Care Service when the new brand goes live. This would probably happen during the 2028/29 financial year to accommodate the time required for co-design, legislation and implementation. For example, the launch could be on 5 July 2028, the 80th anniversary of the NHS. On this date important new entitlements and responsibilities would commence. But it would be neither the beginning nor the end of the path of reform.

We envisage the roadmap comprising the following stages:

Inherit: An incoming government will inherit a system in crisis that is failing to meet its fundamental aims and statutory expectations. But today's system also provides context and foundations for the new service. The Care Act 2014 should be the legislative starting point. Recent government initiatives are first steps towards building a national service, in particular the Fair Costs of Care initiative on provider pricing, CQC assessment of local authority performance, and new data requirements. The government is also planning a new care workforce pathway and skills passport. By the time of the next election it is possible that the government will have recommenced the Dilnot charging reforms. These bring new financial entitlements to individuals but also extend councils' assessment and commissioning responsibilities.

Stabilise: The most urgent priority will be to develop a 'rescue plan' for both adult social care and the NHS. This should mainly focus on recruitment and retention – and therefore pay. We suggest that an initial minimum wage for the sector is in place by 1 April 2025 (subject to an election being held by autumn 2024). Other extra spending at this time should focus on service continuity and ensuring both adult social care and the NHS are able to provide an acceptable minimum level of service.

Prepare: Reforms that start to implement the National Care Service vision using existing legislation should be introduced as soon as financial circumstances permit (eg changes to guidance, measurement and assessment). Local government finance reforms should also commence quickly as they will take many years to implement. The fair pay agreement with improved minimum conditions should be introduced as soon as it is agreed. Co-production and consultation arrangements should be established and used to develop detailed plans on each aspect of the reform. This should lead to a National Care Service bill which should be included in the parliament's second King's speech and ideally receive royal assent by the end of 2026, giving time for secondary legislation. Locally, councils will need to build institutional capacity, establish co-production and partnership arrangements and prepare for new relationships with providers.

Launch: The formal launch of the service could take place in the 2028/29 financial year. At this point new citizen rights and public sector responsibilities would kick in. By this time the new national framework of pay bands and employment terms should also be in place. This is the earliest practical date for launch given the need for consultation, policy development, primary legislation and regulations. An earlier date would not give local authorities sufficient time to improve practice and rebuild organisational capacity, and it would be financially unrealistic given that extra funding that will be required both in the run-up to launch and at the point that new rights and responsibilities go live.

The most urgent priority will be to develop a 'rescue plan' for both adult social care and the NHS.

Embed: Following the launch it will take several years to realise the ambition of the service, as funding steadily improves. New capacity will gradually become established. It will take time and resources to progressively reach more people and improve the adequacy of support. For this reason some commitments on charging reform may need to be introduced gradually, rather than on the day of launch. It will also take a number of years for financial allocations to councils to converge on each area's assessed level of need.

Evolve: The National Care Service will be evolving from the moment is launches. A commitment to innovation and evidence should accelerate the take-up of new models of support and the adoption of technology. It will also take many years to rebalance the composition of the workforce towards higher skilled roles. The independent oversight body is intended to drive improvement and accountability. We also suggest a scheduled stock take within four years of launch to assess progress and examine whether further legislative change is needed. At the same time consideration should be given to further charging reforms to make more support free or reduce the amount people need to pay.

THE NATIONAL CARE SERVICE ACT 2026

"An act to provide for the establishment of a comprehensive care and support service for adults in England"

Drawing on the ideas in this report an act founding the National Care Service could include the following provisions:

- **Duties on the secretary of state**
- **New national functions/structures**
  - » Partnership/co-production arrangements
  - » Workforce and skills arms-length body (standalone or joint with NHS)
  - » Independent scrutiny, evidence and engagement body
  - » Financial regulation of large providers
- **Citizen rights**
  - » NCS constitution
  - » The right to independent living
  - » Carer's right to short breaks
  - » OPTION: formalise existing rights derived from duties on public bodies
- **Revised duties for local authorities**
  - » Co-production requirements and machinery
  - » Partnerships with providers and worker representatives
  - » Requirement to fund peer-led support
  - » Stable public service contracts with 'licensed' providers
  - » Free arrangement of services for all
  - » Carer choice during assessment and care planning
  - » Joint responsibility with the NHS for care following hospital discharge
  - » Transferability of assessments between areas
  - » Financial supervision of small providers
- **Revised requirements for the NHS**
  - » ICS representation/engagement
  - » Joint responsibility with local authorities for care following hospital discharge
  - » Requirement to refer to the National Care Service
- **Professional registration**
  - » OPTION: introduce a compulsory scheme
- **Social security**
  - » Requirement to refer to the National Care Service
  - » OPTION: reform housing and disability benefits in care homes

How to prioritise spending increases?

Earlier in the report we said there should be a 10-year commitment to sustained funding increases and that there will be difficult trade-offs to make when it comes allocating new resources. Each year extra money will need to be spent on a wide range of priorities, as well as to meet annual increases in demand. However our proposals for the phased introduction of the service imply a logical sequence with respect to the issues that should be priorities for extra funding as progress is made along the journey:

- **Stabilise** – workforce pay (sector minimum wage), fair provider pricing
- **Prepare** – improve eligibility and access, prioritise prevention, build local authority capacity, workforce terms and conditions (Fair Pay Agreement)
- **Launch** – workforce pay (National Care Service pay bands), arrange services for all, initial charging reforms
- **Embed** – improve adequacy of support, implement DWP and NHS requirements to refer
- **Evolve** – further charging reforms

In the appendix we set out some more detailed suggestions for sequencing, under the 10 'building blocks' outlined in chapter five. We hope that each action can be taken as early as possible within the window of time suggested. All these options assume that an election is held by autumn 2024.

APPENDIX: THE ROADMAP BLOCK BY BLOCK

BLOCK 1: STRUCTURE AND IDENTITY		
Inherit	(24/25)	• 2022 legislation creates CQC assessment of local authority performance and a power for the secretary of state to intervene • Informal partnership structure without government involvement
Stabilise	(24/25 to 25/26)	• Repurpose and expand DHSC social care division to deliver the NCS • Publish Green Paper and commence public consultation and national engagement exercise • Establish partnership structures for: co-production with people requiring support and carers; negotiating workforce terms and conditions; relations with providers
Prepare	(25/26 to 27/28)	• Appoint high-profile NCS 'chief executive' • Consult devolved national governments on UK wide issues • White paper with key policy decisions • NCS bill in second King's speech of the parliament • NCS Act receives Royal Assent • CQC and local authorities build capacity
Launch	(28/29)	• NCS launch day with commencement of new rights and launch of England-wide digital gateway • Roll-out of NCS public brand across all councils and providers
Embed	(29/30 to 30/31)	• Publish national strategies on key areas for reform • Annual progress reports to parliament
Evolve	(29/30 onwards)	• Review progress four years after launch • Consider long-term organisational structure (eg arms-length executive body like NHS England) • Consider applications for city regions to take over NCS functions and duties

BLOCK 2: WORKFORCE		
Inherit	(24/25)	• Government currently developing a care workforce pathway and skills passport • Proposed level 2 accredited care certificate
Stabilise	(24/25 to 25/26)	• Launch health and care recovery plan focused on vacancies • Fair Pay Agreement provisions form part of an Employment Rights bill in a first King's speech • Launch sector minimum wage (eg real living wage)
Prepare	(25/26 to 27/28)	• Agree and implement sector-wide Fair Pay Agreement • Negotiate NCS employment conditions and pay-scales (modelled on Agenda for Change) • Complete England-wide and local workforce and skills plans • Launch voluntary professional register
Launch	(28/29)	• Introduce new workforce terms and conditions and NCS employee insignia to coincide with formal launch • Continue to review NCS occupational standards and skills • Review providers' regulatory requirements for skills and training
Embed	(29/30 to 30/31)	• NCS pays-scales converge on similar posts in the NHS
Evolve	(29/30 onwards)	• Move towards compulsory professional registration (if not earlier) • A measurable shift in the composition of the workforce towards more senior and specialist roles

BLOCK 3: CO-PRODUCTION		
Inherit	(24/25)	• Existing guidance, good practice and legal requirements
Stabilise	(24/25 to 25/26)	• Launch a co-production process to shape the detail of the NCS (eg deliberative research, citizens' assemblies or a people's commission)
Prepare	(25/26 to 27/28)	• Create national co-production machinery prior to legislation • Use a national strategy, statutory guidance and CQC assessment framework to improve local practice prior to legislation • Primary legislation introduces co-production responsibilities and machinery at national and local level • Launch independent scrutiny, evidence and engagement body led by people requiring support and carers
Launch	(28/29)	• Co-production requirements come into force on or before NCS launch date
Embed	(29/30 to 30/31)	• Spread experience and good practice at national and local level
Evolve	(29/30 onwards	• Review four years after launch to assess practice and culture change

BLOCK 4. RIGHTS		
Inherit	(24/25)	• Opaque rights derived from statutory duties • UN convention of the rights of persons with disabilities
Stabilise	(24/25 to 25/26)	• As part of green paper, consult on shaping new right to independent living, and whether to include other rights in primary legislation • Use a national strategy, statutory guidance and CQC assessment framework to improve local practice prior to legislation
Prepare	(25/26 to 27/28)	• Initiate development of co-produced NCS 'constitution' • Launch appeal system created by Care Act 2014 using regulations • Agree NCS constitution
Launch	(28/29)	• New constitution, rights and associated machinery come into force on or before NCS launch date
Embed	(29/30 to 30/31)	• CQC assessment of practice on information, advice and advocacy
Evolve	(29/30 onwards)	• Refresh NCS constitution four years after launch • Consider if further legal rights required (if explicit rights not added to the Care Act prior to NCS launch)

BLOCK 5. CARERS		
Inherit	(24/25)	• Ringfenced funding for carer support and planned government evaluation of impact
Stabilise	(24/25 to 25/26)	• Green Paper consultation • Use a national strategy, statutory guidance and CQC assessment framework to improve local practice prior to legislation
Prepare	(25/26 to 27/28)	• Initiate development of co-produced NCS 'constitution' • Primary legislation with new national duties for NCS to promote carers' wellbeing, co-produce, and develop related strategies; requirement on local authorities to discuss carer's wishes and provide short breaks
Launch	(28/29)	• Carer related rights and requirements come into force on or before NCS launch date
Embed	(29/30 to 30/31)	• Completion of systems changes required for referrals from other public services • Measurable improvements in outcomes for carers
Evolve	(29/30 onwards)	• Further consultation and dialogue on financial support and services for carers

BLOCK 6. ACCESS		
Inherit	(24/25)	• Emergency government interventions on accessing care after hospital discharge • Delayed preparations for implementing the administrative and assessment requirements of the Dilnot funding reforms
Stabilise	(24/25 to 25/26)	• Use a national strategy, statutory guidance and CQC assessment framework to improve local practice
Prepare	(25/26 to 27/28)	• Prevention – introduce monitoring/benchmarking of spending • Commence Care Act duty for local authorities to offer to arrange care homes for self-funders • Measurable increase in access in numbers receiving support
Launch	(28/29)	• New referral requirements – DWP/NHS to identify people with needs and refer; local authorities to initiate contact and offer information, advice and assessment • Revised assessment guidance, practice and monitoring – on or before launch of NCS • Transferability of assessment between places permitted – at launch of NCS • Free arrangement of services for all (unless people opt out) – phased in with new assessments from launch date. • Transitional arrangements required for existing self-funders if limited liability cap introduced (to avoid spike in demand for assessments) • Increase spending progressively to achieve goals
Embed	(29/30 to 30/31)	• Gradual implementation of arrangement of support for former self-funders • Gradual implementation of lifetime cap (if implemented) • Completion of systems changes required for referrals form other public services
Evolve	(29/30 onwards)	• Improve adequacy of packages to fully realise right to independent living • Review progress on access and consider if new eligibility legislation required

BLOCK 7. MODELS OF SUPPORT		
Inherit	(24/25)	• Existing innovation from individuals, providers, commissioners and support organsations • Government reforms to data and digital
Stabilise	(24/25 to 25/26)	• Roll out effective joint provision by local authorities and NHS following a health emergency or hospital discharge
Prepare	(25/26 to 27/28)	• National strategy and guidance to promote effective care models, including joint work with NHS and housing • Revise guidance on direct payments • National functions/networks on evidence, research and technology • National data requirements/standards
Launch	(28/29)	• Revise local planning requirements and create new use class for 'housing with care'
Embed	(29/30 to 30/31)	• Continual development of models of care, supported by co-production and evidence • Rapid expansion in use of technology and data in all aspects of care and support
Evolve	(29/30 onwards	• Review four years after launch, including of how mix of support has changed

BLOCK 8. PROVIDERS		
Inherit	(24/25)	• CQC financial monitoring regime • Fair Costs of Care initiative to increase provider pricing
Stabilise	(24/25 to 25/26)	• Introduce interim framework for standardised prices (based on existing government initiative)
Prepare	(25/26 to 27/28)	• Form local partnerships between commissioners, providers and worker representatives to co-design new local landscape • Introduce permanent framework for standardised prices and conciliation process • Consider expansion of local authority 'provider of last resort' responsibilities • Pass legislation on financial regulation and supervision
Launch	(28/29)	• Implement new long-term public service contracts with providers on or before launch day (to be in place when new branding commences and commissioners take on responsibility for self-funders) • Implement financial regulation system
Embed	(29/30 to 30/31)	• Option to gradually shift the mix of provision, to include more public and non-profit delivery
Evolve	(29/30 onwards)	• Review Care Act 'market shaping' requirements

BLOCK 9. AFFORDABILITY		
Inherit	(24/25)	• Dilnot charging reforms postponed in 2022. Now scheduled for implementation in 2025.
Stabilise	(24/25 to 25/26)	• Either continue to implement Dilnot reforms (if underway) or commence a very short in-house review of charging reform options
Prepare	(25/26 to 27/28)	• Introduce minor changes to charging rules – eg free care for short-term care including for six weeks after hospital discharge; uprating means-test thresholds in line with inflation; reform DFG means-test
Launch	(28/29)	• Introduce one or more substantial charging reforms to coincide with the NCS launch • Consider announcing a timetable of further charging reforms
Embed	(29/30 to 30/31)	• Embed charging reforms and associated administration (especially important if Dilnot cap is implemented, as liabilities build up gradually)
Evolve	(29/30 onwards)	• Implement further charging reforms, expanding out from initial improvements • Consider expanding eligibility for NHS continuing healthcare to more people with very high support and clinical needs in exchange for charging daily living costs to people in care homes receiving NHS continuing care

BLOCK 10. MONEY		
Inherit	(24/25)	• Stop-start spending increases, and repurposing of funding to emergency response • Better Care Fund to be the starting point for new NCS grant
Stabilise	(24/25 to 25/26)	• 'Year one' financial boost to stabilise the system focused on pay
Prepare	(25/26 to 27/28)	• Ten-year commitment to sustained funding rises • Launch National Care Service investment fund • Consult on and commence implementation of National Care Service formula and grant
Launch	(28/29)	• Uplift in funding when service launches to reflect new entitlements and responsibilities (likely to be 2028/29)
Embed	(29/30 to 30/31)	• Local funding allocations converge with formula
Evolve	(29/30 onwards)	• Review progress as end of 10 year spending commitment approaches

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