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Governance in social care: Lessons for reform

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1 Introduction

With a new Prime Minister lending social care greater political priority than it has experienced for many years, and a renewed sense of urgency injected by bringing forward the Casey Commission, there is a clear opportunity to bring about the far-reaching reform that has eluded policymakers and politicians for three decades. It is now the Casey Commission's task to lay out proposals for a long-term plan that delivers on the broad ambition for a National Care Service.

There will need to be many different intersecting components to that plan, considering funding, eligibility, workforce, the provider market, and ambitions for choice and control. Once those elements have been decided, the plan will need to give careful thought to the structures and processes that will enable the system to operate effectively and efficiently, affording clarity over where responsibility sits and how and by whom decisions are made. These considerations over governance and accountability will need to address the range of problems and challenges that are inherent in the social care system at present.

In her first public address on social care at the Nuffield Trust Summit, Baroness Casey noted that social care has never had a 'creation moment' in the same way that the NHS had when it was constructed in 1948. Instead, it has evolved and developed in an ad hoc way with solutions to issues emerging as sticking plasters and workarounds.* The result is a complex system where responsibilities are spread between central government departments, and across a range of arm's-length bodies; between national and local government; and between government and a vast array of non-public sector providers. Decision-making processes can be opaque and a single point of responsibility for overall oversight and stewardship is lacking. The consequences of this complexity and lack of clarity were highlighted during the Covid-19 crisis and, while that event forced some positive change, there remains a fundamentally fragmented system that lacks a coherent sense of direction.

* A history of adult social care funding flows and regulation in England, Humphries R and Timmins N (2026).

As the Casey Commission explores options for the shape and scope of a new National Care Service, they will also need to ensure that any structural or governance reform is carefully aligned with other government priorities, in particular the ongoing local government reform and devolution agendas.

About this report

This report was commissioned by the Casey Commission on Social Care in the spring of 2026 (ahead of the change in Prime Minister and acceleration of the Commission's timeline) to explore potential options for more effective governance and stewardship in the future. It aims to outline the issues that currently exist in the social care system as it is currently operating, and then draws on material from other areas of public service and international care systems to provide ideas for consideration in the English context. It does not aim to be an exhaustive examination of social care governance arrangements, nor does it attempt to recommend a particular way forward, for reasons set out below. Instead, it is intended as a high level review of options and consideration of potential trade-offs and consequences based on the learning that England can draw from its own history in social care, from other sectors and from abroad.

Our approach

This work was commissioned and completed ahead of a clear articulation of the eventual vision for a National Care Service being set out. While the new Prime Minister has suggested that the eventual ambition is for a more generous system, the plan and detail of that will likely not be set out until after the Casey Commission has reported in the summer of 2027.

Learning from history, from the NHS and from elsewhere strongly suggests that the institutional form should follow the desired function. Embarking on restructuring in the absence of a clear purpose and theory of change at best creates distraction and at worst can have a detrimental impact on a range of outcomes. Well-thought-through reform, with a clear articulation of purpose and implementation, in contrast, has the potential to lead to a strengthening of governance, resulting in better experience and outcomes for people.

With this in mind, we sought to identify dimensions of governance that will inevitably need to be part of any new system, regardless of its ambition, and then identified models and approaches that have been deployed to fulfil those dimensions of governance in other countries or sectors. This was achieved through:

- A roundtable* involving a range of social care sector experts and wider government stakeholders which helped to explore current deficiencies and complexities, and to identify dimensions of governance and stewardship that will be essential in any future system.

- A review of the history of funding flows and governance in England to provide a clear understanding of how complex structures and processes have evolved. This review can be accessed here.

- A review of different approaches to governance in other sectors in the UK that were applicable to the current situation in social care and had addressed similar challenges.

- A review of different approaches to social care governance in a range of other countries. Countries of interest were selected to ensure they represented different options in terms of levels of centralisation or devolution of decision-making; different funding mechanisms; and stages of reform. The countries chosen were: Denmark, Wales, Scotland, Northern Ireland, Republic of Ireland, France, Germany, Japan and Australia. This can be accessed here.

The report is structured around the dimensions of governance that emerged through the document review and in the roundtable as areas where there were opportunities to go some way to addressing known inadequacies or challenges with the current arrangements.

* The roundtable, held in April 2026 under the Chatham House rule, involved 12 key social care stakeholders representing policymakers, providers, regulators, local government and other experts. The event was run by IFG. Attendees were provided with drafts of the background papers ahead of the event.

The first chapter explores what roundtable attendees described as a lack of clear 'system stewardship' within the current arrangements and considers the options available to government – via stronger mechanisms or different structural arrangements – for addressing this deficiency. Subsequent chapters focus on a number of key dimensions of governance within that clearer stewardship where there might be opportunities for improvement:

- Access and eligibility
- Commissioning and market-shaping
- Market oversight
- Workforce planning
- Improvement and innovation

For each of those sections, we set out briefly the arrangement and challenges inherent in the current set up in England; provide examples of alternative models from other sectors or countries; and explore the likely trade-offs, consequences and points for consideration that should be made in any future reform in England. This latter subsection is not an exhaustive exploration of every possible issue but is intended instead to prompt further thinking and raise questions as discussions about governance progress. The examples are described briefly and intended to signpost potential avenues to explore.

This report is not a comprehensive review of system governance. It does not touch on the regulatory and inspection regime, for instance, as that is already the subject of extensive consideration and reform at the Care Quality Commission (CQC), and is substantial enough to warrant its own report.

The report deliberately avoids concluding with particular recommendations. The eventual governance proposals that the Commission may make, and the decisions that the new Burnham government will ultimately make, will need to be driven by overall system priorities, a long-term vision and shaped by people who draw on care. Fundamental choices about that vision will shape all other decisions that follow.

Key findings

1 While there are a variety of challenges within the current system design and there is potential for improvement, there is no technically 'correct' way of organising and delivering social care. Instead, there are a series of difficult choices and trade-offs to weigh up that are ultimately guided by societal values and political choices. The overall vision for the National Care Service, its level of ambition, and the direction of other government ambitions (principally devolution), should also shape these choices.

2 Structural reform may rightly be the solution to some challenges, but not all improvements will necessarily require significant new infrastructure. Learning from other sectors suggests that structural reform can be highly disruptive and any such reform needs to have a clear purpose and theory of change.

3 At a minimum, and regardless of the direction of reform, the Commission should recommend bolstering the key functions of innovation/improvement and workforce planning, in order to reverse the recent trends of shrinking state support and to place these functions on a more stable footing.

4 Governance and accountability arrangements do not sit in isolation, and any changes will have implications for other parts of system reform. Implementing more consistent social care access, for instance, will have implications for funding allocation which in turn will raise questions about the reliance on local revenue raising. The appetite for change, level of ambition in government and fiscal headroom will ultimately determine how far structural change is required.

5 Social care does not operate in isolation and needs to coordinate with the NHS and other services such as housing. Reforms to these other systems and services will affect the form that social care will take. In the immediate term, the ongoing restructuring of local authorities and integrated care boards, and the creation of Mayoral Strategic Authorities, will be of particular significance. These new footprints may provide logical homes for certain functions like commissioning support or local workforce planning, but may introduce greater complexity in relationships between systems.

6 Systems in other countries and sectors rarely stay static. Governance structures that have stood the test of time have been better able to flex to changing political tides and priorities.

7 One last and inescapable point is that successful reform of social care requires political will and bravery to make the choices outlined throughout this report. No amount of reorganisation of governance structures or processes will be sufficient in the absence of political impetus to drive through change and dedicate resources, time and energy to social care. Maintaining social care visibility and priority within the government's agenda will be essential.

2 System stewardship

System stewardship describes the role of policymakers in "overseeing the ways in which (the) policy is being adapted, and attempting to steer the system towards certain outcomes, if appropriate". Policymakers can achieve system stewardship in different ways: through setting goals; setting the rules in which the system operates to achieve these; assessing the system's 'feedback' – or its progress towards these outcomes; and responding to the feedback through adapting the system as necessary. It is a recognition that public services are far too complex for central government to directly manage, meaning that governments should instead set high-level priorities and then create the conditions in which local systems can deliver those aims.

Roundtable attendees identified the absence of clear 'system stewardship' as a significant weakness in the current social care system, driving poor or uncertain outcomes across the various dimensions of governance we discuss below. One of the problems highlighted was the lack of a clear coherent narrative, leaving the sector with little clarity over the overall vision and sense of direction. This was seen as being partly due to the historic low visibility and priority of social care within successive governments' agendas, but also as a consequence of accountability being dispersed between national and local governments.

The attendees described 'loose connections' between the layers of the system making it difficult and slow for change to be enacted or for national policy to be translated into practice. With delivery, and many associated decisions, devolved to local councils which are democratically accountable to their residents, there can be a disconnect between the national policy vision and the experience of people drawing on, and working in, social care.

In central government, attendees felt there has been a persistent lack of capacity and capability for adult social care within the Department for Health and Social Care (DHSC) – a trend which the NHS England (NHSE)/DHSC merger risks exacerbating as the department chases headcount cuts. An absence of leadership for social care within the DHSC is a long-standing

issue, leaving social care the 'too often forgotten, too often invisible, arm of the welfare state.' There is also often poor coordination between different parts of government on policies which affect the sector. Recent examples include rapid flip-flopping on immigration policy and the effect of rapid increases in the national living wage on the sector.

The National Audit Office has outlined some deficiencies in the government's ability to achieve its priorities for social care. These include:

- The absence of a long-term plan to achieve its vision, hindered by short-term spending cycles
- The absence of a 'theory of change' around how reform plans contribute to intended outcomes for the system
- Limited delivery experience within the DHSC

Baroness Casey has described social care as less of a system and more of a 'patchwork'.

Mechanisms and levers of influence

Central government currently has a range of levers available to lay out and incentivise aims for the sector. The list below is not exhaustive but seeks to highlight some of the key mechanisms available.

Legislation

The 2014 Care Act is probably the strongest example of system stewardship within social care. It provides an overall framework for the system and is widely supported by people working in the sector. The Act outlines numerous duties that local government must discharge. Beyond them, councils have a fair amount of freedom to shape delivery as they see fit.

However, it is broadly acknowledged that the Act is not achieving its aims in full, owing to funding and resource constraints, pressures on key parts of the system's delivery infrastructure (e.g. staff, providers, carers), and the

politicisation of the issue, notably during general election campaigns. This has prevented a commitment to decisive leadership and cross-party working on how the system should evolve in the long term.

Even though the People at the Heart of Care white paper and its 'Next Steps' implementation paper sought to build on the intentions of the Care Act to set a vision for system reform, progress has undoubtedly been slow and almost all of the funding earmarked towards this has been funnelled into propping up a struggling system.

There are other pieces of legislation which have shaped the sector. Section 31 of the Health Act 1999 (later replaced by section 75 of the Health Services Act 2006) gave local authorities and health services powers to pool budgets and delegate functions to one another.

More recently, the 2022 Health and Care Act gave DHSC some additional powers including a requirement for CQC to assess how well councils are meeting their Care Act duties; allowing the Secretary of State to intervene directly if local authorities are failing; and an ability to mandate better data sharing.

Funding

Financial flows allow central government to push systems towards its priorities. For social care, fiscal events and the local government finance settlement are key moments at which central government can use funding to support its ambitions.

Government can, first, allocate money for specific aims. For example, the Sunak government created the Market Sustainability and Improvement Fund (MSIF) at the 2022 autumn statement to address perceived instability in the provider market. Central government generally attaches conditions to these funding pots, for example local authorities had to provide central government with a 'capacity plan' to receive MSIF funding. The government sought to drive greater transparency in publishing these reports and insights, with the intention of encouraging better practice in local areas through greater public scrutiny.

The Better Care Fund (BCF) policy framework also sets annual priorities for joint working between local authorities and integrated care boards as a condition of receiving BCF funding. Local areas are required to submit annual assurance returns to justify how they are spending the funding and delivering towards government priorities within the national funding conditions. This power is being brought into DHSC under the NHS Health Bill.

Second, government can use the local government finance settlement to target funding at specific local authorities which it deems to be in extra need. For example, it used the Recovery Grant in 2026/27 to allocate funding to local authorities that were hit hardest by austerity-era funding cuts.

The Starmer government chose to consolidate funding streams and move away from ring-fencing for social care funding. Local authorities have welcomed the increased discretion over spending and the reduction in the associated (sometimes onerous) reporting requirements. However, the change leaves DHSC with less direct leverage over priority setting. There can be a trade-off between these approaches. Increased flexibility allows local areas to target funding where they think it is most needed, using their more detailed knowledge of local context and need. But that often leads to increased variation in access and quality (often colloquially known as a 'postcode lottery'). Central government can be uncomfortable with that variation.

Priority and target setting

The government can also guide behaviour through statutory and non-statutory guidance. The local government finance policy statement accompanies the financial settlement and sets out the broad direction of travel and key local government reforms. It has recently moved from being annual to being set over the whole spending period of three years.

The Ministry of Housing, Communities and Local Government (MHCLG) has developed a local outcomes framework which it will use to hold local authorities to account for priority outcomes in their area. This covers a wide range of services and other outcomes for which local authorities are responsible, including 16 metrics for adult social care. Central government will use progress against these metrics as an indicator of the extent to which local

authorities are fulfilling their Best Value Duty – a requirement to continuously improve in an economic, efficient and effective way.

Since 2026 DHSC has set its own priorities for the system (these are reflected in the priority outcomes of the local outcomes framework). DHSC has also calculated notional allocations for how much it anticipates local authorities will spend on adult social care. As this is the first year of this new approach, there is some uncertainty about how exactly these notional allocations will be used and what impact there will be.

Inspection

Since 2023, the Care Quality Commission (CQC) has inspected local authority adult social care services through the local authority assurance framework. This is a way of ensuring that local authorities are complying with their duties under the Care Act.

The CQC publishes a grade and an overall score alongside a comprehensive report for each council. This gives residents and central government a view on the quality of a local authority's social care services.

Direct intervention

Under best value standards, central government has the power to directly intervene when it deems that a local authority is not fulfilling its Best Value Duty. There is a spectrum of interventions that the government can take, ranging from an improvement board to commissioners taking over responsibility for certain functions.

There are other ways that central government can intervene outside this framework. Recent examples include the Discharge and Admissions Group (DAG), a DHSC and NHS England initiative to work with challenged areas on their delayed discharges and system flow, as identified through performance metrics.

Alternative models and approaches

When looking internationally, England's social care system is not unique in the dispersed nature of its delivery between local and national governments or, in some cases, arm's-length bodies. The level of control exerted by national government varies between countries, as do the levers and mechanisms they use to shape delivery and set a vision. We further explore national and local dynamics under the 'Access and eligibility' section later in this report. Below, we explore central government structures and highlight a variety of mechanisms central governments of other countries deploy to shape their systems and set the direction of travel.

Political priority and visibility

Giving social care greater visibility and prominence on a national level could give it a higher status in decision-making and provide an opportunity to create a more coherent narrative for the purpose and ambition of the system. Indeed, Andy Burnham's commitment to social care reform, stating his willingness to spend political capital on addressing it, has already put it in the spotlight and injected a greater momentum by accelerating the Casey Commission's timeline. A number of countries have taken steps to afford social care greater prominence in the political and policy landscape.

- France is a recent example of a national government making an explicit decision to elevate the status of social care and make it a political priority. In 2021, with Covid-19 acting as a catalyst, France made social care the 5th branch of social security, bringing in much stronger national oversight and coherence between different parts of the system and signalling its importance as a pillar of national infrastructure. The accompanying legislation set the care branch (which had existed since 2005) as the formal body responsible for the sector, with a clear mandate from the state: "The Nation asserts its commitment to the universal and solidary nature of support for people's independence, to be funded through social security". The care branch's budget is now voted by parliament annually along the same lines as the other branches of social security, with clearer long-term financing from the Generalised Social Contribution (France's tax levied on income to finance social security), and an adherence to spending rules.

- Over 25 years earlier, in 1995, Germany made a similar statement. In its extensive reforms of its welfare state prompted by reunification, long-term care was established as the fifth pillar of the German social insurance system, giving it equal status with unemployment, health, pensions and accident insurance. Japan followed suit, using and adapting Germany's blueprint, and established its own long-term care insurance system in 2000, although it adopted a blended financial model with tax and social insurance funding as its heart. Like in France and Germany, the establishment of long-term care insurance in Japan was an important moment, making care visible and redrawing the boundary between state and individual/family responsibility.

- The UK government's Care initiative during Covid-19, which involved the creation of a brand for care, was an attempt to raise the profile of social care. The initiative tried to give social care a status akin to the NHS by creating a distinctive identity, but in the absence of sustained political commitment to reform, it was largely symbolic. The brand is still in use and provides a foundation on which to build. An earlier attempt to raise the status and profile of social care was the Platt Review (2007) which set out a number of possibilities such as a social care skills academy, a research centre of excellence, awards schemes and the creation of a prestigious journal for social care akin to the BMJ or Lancet. Some of these ideas likely fed into other initiatives but there is little evidence of them being adopted and implemented directly.

Mechanisms for priority setting

Alternative mechanisms for driving a vision are in evidence in other countries and sectors. Some examples include:

Governance arrangements	Examples	Approach
International social care examples: Priority setting		
Built-in reviews	Japan	Japan's ministry of Health, Labour & Welfare is responsible for setting the system's priorities and vision, but municipalities are accountable for delivery within strict national frameworks. Every three years, central government undertakes a review of their long-term care system which enables it to adjust levers such as funding and eligibility and to set a direction of travel. These reviews are enshrined in the legislative framework and coincide with similar reviews that take place in the health system. The reviews have been used, for example, to manage demand through raising eligibility thresholds, and to incentivise entrants into the homecare market. In turn, municipalities and prefectures (which provide oversight and support to municipalities) are required to review and submit updated strategies to the central ministry on the same regularity. As such, the ministry that oversees social care has access to very direct levers of influence.
Mandate-setting	Germany	In Germany's social insurance care system, sickness funds operate under a legally enshrined mandate that sets clear parameters and aims. The legal mandate to which arm's-length social insurance funds are held gives a clear steer regarding system priorities, but delivery decisions are left to the funds themselves and other administrative branches of the system. While the arm's-length status of the sickness funds largely depoliticised decision-making, cost pressures in recent years have resulted in more political intervention.

Governance arrangements	Examples	Approach
National steering committee	Wales	Wales has recently introduced a National Office for Care and Support, hosted by and accountable to the Welsh government. It must deliver an annual programme of work agreed by Welsh ministers and is subject to external scrutiny from a group comprised of care providers, charities, trade unions, and the NHS Alliance (previously NHS Confederation). The National Office for Care and Support is also planning to launch a People's Forum for Social Care.
	France	In France, the care branch is designed to operate as a 'parliament', in which the state is present but not a majority stakeholder. Other council members include elected representatives from the VCSE sector, providers, unions, local authorities, and people who draw on care.
Arm's-length scrutiny	Australia	In Australia's newly designed system, the Department of Health, Disability and Ageing sets national policy with the minister accountable to parliament. However, in addition, an independent Office of the Inspector General for Aged Care was established in 2023. The Office is intended to hold the entire system to account (so distinct from its regulatory structures), providing oversight of all bodies funded or regulated as part of the Aged Care system. The Office is directly accountable to parliament and offers an additional layer of scrutiny.
Examples outside social care: Priority setting		
Mandate-setting	NHS	The NHS provides an example of a UK-based attempt to embed vision-setting via an arm's-length depoliticised mandate. Introduced as part of the Lansley reforms (Health and Social Care Act 2012), the intention was for a National Commissioning Board (which then became NHS England) to strengthen accountability and implement the clear vision and priorities of the government beyond the reach of 'political meddling'. There is much to learn from the experience of NHS England's establishment and dissolution (as well as the levers it deployed to shape services) as to what worked well and what did not deliver as intended. Among other things, a difficult dynamic and duplication between NHSE and DHSC, and an ever-increasing list of priorities, are features that could and should be avoided if such a model is pursued for social care.

Structural form

How the centre of government is structured has important implications for which organisations set priorities for the system. Whitehall departments are important features of all sectors. They are the organisations which deliver ministers' political promises and represent the interests of their service to central government. That includes leading negotiations with the Treasury for funding settlements and coordinating with other departments on policy problems.

Responsibility for adult social care is split between two departments. The Department of Health and Social Care (DHSC) is responsible for setting national policy while the Ministry of Housing, Communities and Local Government (MHCLG) is responsible for the distribution of funding to local authorities.

While most services have a single parent department, this is not a unique arrangement. For example, responsibility for children's social care is split between the Department for Education (DfE) and MHCLG.

Some departments establish public bodies to run services or sectors. Others retain near complete operational control over their services. Ministers are often tempted to design new national structures to improve performance in their services. There can be benefit in this, but optimism bias can creep in when embarking on that path.

Roundtable attendees did not see the split between DHSC and MHCLG as a barrier to the smooth running of the current system. Given the likely disruption of any change to this structure, there would need to be a very strong rationale and theory of change associated with any proposals.

Past examples of structural change

It is tempting to recommend that the government should create a dedicated department for adult social care to address the issues described above. History provides examples of machinery of government changes that had similar aims but did not always achieve them:

- **Department for International Development (DFID):** the Blair government created DFID in 1997 to support its ambition to eradicate poverty. Splitting DFID out of the Foreign Office ensured that the aid budget – which was previously part of the wider Foreign Office budget – would actually be spent on poverty eradication. Clare Short (the first Secretary of State in DFID) said that "having a separate department ups the ante right across Whitehall". She also said that it allowed her to set her own priorities and freed her from the "short-term diplomatic perspective" of the Foreign Office. DFID was merged back into the Foreign and Commonwealth Office by the Johnson government in 2020.

- **Department for International Trade (DIT):** The Conservative government created DIT after the 2016 Brexit referendum with the aim of championing free trade once the UK had left the EU. The creation of the department was rushed and ill-thought through. The department did, however, increase the salience of trade within Whitehall. One way it did so was by aligning the interests of ministers with the government's objectives: a DIT minister could raise their profile by signing trade deals. The Sunak government merged DIT with BEIS in 2023 to create the Department of Business and Trade (DBT).

- **Department for Work and Pensions (DWP):** The Blair government created the DWP in 2001 to unite the policy areas of employment support and the benefits system. Before then, the Department for Education and Employment and the Department for Social Security had been responsible for those areas, respectively. The continued existence of the DWP indicates the success of that change. One key reason for its success was that the government had a strong rationale for the change and took its time to consider how best to design the department, including establishing a committee to assess the question of why it was needed.

- **Department of Energy and Climate Change (DECC):** As with the DWP, this brought together two previously separate policy areas: energy and climate change. The department was effective at raising the political profile of climate change and brought coherence to policymaking. However, while the previous arrangement forced external debate between two departments with competing priorities (the economic versus ecological consequences of climate policy), the creation of DECC hid that

debate from view. This meant that the Secretary of State and Permanent Secretary were more important for reaching successful policy outcomes. DECC was eventually absorbed into the Department for Business, Energy and Industrial Strategy in 2016.

Different departments in Westminster take different institutional approaches to managing the day-to-day operations of their systems. Some create arm's-length bodies for that purpose. There is less need to consider how central government should manage the operations of the adult social care sector under current arrangements as local authorities are responsible for commissioning services, and providers manage their own operations. One odd quirk of the sector is the outsourcing of the workforce development and improvement functions to external independent organisations (Skills for Care and the Social Care Institute for Excellence (SCIE), respectively,* as discussed in more detail in the sections on innovation and workforce later in this report). Still, if there was a shift to a more centralised model of delivery of adult social care, then there may be a stronger case for an arm's-length body. Some models that provide learning include:

- **NHS England (NHSE):** The coalition government created NHSE in 2013 to place operational management of the health service further from ministerial interference. It also had responsibility for overseeing clinical commissioning groups and commissioning a selection of services (including general practice, dentistry, and maternity care) itself. The creation of a new organisation led to confused lines of responsibility for frontline services and duplication of functions between the DHSC and NHSE. The Labour government announced the abolition of the organisation in 2025.

- **HM Prison and Probation Services (HMPPS):** HMPPS is an arm's-length executive agency that manages the operations of the prison and probation services. Alongside running operations, it also performance manages those services and is responsible for reducing reoffending. It also manages contracts for private prisons.

* Of these two, Skills for Care is the more unusual organisation. Other sectors have "What Works Centres" that fulfil similar functions to SCIE and are also charities.

- **Job Centres Plus (JCPs):** JCPs deliver employment support services and are unusual in how centralised they are. The DWP manages the operations of JCPs directly, without the mediation of any ALB or regional or local organisations following the abolition of an executive agency (confusingly also called Jobcentre Plus) which ran the service until 2011. Now, civil servants run JCPs in minute detail, for example dictating how much time job coaches should spend with people seeking employment.

There are examples from outside England of different departmental arrangements:

- Responsibility for social care in other countries generally sits in a single national ministry that holds accountability (to different degrees*) for both funding and policy.

- In several countries, the ministry that holds responsibility for social care also holds responsibility for health. In some countries, that ministry has a wider remit (e.g. in Japan, the ministry oversees all of welfare, health and employment policy). In theory this provides opportunities for greater integration and joint working, but we know from DHSC experience (and broader health and care research) that mere co-location is no guarantee of integration.

- Denmark and Australia have different oversight and delivery infrastructure for services for older people and working-age adults. A single ministry in Australia holds accountability for both. In Denmark, care for older people sits in a ministry dedicated to services for older people, while support for working-age adults sits in a separate ministry.

- As noted elsewhere (typically in countries with a social insurance structure), there are examples of delegated delivery to arm's-length bodies, held to account by mandates.

* See Governance in social care: Models from other countries, Oung C, Lobont C and Curry N (2026).

Trade-offs, consequences and considerations

On priority setting:

Central government is perennially tempted to set ever-tighter criteria and targets for local systems, and there can be benefit in this. Targets can be effective at improving standards among some of the worst performing areas (though do little for highest performing areas). But they also come with risks. Local systems tend to game targets and they often depend on imperfect measurement approaches to improve intended outcomes, and a proliferation of targets dilutes a system's focus.

The government should also be wary of setting too many priorities that are not matched with adequate funding to deliver on these objectives. The lack of commensurate funding to deliver on the Care Act, for example, is seen as the biggest reason for its incomplete implementation.

Creating dedicated funding streams for government priorities has been a tool used in England and does result in more money being spent on that area. The last Conservative government increasingly relied on small, tightly ringfenced pots of money to fund local government.

As a condition of providing any form of grant funding, it is legitimate for central government to ask local authorities to support its priorities. However, the focus on prescribed priorities can come at the expense of reducing local discretion over how to spend money. A tension can then arise between ensuring that local authorities deliver value for taxpayer money and intervening too extensively in organisations that have their own democratic mandate. This needs to be given careful consideration in the context of a greater commitment to devolution. The government should be wary of intervening too extensively or deeply in local delivery of the system, unless there is strong reason to do so. The failure of the Scottish government to move accountability for social care from local authorities to Scottish ministers, and the large tensions that have resulted, exemplifies how difficult this can be to do in practice.

On the creation of a dedicated department for adult social care:

The creation of a single dedicated department for adult social care may be seen as a potential solution to some of the challenges around securing visibility and in the joining up of services, and such a move may deliver results. Following the creation of DFID, DIT and DECC, for example, there was increased political attention paid to those policy areas. However, it is likely that the creation of these departments was the result of political will and attention, rather than the cause of it. Besides, the abolition of DIT and DFID show that the existence of a department is not enough to guarantee that a future government will focus on that policy area.

Bringing connected policy areas into one department is attractive as it potentially reduces the difficulty of cooperating across departmental lines. The creation of DWP is a good example of this working well. But all sectors are deeply interconnected and forming a new department may create new siloes and boundaries. A new department for adult social care would still need to work closely with the remaining department of health and MHCLG.

History suggests that no administration should make changes to the machinery of government without careful consideration. They are always costly and time consuming, they often fall short of expected savings, and they tend to be very disruptive for staff and can be very bad for morale. FCDO morale fell substantially during the merger and remained lower for years after. Unless there is a clear, well-considered reason for creating a new department, the process is often not worth the time, energy and expense of doing so.

Given the view of roundtable attendees that the current departmental arrangement was not problematic, forthcoming reform plans would need to provide a strong rationale for the creation of a single, new department. If the government does decide to create a new department, then it should follow the Blair government's example with DWP and take its time to work through the complexities, potentially including establishing a committee to examine the pros and cons.

In a reformed adult social care system, there may be a stronger argument for an executive agency or arm's-length body. If so, there are some factors to

consider. There is a tendency to swing back and forth between giving ministers more power and putting them at arm's length. This is most apparent in the NHS, where governments have oscillated between those extremes since the establishment of the NHS. Each come with advantages and disadvantages, and it should not be assumed that one will always work better in every situation. As ministers have discovered, creating arm's-length organisations removes power but does not remove political accountability: when something goes wrong in the NHS, the Secretary of State is held more publicly responsible than the chief executive of NHSE.

3 Dimensions of governance

In this chapter, we discuss several dimensions of governance that emerged as areas with scope for improvement during our roundtable. These are functions of governance that will need to be present in any national care service and that, with the right system stewardship, could be strengthened relative to current arrangements. In each subsection, we briefly outline the current arrangements in England and where there are gaps or weaknesses. We then describe examples of alternative approaches drawn from other countries or public sectors and, finally, explore the likely choices that the Commission or government will need to make and the considerations and trade-offs they will have to navigate.

Access and eligibility

Determining who has access to publicly funded social care is a key dimension of governance and will need to be defined in any newly reformed care service. At present, eligibility for any state funding in England is determined by both needs and financial means, which means that resources are concentrated on those with the highest needs and lowest means. This is quite distinct on the world stage, with most countries basing eligibility for some state-funded care on need alone. Often a means test is then applied to determine what the individual contributes but people with needs generally have access to some state funding.

Variation in eligibility for, and access to, social care is a well-documented issue within the English social care system. Under current governance arrangements, duties for assessing and meeting needs sit with each of the 153 local authorities which hold social care responsibilities. Despite an attempt to introduce more standardised eligibility criteria as part of the Care Act 2014, variation has persisted (although the limitations on data availability

in this sector make that variation difficult to quantify exactly). Although the legislation outlines that councils must meet needs related to a set of criteria, local authorities have a certain amount of discretion in setting thresholds of need. They also have discretion over the means test, but to a lesser degree (the national rules are very clear and, while councils can choose to be more generous, they cannot be less so). There is also variation in terms of the process someone must go through to be assessed; in how long someone might wait for an assessment or package of care; and in the level of public funding someone eligible for care might receive.

The result is that people with a care need might have very different experiences depending on which council they reside in, and may have access to very different levels of public funding or support for the same level or scope of need. Available data indicates that there has been a fall in the number of older people accessing public funding for care over the last decade, despite the rise in the proportion of older people in society. It is not clear to what extent that drop can be explained by tightening needs assessments or the fact that the means test has not been adjusted since 2010. What is clear is that the financial pressures that councils are under are causing them to review and tighten eligibility criteria. The lack of a standardised needs eligibility process means that there is very little certainty for individuals about what they might expect from the system. Furthermore, councils have the freedom to organise their processes as they see fit, and many people find navigating the system stressful and complex.

Our roundtable discussion identified access and eligibility as an area where there is an opportunity for improvement in a reformed system. Reducing variation and providing greater certainty and consistency in who can access publicly funded care, and how much, were identified by attendees as a system priority. There are a number of different approaches that have been used around the world and in other sectors that could be considered for social care in England, although each would come with complexities and implementation challenges.

Alternative models

In the selection of other countries we studied, it is notable that several (particularly those that have undergone recent reforms) have adopted a national approach to eligibility and access with the intention of reducing variation. Concern around variation has centred on a sense of lack of fairness and certainty, with inconsistency in offer seen to be unacceptable in those systems. Within the cohort of countries we studied, eligibility processes vary in how prescriptive they are and in whether assessments are carried out by local or national bodies.

Governance arrangements	Examples	Approach
International social care examples		
National standardised eligibility assessment with local implementation	Germany	Germany was one of the first countries in our cohort to adopt a national assessment process, in 1995, as part of its introduction of a new long-term care insurance system. A standard national framework, developed by the central ministry, assesses a person's ability to manage with respect to six domains. These are carried out by local medical review boards which are independent bodies contracted by long-term care insurance funds. The assessment assigns those eligible to one of five levels of need. Individuals have the right to be reassessed if they disagree with the level assigned.
	Japan	Japan adopted the German approach in 2000 but adapted it to be even more prescriptive and granular. A standard form is used across the country that assesses needs against 74 criteria. The assessment is, as in Germany, set by the ministry but undertaken by a local municipality assessor who assigns a level of need between one and seven for those eligible. All assessment results are reviewed by a multi-disciplinary long-term care insurance certification committee.

Governance arrangements	Examples	Approach
National standardised eligibility assessment. No local implementation	Australia	Replacing a number of different pathways, Australia's new single Integrated Assessment Tool (IAT) is administered by independently accredited organisations that are contracted by the national government. They all utilise the IAT and results are fed into the new 'My Aged Care' online portal, which functions as a single point of access to the system and assigns a level of need. The Australian reforms have sought to address two main concerns identified in its recent Royal Commission: inconsistency in access across the country; and complexity in navigating the system. Unlike in Germany and Japan, where the results of assessment are reviewed by professionals, Australia's system relies on an algorithm to assign level of need, and concerns have been raised about its accuracy and lack of ability for professional discretion or influence.
National principles but strong local discretion and implementation	Denmark	Denmark has a highly devolved approach where local municipalities have accountability for social care for older people. National government sets some high-level principles to guide the system but, otherwise, municipalities are able to design eligibility criteria, access and make funding decisions.

Governance arrangements	Examples	Approach
Examples outside adult social care		
National standardised guidelines	Sentencing Council	Another sector that has sought to introduce more national standardisation is the criminal justice system. The Sentencing Council is an independent non-departmental public body which aims to provide consistency in sentencing approaches. The Council sets sentencing guidelines for the judiciary within the ranges established in legislation. Although independent, the justice secretary and Lady/Lord Chief Justice have, since September 2025, been given veto over new guidelines in an attempt to address a perceived 'democratic deficit' following a dispute over consideration of protected characteristics in sentencing guidelines.
Local authority discretion	Children's social care	In a similar way to adult social care, local authorities have reasonable discretion over when to take a child into care. The reasons for this are complex, including different views on the appropriateness of care settings and differing levels of risk aversion between local authorities. The Children's Commissioner has argued for "national thresholds for assessment and support under section 17, through defined national thresholds of needs and strengthened national guidance for local authorities".
Eligibility criteria design and implementation	Benefits	Eligibility for certain benefits has been the subject of much recent debate. Reviews of the strengths and complexities of the eligibility processes and criteria for different benefits provide a great deal of learning for government on the potential design of an approach for social care. The eligibility criteria used for Universal Credit, for instance, has favoured simplification but its rollout has been lengthy and fraught with IT difficulties. The design of the Personal Independence Payment has been critiqued for creating cliff edges between binary categories, so while the introduction of more nuanced categories may address that, it would bring greater complexity in defining categories and in people moving between levels more frequently.

Trade-offs, consequences and considerations

Establishing greater consistency and fairness in eligibility is likely to be a central pillar of a National Care Service. Without some sort of clear offer or certainty of access, it is difficult to see how a service can be framed as 'national'. The clarity and consistency that would result would also help to address deep-rooted concerns about fairness and could build trust and support among the public.

England is not new to this debate, and previous attempts to introduce greater standardisation in eligibility suggest that another attempt would not be without challenges. While a more consistent approach to deciding who receives public support would help to address unfair variation and uncertainty, the Commission would need to carefully consider a range of trade-offs and potentially complex consequences. It is worth noting that despite having a 'national' health service, there is still widespread and well-documented variation in patient experience, spending, access and outcomes.

Determining eligibility to public funding via a needs threshold is a key lever that local authorities possess to control their expenditure in this area. Without that local discretion, local authorities would potentially be put under unreasonable pressure. In all the other countries with a national needs assessment process, funding commensurate with the individual's level of need flows from central government or social insurance fund to either the individual, their provider or their local authority. For national eligibility criteria to consistently work in England, it is likely that reform to funding allocations would be required to ensure that councils receive adequate funding to provide the appropriate level of care. Under the current system, where councils rely to a large degree on variable local revenue raising (which does not necessarily align with level of need), a requirement to provide a set amount of funding based on a standardised assessment of need would be difficult. Reform to the local government funding allocation formula, along with adjustment to the adult social care relative needs formula, is intended to adjust grants to better reflect need. But further consideration would be needed as to whether these adjustments would be sufficient to support a national eligibility process. It is notable that all the other countries in our cohort have some form of national pooled approach to funding.

Monitoring the impact of any change to needs testing on financial sustainability will be crucial. Japan's experience is useful to note here. When initially introduced, the system was very generous with thresholds of need set deliberately low to build public support. However, need grew beyond what had been estimated and after five years the eligibility criteria were raised, pushing the lowest two levels of need into low-intensity preventive support programmes. Embedding reviews every three years into the overall governance of the system provided a mechanism for the government to make this adjustment without legislative change. Germany, on the other hand, has to undergo legislative change to make such adjustments, although it has done so semi-regularly.

There is then also a question over which organisation should set the criteria for eligibility assessments. There are international examples of this sitting within the responsible ministry (e.g. Japan and Australia) or in arm's-length bodies (e.g. Germany). Placing responsibility for setting criteria in an arm's-length body may help to de-politicise the crucial point of decision-making. However, the example of the Sentencing Council demonstrates that, despite the intention to depoliticise the issue, ministerial control has been reintroduced to address a perceived weakness. It is possible that a similar desire for ministerial control could be a factor in social care too.

A rare example of where criteria-setting in an arm's-length body has endured is in NICE, which was established to set national evidence-based guidelines for clinical diagnosis and treatment without political interference. It is interesting to note that, after over 20 years of operating, recent changes have resulted in greater ministerial influence and the removal of a requirement to consult on method changes that emerge from ministerial direction. While there is potential (and likely great value) in bolstering NICE's capacity to undertake evidence-based assessment or evaluation in social care (see section on innovation and improvement), it is unlikely to be the right organisation to pass judgement on social care eligibility criteria. It is rooted in the medical model, which could conflict with the vision that the government and the Casey Commission want for a social care system. Furthermore, decisions on a threshold or criteria of need for state-funded social care is less of a technical question and one more rooted in political priority, judgement and social values.

A further issue to explore is how, and by whom, any criteria that are set at a national level are then administered. Should this be by local government, a nationally appointed representative, or an independent body? Deciding where to balance consistency versus local flexibility in designing a new assessment process will need to be a key consideration. A further consideration will be deciding how prescriptive the process is, versus allowing some discretion based on professional judgement, individual need or preference. Having the appropriate infrastructure to administer a more standardised approach is a prerequisite.

A single online portal to guide a person through the system has merit, although digital exclusion, particularly among a large cohort likely to be accessing care, is a very real concern. In Australia's highly centralised system, there is no physical local 'front door' to the care system, and a number of agencies have emerged to help people navigate the complex design of the new system. The rigid online system allows no professional discretion or judgement within the assessment, and some experts have raised concerns. Japan, by contrast, has ensured that municipalities are very clearly the administrative body from which people can seek assistance. Having clarity over how, and by which agency, a needs assessment is undertaken is important for building trust and clear accountability into the system.

Lastly, determining the outcomes of any eligibility process needs to be part of the reform to access. In addition to consistency of process, true consistency would also require a standardised 'offer'. That could be in the form of a scale of need with associated funding (in Japan and Australia this is in kind; in Germany it can be taken in a mix of cash and/or in kind), or it could be a defined package of care, such as free personal care in Scotland. The latter brings with it a certain clarity but has been critiqued for its lack of flexibility – for example one person may benefit more from assistance in other parts of their life than from free personal care.

Commissioning and market-shaping

Councils hold an explicit duty, set out in the Care Act, to shape their local markets. There is a question about where any commissioning and market-shaping function should sit in a newly reformed system, and the answer will largely depend on broader decisions about the overall shape of any National Care Service.

This means councils must understand their local care provision to stimulate a stable and diverse range of care and support services that can give individuals a choice of providers to meet their needs and preferences. This duty applies not just for the people they fund, but for all their residents, some of whom will fund and/or organise their own care. There are clear advantages to councils shaping their care markets to meet local population need, and some level of variation may be warranted to reflect this. However, with 153 local authorities holding commissioning responsibility, there is the potential for 153 different outcomes. Furthermore, at time of writing, plans for local government reorganisation remain uncertain, and there is no national framework to set broad ambitions for provision, and limited platforms to share good practice.

The outcomes of these decisions are not always positive for people who draw on care, especially when commissioning decisions are driven primarily by pressures to balance budgets (another council responsibility), further compounded by short-term national funding cycles, propped up by emergency cash injections, that are translated into short-term contracting between local authorities and providers. We have previously written about factors which contribute to large variations in approach to market shaping between councils, such as the relative wealth of an area, and the capacity, capability and culture of commissioning teams in each council.

There are several reasons why this may be a problem. First and foremost, it means that people who draw on care and their carers may have an inconsistent and unequal experience of their local care provision – a key issue that the previous care minister had stated as an issue to resolve. Second, there is significant variation in the fees paid by different local authorities for the same service, which drives market instability and leaves providers of care vulnerable to external shocks. Commissioning across 153 local authorities also

creates inefficiencies, especially for the providers who work across multiple local authority boundaries and must manage different approaches, for example to contracting, payment and performance management.

Roundtable attendees highlighted market shaping as a key area for improvement, especially to address the large variation in fee rates across the country. They discussed whether there could be potential to make commissioning approaches more coherent, and to create a 'fee floor' or basic minimum expectation for what markets for care should deliver. Some participants questioned whether a greater national role could enable this.

Alternative models

Our studies of other countries and other public services highlight a spectrum of governance arrangements to strengthen market shaping, commissioning and fee setting, outlined in the table that follows. The different approaches range from the strongest to the softest levers. More specific examples around financial oversight and improvement and innovation are also featured in the following sections.

Examples from other countries/public service areas:

Governance arrangements	Examples	Approach
International social care examples		
National frameworks, but local market shaping	Japan, France, Scotland	Local areas have market-shaping powers and responsibilities but operate within national frameworks which set provider payment rules, for instance through: fee schedule (Japan, Germany, Australia), national minimum contract rates (France, Scotland), legislation to set maximum annual fee increases and transparency on prices (France). In Japan, municipalities must undertake needs assessments and submit plans to prefectures every three years to demonstrate how they are meeting needs.
Local market shaping for majority of services, but with national/ regional commissioning of specialist or specific services	Proposed in Scotland as part of National Care Service reforms	Plans to introduce a National Care Service in Scotland include a proposal to develop a national commissioning and procurement team for complex and specialist services, custodial settings, and residential care homes, and to set the National Care Home Contract.
National or regional support function for local market shaping	Wales	Wales has developed a National Office for Care and Support to develop national commissioning principles and standards, and provide commissioners and providers with a commissioning toolkit.
Fully autonomous local market shaping, set within broad national principles	Denmark	Legislation sets broad national aims and principles and some specific requirements for local areas to follow (for example the legislation stipulates that providers must provide services across the whole pathway, or that people must have a minimum number of state-owned and non-state-owned providers to choose from). But there are limited oversight mechanisms – market development and shaping is entirely left to local authorities.

Governance arrangements	Examples	Approach
Examples outside social care (public services in England)		
Regional market shaping	Children's social care	Pilot of Regional Care Cooperatives currently underway to test whether these can strengthen power held by commissioners rather than providers, support more strategic commissioning, and reduce competition across local authorities.
Local market shaping for majority of services, but with national/ regional commissioning of specialist or specific services	NHS specialist services	NHSE took on the role of specialist commissioning in 2013, before which strategic health authorities undertook the role. Although moves were made in 2022 to delegate more responsibility for specialist services to ICBs, NHSE has retained accountability for them to ensure consistent national standards and ensure quality and improvement.
National or regional support function for local market shaping	NHS Commissioning Support Units	NHS CSUs were established in 2013 to provide back office support, analytical capability, and advice to then-CCGs, and to help spread learning and good practice. After undergoing consolidations and mergers over time, CSUs are being disbanded but provide possible learning about the provision of regional commissioning support. There are now questions about how to preserve some of the analytical and commissioning capability under the new governance arrangements.

Trade-offs and consequences

Social care is fundamentally about the people who draw on it, and the communities they live in. It makes sense, therefore, to have some level of local direction in shaping the provision of care at the level in which these communities exist, and local authorities are well positioned to do this. However, the lack of a consistent offer across the country means that many lose out on the care that best supports their needs, despite the principles set out in the Care Act which already outline broad ambitions for what a local market should achieve. There is therefore scope for improvement that could be addressed at national, regional, or local levels.

How the governance of market shaping needs to evolve to achieve this depends on the overarching vision of the care system, and the choices to be made by the government about the extent to which consistency is valued over flexibility and choice. It is interesting to note that almost all of the countries we have reviewed have sought to bring in a greater level of national oversight on market shaping – although to varying extents, ranging from a fully national and prescriptive approach in Australia to a more principles-based approach in Denmark, and relying on both hard (e.g. legislation, mandatory frameworks) and soft (e.g. guidance and support) levers. Many of these countries have explicitly turned to more national or regional levers to address unwarranted variation.

There is an opportunity for a stronger national and/or regional role in England too, although each choice will have its own trade-offs and consequences that fall along a spectrum from light-touch change to existing arrangements to more radical approaches.

Perhaps the least risky option would be to increase national and/or regional oversight through commissioning support functions, without necessarily changing existing structures. This could take the form of a more explicit commissioning support function that would sit within DHSC or as a separate office (as is the case in Wales) to signal at a national level, for example, the intentions for the sector and what types of care should be prioritised to manage current and future need. A support offer could be developed at a national or regional level, for instance through training and the development of a career pathway, guidelines and the provision of support to identify and spread models evaluated as 'good practice'. Some of these elements (such as the career pathway) are already under development. The LGA's Corporate Peer Challenge could provide a good foundation for scaling and spreading good practice (see 'Improvement and innovation' section).

A stronger option could be to employ more robust legislative levers that strengthen national oversight while maintaining current governance arrangements (although reducing local authority ability to control pricing and demand). This could be achieved, for instance, through regulatory frameworks to determine how providers set and increase their fees, or to mandate more transparency, as has recently been introduced in France, and was attempted through the past government's fair cost of care exercise. At

the more intensive end of this spectrum, more significant structural changes could be used to support minimum standards – such as moving some or all commissioning to a national/regional level (as in Australia), and/or setting a national/regional minimum fee or schedule for care (as in Australia, Germany, Japan). The NHS's tariff and payment by results offers experience closer to home on the potential consequences of moving towards a strict national approach to fee-setting and the pros and cons of using payment to influence behaviour.

All of these options hold the potential to reduce duplication of work, drive more consistency in the way care provision is organised, and move towards delivering some minimum standards for care. But each option also comes with trade-offs. For example, less directive approaches would cause minimal disruption to the status quo, but may be less obvious in their impact, as has been demonstrated through previous government efforts to develop a training programme for commissioners which produced limited results. At the other end, setting a national contract or fee schedule for care could support market stability (depending on where it is set and the funding available), but would likely be inflexible in design and remove local ability to manage, respond to, and shape demand. In the Australian example, in which the market relies on individual choice and competition but has no local market shaper, there is a risk of poor outcomes for people who draw on care, in the absence of perfect information to support people to make their decisions.

For any of these options to lead to their desired outcomes, it will be essential to consider what infrastructure and capabilities need to be developed alongside. To continue with the previous case study, Australia for example introduced a national portal to help individuals navigate the complex care landscape.

The return to multi-year council settlements (made possible by the multi-year spending review in 2025) should enable longer-term strategic commissioning decisions, provided that local government funding keeps pace with the evolution of need. A balance will need to be struck between 'time and task' spot purchasing approaches that drive instability and poor outcomes for people, and block contracts set over too long a period (some places have contracts over 25 years) that can be inflexible and prevent the ability to shape supply around changing need.

As we discuss in the next section, the government already focuses its approach to market oversight on the care market's largest providers, but there may be scope to consider whether other types of provision warrant different approaches to market shaping. For example, there may be some types of specialist care where a more regional or national approach to market shaping could ensure there is sufficient provision (e.g. learning disability residential care). The government may wish to be more active in signalling specific areas that are a priority for the market, but currently under-developed, for instance by setting a national steer on what 'good' looks like for dementia care. It will be important to consider the potential implications on the wider market of prioritising different approaches for different types of care. The fair cost of care policy implemented in 2022 focused on older people's residential care, and this had knock-on effects on the learning disability sector. It did not receive the same level of policy attention and funding, and it resulted in contract hand-backs in some areas.

Market oversight to prevent provider failure

Alongside their duty to shape markets, councils also have a distinct statutory duty to oversee their markets, and act when providers fail. The English care sector has seen some high-profile closures of residential providers in recent years, often as a consequence of financial mismanagement and unsustainable business models with high debt burdens (as was the case with Southern Cross and Four Seasons). These closures, which led to distressing situations for the thousands of people who relied on these services, have resulted in a more stringent national oversight framework to scrutinise activity among the care market's largest providers.

As such, since 2015 the CQC holds responsibility for overseeing the financial information of around 65 of England's largest care providers (approximately 30% of the overall market), and for intervening to ensure continuity of care if they are at risk of failure. The regime did not extend to cover the sizeable proportion of providers which are small and medium sized, and which also experience instability with high rates of mergers, closures, acquisitions and exits.

It is worth noting that the responsibilities afforded to CQC were less interventionist than those originally proposed, which would have required a significant expansion of CQC's remit and created potential sensitivities around commercial law. As a result, CQC can only intervene to manage collapse, but cannot prevent it or require owners to improve their financial position. Through their statutory duty of market oversight, local authorities must ensure continuity of care in the event of a large provider exiting the market at short notice. This can be difficult to manage at a local level, particularly when these large providers operate across multiple council boundaries.

In our previous work on care markets, the CQC's role in the financial oversight regime was described to us as a 'spectator at the site of a car crash', due to its limited ability to intervene prior to collapse or to support or remove failing providers from the market. This function is furthermore hampered by the opacity of financial data and the limited analytical capacity available to analyse it.

More broadly, there are limited levers at both local and national levels to oversee the behaviour of care providers beyond those 65 largest organisations, leaving many blind spots. The care market fluctuates rapidly, with high turnover due to rapid exit, entry (especially in the home care market), and mergers. Opaque ownership structures and frequent renaming of organisations can make it difficult to follow these trends and understand the impact of different types of care provision on the quality and continuity people receive. There is also poor transparency on the fees paid to and charged by providers, in particular for people self-funding their own care, who are on average paying 40% more than the local authority for the same service.

These issues raise the question of whether the existing infrastructure for financial oversight sufficiently protects people who draw on care from unexpected closures and unclear costs. In recent years, the government has sought to encourage more transparency through reporting, for instance to understand how local authorities apply fee increases as a condition of the Market Sustainability and Improvement Fund. But while the publication of these figures supports a greater clarity over local authority fee paying practices, there are further opportunities to strengthen existing governance arrangements to more actively oversee and manage this market which primarily depends on public funding.

Roundtable participants emphasised the large number of providers in the market and the implications for the regulator, whose inspection regime currently struggles to keep pace with the market, if it were to achieve more comprehensive market oversight. Provider representatives in attendance felt that there could be greater scope for the government to set a clearer expectation of the types of provider that should be providing services – or rather, whether any types of provision would be undesirable.

Alternative models

Many of the models discussed in the previous section on market shaping could also be extended to support better financial regulation of the markets for social care. The examples we outline in the next table could also support a strengthened approach to market shaping, but we have chosen to discuss them here for their particular relevance to addressing financial oversight issues.

In recent years several countries have also strengthened their national levers to provide greater scrutiny of financial practice – for instance through setting fees or barriers to entry to the market, or through mandating strict and transparent provider returns of their accounts.

Governance arrangements	Examples	Approach
International social care examples		
National fee schedule for care	Germany, Japan, Australia	Countries such as Germany, Japan and Australia have adopted a comprehensive national fee schedule for all services which guarantees a set rate to providers for a particular service or level of care for the publicly funded element(s) of care. These approaches have varying degrees of local flexibility with Germany, Japan and Australia all adjusting for variable local market costs. In all these countries, the fee schedule acts as a minimum rate that providers can expect to be paid which offers security.
National minimum tariffs	Scotland, France	Other countries have stopped short of a comprehensive fee-schedule but have sought to put in place some minimum pricing. France and Scotland have introduced a national minimum tariff, which sets a basic guarantee for providers. In Scotland, this takes the form a national care home contract, intended to set an annually agreed rate for care home placements. It negotiated between representatives of local authorities and providers.
Barriers to market entry	Germany, Japan, Australia	Countries such as Germany and Japan have set high barriers for providers to enter the market, for instance through strict staffing ratios or building requirements. Japan, too, restricts for-profit organisations from entering the residential care market. For-profits are free (and in fact encouraged) to enter the home/community care sector. Australia's new regulatory regime involves an in-depth financial and organisational audit as a condition of registration.
High transparency	Denmark, France, Australia	Countries such as Denmark, France and Australia mandate higher transparency through requiring detailed provider accounts, such as proof of solvency. In France, local areas have the discretion to set profit caps. Australia's new market management system requires quarterly financial statements including solvency reports. Furthermore, care homes in Australia are required to provide residents with a detailed itemised bill to aid with transparency.

There are some limited examples of established approaches to developing more stringent financial oversight from other public sectors.

Governance arrangements	Examples	Approach
Examples outside adult social care		
Strengthened local authority buying power	Children's social care	The Regional Care Cooperatives currently being piloted for children's social care were devolved, in part, to increase the negotiating and buying power of local authorities which is currently concentrated in the hands of private providers.
Profit caps	Children's social care	The government is giving itself greater oversight powers in the children's care market. Under new legislation, the government will be able to cap providers' profits in the instances where they believe it to be excessive. The government also intends to create a 'financial oversight framework' to have clearer sight of the finances of predominant providers, a decision which is intended to prevent large-scale failures. The way that the government will implement these reforms is still unclear.
Profit ban	Children's social care	Wales has already implemented a similar approach. The government introduced legislation in 2025 which intends to remove profit from the children's social care sector. The first phase of implementation, effective from April 2026, prevents new for-profit providers of specific services from registering with the Care Inspectorate Wales, and limits the scope of existing providers to amend their registration. From April 2027 it will no longer be possible to place a child in a for-profit organisation in Wales or England unless through exceptional agreement from Welsh ministers.
Nationalisation	Childcare	The government has increased the nationalised provision of childcare through the expansion of school-based nurseries, which it is partly doing to compete with private providers and drive nursery fees down for families. This expansion also supports a local market-shaping role in giving local authorities greater negotiating power with private providers.
Rent control	Housing	Since the end of the nineteenth century, the government in England has provided some form of social housing. This is housing that is typically provided by either a local authority or a housing association. Those properties are more affordable than properties available in the private rental sector, with rents often linked to the level of local incomes. This provides secure, affordable provision to people who would struggle to access appropriate accommodation in the private sector.

Trade-offs, consequences and considerations

There is a strong case for strengthening the regulatory framework to prevent or better manage provider failure and reduce the consequences for people who draw on care. However, any changes to the regulatory landscape should sit within a clear and articulated vision of what the system is intended to achieve, and how different types of provision sit within that. Any significant reforms should also be carefully phased to avoid suddenly disrupting the market, with a clear timeline for implementation and a proactive approach to identifying and mitigating unintended consequences. The priority for reform should be strengthening protections against providers who engage in malpractice and put people who depend on their services at risk (whether around financial mismanagement or safeguarding issues).

Decisions about how to frame these issues, and how to design the regulatory tools to address them, need to consider a number of factors. For instance, a strengthened regulatory framework could choose (or not) to be agnostic about types of provider ownership. It is interesting to note the example of Wales, where an explicit decision has been made to eradicate for-profit provision for children's care. Recent legislation has therefore specifically focused on restricting how for-profit providers operate in the Welsh children's care market, leading to calls for the same to happen for adult care. Japan, similarly, has rules that restrict for-profit providers entering the residential care market. Within the for-profit sector in England, there are a range of ownership models ranging from small, private, often family-owned enterprises to large multi-national private equity-backed providers.

In England, the current distribution of provision, in which private providers dominate and only a very small proportion is operated by the state, has emerged in a largely uncontrolled and unintended way (see the Humphries and Timmins working paper). The Commission and the government may wish to take an explicit position on the balance of public, not-for-profit, and for profit provision, and whether social care is a sector where profit from public funding is tolerable – as the government under the previous Prime Minister announced for the children's care sector with the intention to set profit caps for private providers. The role of private equity in the market is of particular significance and its benefits of attracting investment versus its risks of instability driven by high debt ratios needs to be carefully examined.

The impact of any changes on the health of the different parts of the existing market and to what extent exits (with the risk of reduced capacity) are desirable also need to be considered.

A further factor to consider is whether strengthened oversight infrastructure best sits at local, regional, and/or national level. One option would be to build on existing national structures (e.g. CQC or DHSC) and equip them with stronger tools and levers for intervention. More robust financial oversight, for example, would require improved national data and enhanced capability and capacity to understand opaque financial returns. Hosting some of this capacity at a national level could create some efficiencies of scale. In addition to national oversight, there could be value in bolstering the financial literacy and capacity at local and possibly regional level too, to capitalise on existing relationships and on local insights, especially for smaller and local providers that will be much better known to local commissioners.

Currently, the financial oversight function sits with CQC. There are questions about whether this arrangement is working as it should, given the pressures the CQC already faces around its wider inspection capability and primary focus on quality assessment. Initial proposals centred on the-then financial regulator Monitor holding the role based on its financial expertise, but it was eventually placed with CQC to align financial oversight with quality inspection and social care expertise. There was careful consideration at the time, that is worth revisiting, of whether separation of economic and quality regulation was desirable and which organisation was best placed to take on the role of formal regulation of 'difficult to replace' providers. Of course, Monitor now no longer exists as its functions were absorbed into NHS Improvement, which in turn was absorbed into NHS England. There could be scope to consider the intersecting roles of wider market regulators, such as the financial watchdog, the Financial Conduct Authority, particularly in light of its more recent activity to understand risky investment schemes into care homes. Looking forward, there is a need to ensure that the responsible body has the skills and capacity to undertake the role and an ability to work closely with related agencies.

Many other countries have adopted national-level approaches in recent years to address issues of provider failure. This may reflect the fact that scandals relating to provider mismanagement have emerged more recently in these systems than in England, so have led to more intensive reform activity. These approaches

often involve setting higher barriers to entry and stricter rules governing provider behaviour which could reduce opportunities for mismanagement. However, there are some trade-offs: such measures could constrain new capacity and give existing providers more market power. This has occurred in children's social care and led to poor outcomes where children are subjected to unsuitable care, sometimes with far-reaching consequences.

Stronger intervention on fee setting could be considered as a mechanism for driving greater stability and transparency in the market. Some progress was attempted towards this under the last government's fair cost of care exercise in 2022. Introduced to support plans for a cap on care costs, the exercise aimed to establish a local median cost of care to promote greater consistency in fee setting. The policy received some criticism as it risked reducing the incentive to provide more complex or higher-quality care. Alternative approaches to more uniform fee setting could be explored – from highly rigid needs-related tariffs to broad minimums allowing for local flexibility. Mandating greater transparency of fees charged by providers would be a more light-touch approach, which could lead to more certainty for both local authorities and people who self-fund their care and could reduce the scope for risky financial practice. As with many of these issues, it will be important to be clear about the purpose of any reform and to ensure the risks and potential benefits of the proposed action are balanced.

Improvement and innovation

Although there are no explicit duties in the care system for commissioners and providers to stimulate improvement, a commitment to continuous learning and developing innovative models of care are deemed markers of outstanding provision in the regulator's assessment of both care providers and local authorities. In practice, many areas struggle to do innovation consistently, hampered by a transactional approach to contracting that leaves limited headroom for experimentation. The local authority duty to balance budgets can also contribute to a culture that is averse to taking the – sometimes large – risks required to test out new approaches.

There is limited infrastructure to support the uptake of innovation in the sector, and most sits at a national level. The Social Care Institute for

Excellence (SCIE), a charitable organisation independent of government, provides support to the DHSC to promote collaboration and innovation within the sector to improve the lives of people who draw on care. It does this through the provision of local and national consultancy support, the generation of research and evidence, training, and the production of resources to support best practice. The National Institute for Health and Care Excellence (NICE) is the formal body with responsibility for providing evidence-based recommendations of 'what works', which it does through providing recommendations on the effectiveness or cost-effectiveness of specific interventions or services.

The DHSC has also held a role in supporting innovation. The 'People at the Heart of Care' white paper (2021) led to the creation of an improvement and innovation unit within DHSC, which set out a number of priorities for improving the sector and managed a national innovation fund from 2023 to 2025. SCIE supported local areas to implement their projects and support their long-term sustainability, and possible dissemination across other areas.

At a regional level, the NHS Health Innovation Networks are intended to provide local support to health and social care services, although it is not clear to what extent they are regularly supporting innovation within the care sector. Many local authorities test and trial their own innovative approaches to care, sometimes in partnership with universities. However, approaches are not consistent across the country, and it is difficult to spread good practice from one area to another.

The infrastructure to support more innovation among care commissioners and providers has certainly accelerated in recent years. However, this infrastructure remains unstable and patchy. For instance, SCIE's status as a charitable organisation independent of, but holding a contract with, government means it has been able to grow close links and trust with the sector, but also means it has been at the mercy of contractions in central government funding: recent years have seen a decrease in income from DHSC grants from 64% in 2020/21 to 43% in 2025/26, creating financial uncertainty. NICE, as an executive non-departmental public body, has greater financial security, but roundtable participants were unanimous in their criticism of NICE's ability to support the sector, highlighting the very small amount of resource dedicated to social care (a roundtable attendee claimed

that NICE only has 0.5 FTE dedicated to social care, though we have been unable to independently verify that fact), and this was indicative of a lack of prioritisation, having not issued any guidance in the last four years. NICE was given statutory responsibility for social care in the 2012 Health and Care Act. For some time, it contracted out social care guidance development and standard setting to SCIE but took this in-house in 2018, since when only a small number of outputs have been published.

And, while DHSC's improvement and innovation unit enabled areas to test out small-scale initiatives, the National Audit Office has previously questioned whether the Department is best placed to hold this sort of role – citing limited delivery experience and a lack of powers to hold local areas accountable for change. It is not currently clear to us whether the improvement and innovation unit is still operational. There have been limited incentives through an inspection regime that has historically been deemed 'reactive'. This is evident through the CQC's own analysis in 2020, which found that there is a small cohort of providers who only ever receive a rating of "requires improvement", and a further cohort who can only sustain improvements for short periods of time.

These issues suggest a gap in the existing governance infrastructure of the care sector to better support improvement and innovation. Attendees at the roundtable questioned the approach of having crucial national support functions located in organisations contracted on short-term contracts, with the inherent financial uncertainty that brings (e.g. SCIE and also Skills for Care, see section on 'workforce planning'). They were also critical of the 'patchwork' of organisations in this space and the extensive focus on targets and frameworks as ineffective levers for change. While the organisations in question were felt to be highly effective in executing their briefs, given the pressures at play in the care sector, they felt that a stronger and more financially resilient infrastructure was necessary to enable local areas to think more creatively outside of the day-to-day 'firefighting'.

Alternative models

Some countries have sought, in recent years, to strengthen their national infrastructure for improvement and innovation, with the intention of giving local areas the tools to pursue innovation outside their day-to-day operations.

Countries that have placed a big focus on innovation have tended to develop specific arm's-length bodies to spearhead innovation. These are separate to both the regulatory infrastructure and policymaking function but operate in close collaboration.

Governance arrangements	Examples	Approach
International social care examples		
Specific innovation fund	France	In the last six years, France has heavily strengthened its infrastructure for improvement and innovation. The recovery programme which was introduced following the Covid-19 pandemic included €1.5 billion to modernise residential and nursing homes and develop new models of care. An additional €125 million was awarded for daily capital improvements, and some €600 million was awarded to strengthen the digital infrastructure for care records that could be joined up with health records.
Improvement financial incentive	France	Alongside the new minimum hourly tariff for home care in France, reforms introduced the possibility for home care providers to receive an hourly uplift (around 14%) if they were demonstrating improvements to the service or trialling innovations or new ways of working. The uplift is fully funded by the care branch and based on calls for expressions of interest in line with national policy needs.
Central innovation hub	France	Following the establishment of social care as the 5th pillar of social security in France, a 'laboratory for the solutions of tomorrow' has been developed to guide investments to transform care homes to be adapted to the future. The laboratory brings together managers and staff working in care settings, interior design specialists, university experts, local authorities, people who draw on care and their carers to work with members of the care branch to test out new approaches and develop tools to embed these at scale.
	Denmark	In Denmark, recent reforms to move more care into the community have introduced a new National Centre for Health Innovation to boost the development and spread of national and local innovation initiatives. This complements existing regional centres for innovation, some of which have generated evidence to guide the development of local and regional uptake of telecare options.

Across other public services, there are many well-established models:

Governance arrangements	Examples	Approach
Examples outside adult social care		
Sharing good practice	Health, social care, children, local government	Many areas of public service have independent 'What Works' centres that have been developed to create and make better use of evidence in decision-making (as discussed, NICE holds this role for social care). Foundations, the What Works Centre for vulnerable children and families, is well-established and has shaped and influenced key policies for children since its inception. The Department for Work and Pensions operates a highly centralised approach to JobCentre Plus based on its evidence of what works. It operates strict rules on how staff should operate based on that evidence.
Peer review/ support	Local government	The Local Government Association helps local authorities to support each other through the Corporate Peer Challenge, in which senior councillors and officers visit other local authorities to review their finances, performance and governance approaches.
Improvement support function	Local government	The Local Government Association also hosts the Partners in Care and Health Partnership, which brings together ADASS, the LGA and SCIE to provide improvement support to local authorities. In London, the local government innovation team, the London Office for Technology and Improvement (LOTI) supports London's local authorities to use innovation, data and technology through capacity-building, knowledge sharing, influencing change, and collaboration. LOTI is currently developing a Sandbox approach for adult social care innovation.
Evaluation support	Cross departmental UK government	The government established the Evaluation Task Force (ETF) following the 2020 spending review as a joint team between the HM Treasury and the Cabinet Office. The ETF is designed to improve the evaluation of government programmes, to support decisions about whether they should be "continued, expanded, modified or stopped". They are primarily intended to support decision-making by HMT spending teams. But the ETF also works with departments to improve evidence across government. The ETF launched the evaluation registry in March 2025, a repository of evaluations.

Trade-offs, consequences and considerations

Given the government's own ambition to deliver improvements to the care sector, there is clear scope to strengthen the infrastructure to do this. Indeed, stronger support for innovation and improvement is a necessity if the sector is to meet the evolving needs and preferences of the people it supports. There are many well-established models from other countries and across other English public services that can serve as a blueprint for a strengthened improvement offer for social care at a national level. This was strongly encouraged by the attendees at our roundtable, who called for a clearer 'theory of change' from government on how to adopt good practice and achieve this across multiple different areas.

An enhanced national innovation function could provide clearer central direction for the sector, reduce duplication of effort, and signal to local commissioners, providers, and innovators which innovations would be needed to achieve these ambitions. This would need to capitalise on, rather than duplicate, existing support providers – for example, a simple approach could be to bolster SCIE's evaluation and support capacity, and recognise it more formally as the government's independent innovation support function with commensurate stable financial support. Another option could be to build an in-house innovation function within DHSC, continuing with the direction of the previous innovation and improvement unit. While this would allow a more consistent link between the improvement offer and the development of policy, it would lack the independence to scrutinise its own initiatives and could lose the trust of the sector.

A balance will need to be struck, however, between setting a national direction and having too strict a national framework or too strong a focus on performance management. Evidence on the role of government in improving employment support for people suffering from ill-health shows that a strictly centralised approach, albeit based on good practice evidence, has limited innovation and prevented better integration at a local level. Indeed, innovation is often delivered by frontline services despite, rather than because of, central government intervention. The government should consider the enabling conditions that allow that innovation to take place. This includes things like creating policy stability, setting long-term funding, and reducing the number of tightly mandated targets, among others.

As one roundtable participant described, there is a need to combine a 'more centralised direction with more locally flavoured ingredients'. That could involve central government setting long-term priority outcomes, while allowing local areas flexibility in how they achieve improvement. As such, there may also be value in embedding this improvement offer at regional or local levels which could be more closely adapted to operational realities, for instance in the shape of regional evaluation taskforces. Roundtable attendees suggested that the new Mayoral Strategic Authorities could hold potential in delivering innovation support across a larger footprint than local authorities, offering potential economies of scale. However, their role would need to be clearly confined to supporting innovation, rather than performance management, given they have no ability to hold constituent local authorities to account. How any new centralised functions align or conflict with ambitions around devolution will need to be a central consideration.

It is worth noting that bestowing statutory responsibility on an organisation (NICE) for social care has failed to deliver to date, and so it is important to think more about what attributes an organisation holds, rather than focusing on its legal status. To deliver the role effectively, an organisation would need to have visibility, commitment, resourcing, capacity and capability as well as strong links and delivery routes with the sector.

Workforce planning

Despite the social care workforce numbering more than 1.5 million people occupying over 1.6 million posts, there is no statutory workforce regulator or support body and there has been no government-led dedicated social care workforce strategy since 2009. With no mandatory register of care workers, low unionisation and approximately 19,000 separate employers spanning a range of private, voluntary and public sector organisations represented by at least 10 different membership bodies, this is a vast and complex landscape. While there is good data on the minority of regulated professions that work in the sector (e.g. nurses, occupational therapists, social workers), the absence of any form of workforce register means there is patchy, albeit improving, data on the 'frontline' workforce. There is no data at all on the officers that work on adult social care within local authorities, meaning there is limited understanding of the characteristics of that part of the workforce. However,

the sector's workforce is known to have extensive challenges, including persistently high vacancies, high turnover, poor recruitment and retention rates, low pay and poor terms and conditions. Furthermore, although data is limited, there have been indications that capacity and capability within local authorities have been lost during the previous decade.

The national strategic workforce development body, Skills for Care is an independent charitable organisation contracted by government. Similar to SCIE (see 'innovation' section), the grant awarded by DHSC had been reduced sharply in recent years (from £30.2m in 2023/24 to £13.5m in 2024/25). Last year, its contractual status was changed, shifting it away from grant-funding towards a commercial footing. The organisation holds crucial data about the workforce – collected under a voluntary scheme from individual providers – and undertakes analysis on the state of the sector's staffing (e.g. in terms of vacancy rates, turnover, pay etc) on behalf of the DHSC. Because data submissions to Skills for Care are not mandatory, data completeness and quality is variable, although improving. Skills for Care undertakes data cleaning and modelling based on assumptions to produce total representative estimates of posts, vacancies and other areas. Despite this critical role, Skills for Care is not formally accountable within the system beyond the terms of its now commercial contract which runs only to 2029.

There is some lack of clarity over where ultimate responsibility sits for workforce development, planning and oversight, with much of the monitoring and activity based at Skills for Care but with discrete initiatives such as the career pathway being led by DHSC, albeit in partnership with Skills for Care. Skills for Care developed and launched a strategy for the social care workforce in 2024 in collaboration with a wide range of sector stakeholders. However, DHSC has not adopted the strategy and Skills for Care continue to roll it out independently with the resources and reach they hold.

One consequence of the lack of central national strategy or point of accountability, besides persistent vacancy issues, is regional variation in recruitment and retention rates and in terms of support available for local workforce planning. For instance, some areas have care workforce academies intended to support recruitment campaigns, training, mentoring and research, but these are by no means consistent across the country. One notable example, located in Leeds, offers support and development to the entire local health and care workforce.

Another consequence of loose national oversight, regulation and planning was seen in the wake of the expansion of the health and care visa to social care in 2022 and the extensive exploitation that took place among some unscrupulous employers. Relatedly, the social care workforce is impacted by policies and dynamics beyond the sector's control. Sudden shifts in immigration policy have had profound implications for this workforce. NHS terms and conditions and recruitment initiatives, too, can adversely affect social care by drawing in workers and exacerbating vacancies. Lastly, wider employment policies, such as the national minimum wage, are a major driver of costs in the sector and can pose challenges for employers in local labour markets where competition from other sectors is stiff.

Of course, one major national development that currently sits with the DHSC is the Social Care Fair Pay Agreement. This forms part of the Employment Rights Act 2025 and is intended to improve the poor pay and terms and conditions in social care. This is being developed in advance of, and in isolation of, a long-term workforce strategy but will have profound implications for any and all other workforce considerations. It will be important to consider how best to integrate this work on pay and terms and conditions, and its eventual enforcement, with broader ambitions for the shape of the workforce.

Workforce oversight and planning could consist of a variety of different activities, from better data collection and registration to stronger regulation, national pay-setting and training and career progression. Below, we have focused on registration as a specific activity for which there are alternative models from elsewhere and on other structural models for strategic planning. There may be many more detailed examples of specific activities beyond these that could form a whole report on their own. Several of the broad points made in this section emerged from the roundtable, but a lot of the international models are discussed in more detail in the Nuffield Trust's work on professionalisation of the workforce.

Alternative models

Regulation and registration

England is somewhat of an outlier in its absence of any form of care workforce register and associated regulation. Although a voluntary register was tentatively mooted by government in 2021, it was not further developed.

Other organisations such as the Care Professional Organisation (formerly NACASC) have sought to implement voluntary registers, but so far none have been made mandatory.

The other UK countries all have care worker registers and associated regulatory requirements. The requirements associated with registers in Wales, Scotland and Northern Ireland vary in their design but are all now mandatory and overseen by their respective workforce regulators, which are statutory bodies with a social care-specific remit. Each of these UK countries has made minimum qualifications a condition of registration, although rules allow workers to gain qualifications on the job. Ongoing training is also a condition of remaining on the register.

Similarly, many countries and regions further afield – Japan, Denmark, British Columbia, and California, to name a few – also hold workforce registers and associated regulation in their care systems. The evidence about the risks and benefits of social care worker registration is mixed, and careful design and implementation is required to avoid some of the pitfalls (e.g. creating barriers to entry, cost of implementation) while promoting the benefits (e.g. better-quality data on the workforce and the potential to create a professional identity). Countries that held data about staff in registers were better able to reach, support and train their workforce during the Covid-19 pandemic. Some countries have abandoned plans for registers following implementation challenges. Ontario, Canada, for example, discontinued its register because of administrative difficulties, particularly in removing people from it.

Examples from other parts of the British state also provide models which hold potential learning about design and implementation:

Governance arrangements	Examples	Approach
Examples outside adult social care: registration and regulation		
Registration and regulation	Social work	Registration was introduced in 2001 under the Care Standards Act and protection of the title was bestowed upon the profession in 2005. There is some research to suggest regulation has instilled greater public awareness of social workers as professionals. Recent increases to the cost of renewing registration has caused controversy, however, with lobby groups raising concerns about large-scale exits. Regulation of social workers was shifted from the Health and Care Professions Council, which oversaw 16 professional groups, to a dedicated body, Social Work England, in 2019. An independent review of broader social work regulation is expected to be published imminently and will likely hold relevant learning for social care registration, regulation and oversight.
	Childcare	Childminder registration, along with inspection by Ofsted, was introduced in 2001. Security guard licensing introduced in 2001 is a further approach. Although neither has been the subject of independent evaluation, there is some evidence that associated qualifications have helped to raise the status of childminders. Other evidence suggests that the professional regulation of a range of low-paid roles, such as security guards, may be associated with higher earnings over time.
	Children's social work	The children's social care workforce has had stronger regulation and government oversight than its adult equivalent. The sector has historically been heavily reliant on agency staff to fill gaps in the workforce. The Labour government implemented guidance intended to reduce reliance on agency staff. This includes a prohibition on hiring agency staff that have recently left permanent roles and a cap on agency fees.

Oversight and planning

There are examples of other sectors in England and other UK countries in social care that have national infrastructure with a planning or oversight duty of their workforce. When considering other models, the particular features of social care, with its numerous and largely non-public-sector-owned employer landscape, should be borne in mind.

In other countries beyond the UK, responsibility for workforce initiatives generally sits within the responsible ministry. However, given the fact that many struggle with vacancies and other similar challenges to England, it is not evident in the research we have undertaken that many countries have developed comprehensive workforce planning infrastructure or strategies. There is certainly learning to draw from other countries' experiences but few 'models' to emulate.

Australia's then Ministry of Health and Aged Care hosted an Aged Care Workforce Strategy Taskforce between 2017 and 2018 with a remit to assess trends, engage widely and develop cross-sectoral proposals for workforce development. However, that was dissolved, and while the ministry's website lists resources and support for the workforce, calls from stakeholder bodies for a strategy suggest there is no current plan in place. Similarly, although Japan has developed a range of workforce initiatives such as qualifications pathways and international recruitment, it does not have a long-term workforce strategy. Likewise, although Germany brought in legislation in 2018 to improve the attractiveness of health and long-term care for employees, which introduced measures such as staff ratios and better remuneration for trainees, there does not appear to be an overarching workforce strategy.

In Denmark's recent reforms of its care system, it is interesting to note a specific and extraordinary intervention from central government in long-term care labour market dynamics. Prior to this, central government has rarely directly intervened in pay and conditions in the public sector, instead relying on collective bargaining to agree terms. In 2023, with the aim of addressing challenges in recruitment, the Danish government, along with partners in the collective bargaining processes, made an agreement on pay and working conditions for 'frontline personnel' in the welfare sector – this covered long-term care workers as well as other groups such as nurses, nursery workers, prison guards and health care assistants. Part of the driver of

this unusual intervention was to address the gender pay gap (in recognition that most of those workforces are female-dominated) and sought to make it more attractive to work full-time rather than part-time and to take on shift work. Beyond this intervention, however, it is not clear that there is a central workforce planning function within the highly devolved Danish system.

In France, since its formalisation, the care branch holds a mission enshrined in law to strengthen the attractiveness of roles in the care sector, notably through encouraging the training and professionalisation of staff. This mission is a main objective of the five-year convention signed between the care branch and the government. To this end, in 2021, the government developed a national plan to strengthen the attractiveness of roles and introduced salary increases associated to a career pathway. The care branch provides funding to 20 support platforms developed by local authorities or local job centres to raise awareness of roles in the sector, train staff and support them to gain experience in the area, and improve individuals' employability (e.g. 'jobdating', support with CV writing). These platforms are being piloted with a view to being generalised across France by 2027, and a national website supports prospective staff to enter into the sector. Despite the initiatives of both the government and the care branch (CNSA, national solidarity for independence fund) to meet the objectives of the overarching plan, national audits have identified some persistent outstanding issues, for example the high level of reported work incidents among these staff.

Governance arrangements	Examples	Approach
Examples outside social care: Oversight and planning		
Central arm's-length body	NHS	The future NHS workforce has been a significant focus of central policy and planning. The central infrastructure has changed over time, with arm's-length body Health Education England (HEE) being established in 2012 and then merged into NHS England in 2023 (with plans to further shift the workforce planning function into DHSC by April 2027). The creation of HEE was not without controversy at the time, with concerns raised about the fact that HEE was to oversee planning without holding financial oversight of workforce decisions. While HEE published a number of different strategies on particular parts of the workforce, it did not produce an overall strategy. NHSE published the first comprehensive Long-term Workforce Plan in 2023 which sought to set out future demand and supply requirements for the following 10 years, outlining plans to train and retain, reform ways of working, and improve workforce culture. However, while the plan was welcomed by many, analysis found that progress against ambitions was slow and, just two years later, the new government's 10 Year Health Plan rejected the 'unrealistic' projections in the plan as 'fiction', promising a revamped version in Spring 2026 that is still awaited. The interaction of a national plan with local workforce planning (responsibility for which was given to ICSs in the 2022 Health and Social Care Act) will be important to track. Perhaps the lesson emerging from this example is the fact that producing a plan is not enough and that implementation and delivery needs to be feasible and enabled.
Non-departmental body	Children's services	The Children's Workforce Development Council (CWDC), established in 2006 and abolished in 2011, was a non-departmental body responsible for supporting the development of the entire children's workforce, spanning early years provision, social work and care, parenting and play. It was created with the intention of integrating different workforces and raising qualification and training levels. While specific schemes run by CWDC were evaluated, it is not clear that the Council's impact or effectiveness itself was the subject of independent evaluation.

Governance arrangements	Examples	Approach
Specific staff group initiatives/ targets	NHS	In addition to the overall plan, there have been parallel initiatives to boost specific sub-groups within the NHS with varying levels of success. For instance, the successful effort to recruit 50,000 nurses and the successful (but with some far-reaching unintended consequences) programme to expand roles in general practice. The experience of the latter emphasises the importance of a strategic approach, considering the integration of new and expanded roles and the possible consequences for the existing workforce.
	Department for Education	The Department for Education (DfE) sets annual targets for the number of trainees to enter postgraduate initial teacher training (PGITT) which is intended to ensure that the teacher workforce can meet future demand. The government has missed its target for the number of people starting PGITT for most years since 2011/12, with particularly large shortfalls since the onset of the Covid-19 pandemic. The DfE's workforce planning process is not particularly rigorous. For example, its target for the number of people starting PGITT assumes that the current workforce is sufficient to meet demand, meaning that it ignores built-up deficits in teacher numbers.
	Police	At the 2019 general election, Boris Johnson promised to deliver 20,000 more police officers by March 2023, up from 123,000 in 2018/19. His government achieved that target by providing specific funding to forces that increased their headcount. This arguably came alongside allegations of hiring standards being relaxed, and recruitment coming from the police community support officer (PCSO) workforce.

Trade-offs, consequences and considerations

It is difficult to envision a reformed sector, and national care service, without more robust infrastructure to plan for, develop and monitor such a huge and important workforce. The independence of the DHSC's workforce development partner may hold advantages in its ability to reach into and build trust with the sector, but the outsourcing of such a vital role to a third-party contractor (albeit one with considerable skills, expertise and capacity to execute its duties) without the security of an ongoing grant carries substantial risks. Compared to other sectors within England and to social care within

other countries (even within the UK), it is clear that England is an outlier in this regard. The lack of official long-term workforce plan carries increasing risk as the population ages and becomes increasingly complex.

Although care workers make up the majority of the workforce, concern about a lack of advance planning isn't limited to them – a growing shortage of registered social care nurses is proving challenging for more specialist providers. In addition, a very immediate concern is the lack of pipeline of Directors of Adult Social Services. This is already a difficult role to recruit into, and councils are likely to struggle even more to fill vacancies once the number of councils has risen should currently paused restructuring plans go ahead. (It is notable that the Platt Review in 2007 noted the importance of the-then newly created DASS role and proposed that they should be supported via a social care leadership academy as a priority.) Having a single body with oversight of the entire workforce and with the powers to roll out a strategy across the whole sector would hold value, and could help to ensure that proposals like the one put forward in the Platt Review are taken forward. Whether that function is best located at a national level or based regionally will be a question for policymakers to answer.

While a single national entity would have the advantage of total oversight with likely economies of scale, arms of a strategic body rooted in regions may have greater ability to understand different employment market dynamics. There may be a need for different approaches for different types of roles – e.g. planning for care workers roles, which are sensitive to the dynamics of local markets, could be well placed at a local level whereas support and planning for DASSs (where there is just one per council) could be better located nationally or regionally.

Another key consideration for the Commission and policymakers going forward will be how any social care workforce strategic body interacts with other areas of policy. In the recent past, policy made elsewhere (e.g. immigration policy) has directly conflicted with the needs of the social care sector. Retention of staff in the social care sector, as well as recruitment, also needs to be a central consideration – recruitment campaigns and attractive packages for NHS roles risk drawing staff out of social care. A more unified approach between health and care, where social care is viewed and treated as a profession of equal value, and not just a stepping stone into the NHS, would help to turn that tide. The Leeds Health and Care Academy is a model

worthy of further exploration: covering a specific region, it aims to plan, support and develop the entire health and care workforce, offering potential to align ambitions and to reduce the risk of adverse consequences for one sector from initiatives in the other. Recent announcements by the new Prime Minister, Andy Burnham, have hinted that there is an ambition to move closer to a single health and care workforce with unified pay, terms and conditions. The Commission and policymakers will need to consider the financial implications of that approach and where they will fall (councils, employers, self-funders) in any newly designed system. Where the burden of costs falls will impact on the dynamics of the provider market and the ability of providers and commissioners to ensure needs are met.

Experience from other sectors of the English state suggests there is no single successful model on which to base a possible future social care workforce strategic body. Whether it should sit within government – as NHS workforce planning will be from 2027 (and as teaching sits within DfE) – or in an arm's-length body (as NHS and children's workforce planning once was) depends on the priorities and ambitions of the government and how it sees this function fitting with other design choices. Of particular importance will be how any strategic body interacts with infrastructure around the Fair Pay Agreement negotiating body and Fair Work Agency. One option would be to put Skills for Care on a firmer footing with clearer statutory duties, along with more secure funding, with the advantage that it has an established status as a largely trusted and independent voice in the sector. But this move might run counter to the broader direction of travel within government to shrink the number of arm's-length bodies.

The NHS experience raises many questions and considerations for social care. The abolition of HEE clearly shows that its status as an arm's-length body does not bestow immunity from political influence. The CWDC, too, is another example of a workforce planning function that was abolished in favour of bringing its functions back into a central government ministry. Perhaps more important than institutional status, therefore, is ensuring that whichever body holds the function is supported by high-quality data to inform robust assumptions and modelling of realistic projections, and an ability to monitor progress and evaluate impact, driven by clarity of ambition and challenge. It will also be important that any new body or function is underpinned by good relationships with key stakeholders and that its duties do not duplicate or run counter to those of others.

4 Discussion

The Casey Commission has an opportunity to make bold proposals for the creation of a new National Care Service. The Prime Minister's very public commitment to the reform of social care has injected a new sense of urgency into the debate and provided optimism that tangible change is on the horizon.

Governance structures and accountability will be crucial elements of any reform plans, but they do not sit in isolation and, if anything, should be seen as the support struts that facilitate and enable the delivery of a long-term vision. As such, the ambitions and vision need to be defined before the supportive scaffold is erected around it. This paper has presented a collection of ideas of alternative models that could be considered to address a set of defined weaknesses or gaps in the current system. It has not sought to be exhaustive or comprehensive, but instead to lay out options guided by a set of dominant themes that emerged from the stakeholder roundtable.

Given the importance of form following function, we have not sought to draw out specific recommendations, but there are a series of observations, lessons and further questions that are useful in guiding the Commission's thinking as it starts to lay out a vision for the future.

The scale of change to governance required will depend on the level of system ambition

It is clear that there are a number of issues within the current governance arrangements that pose challenges to the effective delivery of the care system. There are opportunities to address or mitigate them in a system redesign – from strengthening overall stewardship and direction to providing greater oversight and support to workforce planning and innovation. Many of the issues apparent in the system that we have outlined in this report are the result of incremental and, at times, accidental developments that stem from the absence of a 'design moment'.

The 'solution(s)' to these problems largely depend on what the overall ambition of the system is, the level of priority of the issue within the programme of reform, its coherence or otherwise with other political priorities, and from whose perspective the challenge is to be addressed. For instance, the extent to which decision-making should be consolidated centrally or further devolved to local areas depends on whether consistency of offer, access and benefit is sought above flexibility, choice and individual control. The alignment, or otherwise, with the government's ambitions for further devolution should also be considered.

Some 'fixes' might be more easily achieved than others. For instance, achieving stronger system stewardship would not necessarily require significant new infrastructure but could largely be achieved with a combination of a strong narrative for reform, greater capacity in central government, ongoing high political priority and clear leadership. Implementing absolute consistency in eligibility and access, however, would likely necessitate wider reforms to funding flows and revenue raising, and require substantial new capacity to administer. There are also broader questions about whether the current reliance on local revenue raising would need to be factored in, with potentially significant implications for council tax and the distribution of resources. The appetite for change in government and the order of priorities will ultimately determine how far such reforms should go.

There is no silver bullet, only hard choices and trade-offs

It is clear from looking at other countries and sectors that there is no single approach to governance and no 'right answer' to the challenges faced. Instead, a series of decisions and choices will need to be made that will inevitably involve boundaries, transitions and trade-offs. For instance, when thinking about the challenges of accountability distributed across different central government departments, a solution might be to consolidate social care functions in one. However, bringing together responsibility for social care completely into one central government department may enable closer working with services such as housing but has potential to create greater structural division with the NHS. Models in other countries, for example

Denmark, see care for older people administered in a separate department to support for working-age adults. That may assist integration with benefits but has the potential to create transitional challenges across services, as we observe in England between children's and adults' social care. Likewise, choices about centralisation and devolution of powers and decision-making functions bring their own pros and cons.

Structural reform may not be the answer to all ills and may not endure

Structural reform may well be the solution to some challenges, but there needs to be a clear rationale for embarking on it. Evidence from previous (and current) NHS reorganisations suggests that such exercises come with significant disruption and rarely deliver the desired savings or anticipated improvements in performance. The purpose and theory of change need to be well-defined and carefully implemented to ensure the eventual benefits outweigh the costs of disruption. Consideration of what powers are needed and whether levers and influence sit at the right level of the system should be the starting point and then the structural reform should follow.

The evidence, particularly from England itself, is that structural reorganisations are a frequent feature of our public services landscape, so choices made under one administration could easily be undone by a future one. Similarly, initiatives that are intended to be temporary fixes under one administration or incarnation of policy can unintentionally become permanent features of the system (e.g. the Better Care Fund). Governance structures in other countries that have stood the test of time have been able to flex with changing political tides and policy priorities. This has been aided in the case of some countries (e.g. Germany) by locating accountability in arm's-length bodies. Experience from the NHS, however, suggests this approach in England has struggled to endure.

Regardless of ambition, certain key functions should be put on a stronger footing

The Commission should recommend the immediate strengthening of the key functions of innovation/improvement and workforce planning to lend greater resilience to them. There is also an opportunity to enable more sharing of evidence and experience as well as to embed greater consistency in, for instance, workforce practices. Recent trends of shrinking state support have left these vital functions in highly vulnerable positions. There are advantages and challenges of maintaining the independence of the current delivery bodies – SCIE and Skills for Care – from government and careful consideration needs to be given to any change to that status. However, regardless of where they are located or their organisational status, it is clear that these functions need to be put on a more stable financial footing to lend greater resilience to the sector and to enable strategic decision-making.

Social care is part of a wider ecosystem

Social care also does not sit in isolation of other services and systems. Its association, and need to coordinate, with the NHS is well-documented but it is also a service rooted in local communities alongside others such as housing. Many people who draw on social care also receive welfare support, such as personal independence payments (PIP), from the government. Reforms to these other systems and services will affect the form that social care will take. In the immediate term, the ongoing restructuring of local authorities, NHS England, and integrated care boards will be of particular significance. The creation of Mayoral Strategic Authorities may create both opportunities and challenges for social care. These new footprints may provide logical homes for certain functions like commissioning support and local workforce planning but may introduce greater complexity in relationships between systems.

The political and economic climate are inescapable factors

Ultimately, the scope of ambition for the scale of reform will likely be set by the financial headroom available for reform and implementation of a new system. The examples drawn out in this report have outlined various different approaches and structures but not considered the financial implications of them. Detailed costings would need to be considered alongside any new arrangements.

One last and inescapable point is that successful reform of social care requires political will and bravery to make the choices necessary to create a new National Care Service. No amount of reorganisation of governance structures or processes will be sufficient in the absence of political impetus to drive through change and dedicate resources, time and energy to social care. The prominence and level of priority that Andy Burnham has given to social care since taking office, and the momentum he has created by accelerating the Casey Commission, needs to be maintained. History has shown that social care suffers from an invisibility problem and is soon forgotten when it slips from the headlines. There is a job for the Commission, the government and the sector as a whole to keep social care and the importance of reform in the public eye to continue to build support for change.

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