# WHO CARES?

## Solutions for the Social Care Review

September 2025

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# FOREWORD

For several decades successive Governments have grappled with the problems of social care. There have been learned commissions making recommendations about how to put the sector on a less fragile footing, and even a new Care Act put into law more than a decade ago, but stability is as far away as ever.

This paper is a contribution by the Social Care Foundation containing analysis of the problems and more importantly some solutions. The SCF is a UK-wide cross-party think tank and pressure group promoting debate on adult social care to encourage the Government and all political parties to give the issue more urgent attention. SCF does this by using evidence from the sector itself as well as providing a platform for academics and researchers.

The underlying message of the report is that change is not only urgent but needs to be radical. It will involve changing the way we fund adult care as well as the way it is commissioned and delivered. Workforce recruitment and retention needs significant change, as does the use of technology. Proper integration with the NHS is necessary if either healthcare or social care is to be delivered efficiently and with proper respect for those who need it.

I want to thank Dr Jane Townson OBE, Professor Martin Green OBE, Jeremy Richardson, Daniel Casson, Bill Morgan, Sam Monaghan, James Tugendhat, Nadra Ahmed CBE DL, Lionel Zetter and Dr Robert D. Kilgour for their ideas and contributions to this paper. Particular thanks are due to Dawn Park for her work on preparation and production. Any mistakes are mine, as is overall responsibility for the views expressed.

**Rt Hon Damian Green**
Chair, The Social Care Foundation

# BIOGRAPHIES

## Rt Hon Damian Green
**Chair, The Social Care Foundation**

Damian Green's interest in social care dates from his period in Parliament, when he chaired the All-Party Parliamentary Group on Adult Social Care between 2019 and 2024. He also chaired the APPG on Longevity in the same period, which dealt with many issues involving older people, including how to minimise the burden of care.

He was the MP for Ashford between 1997 and 2024. His Ministerial career included being First Secretary of State (Deputy Prime Minister) in 2017, and before that Secretary of State for Work and Pensions, Minister for Policing, Criminal Justice and Victims, and Immigration Minister.

He wrote the paper "Fixing the Care Crisis" for the Centre for Policy Studies in 2019, and chaired a Commission on Social Care for Public Policy Projects in 2020/21.

## Dr Robert D. Kilgour
**Founder, The Social Care Foundation**

Robert founded Four Seasons Health Care in 1988 in Scotland. He left in early 2000 when it was the UK's fifth largest care home operator with 101 homes and over 7,000 staff – making his final financial exit from the company in 2004.

In 2004, he founded, and is Chairman of Renaissance Care which currently operates 19 soon to be 20 care homes throughout Scotland employing over 1,500 staff.

Robert's long history with Macmillan Cancer Support includes chairing an appeal that funded the building of a hospice in Fife and personally donating the funds to enable the establishment of the first Macmillan Cancer Information and Support Centre in 2007; there are now 171 such centres throughout the UK interfacing with close to 300,000 people a year.

In 2023, he was awarded an Honorary Doctorate by the University of Stirling for his 'outstanding contribution to entrepreneurship and philanthropy.'

# Executive Summary

Social Care is too important to be left in limbo and urgent action is required. The Social Care Foundation offers its analysis of the problems and recommendations for action to the Casey Commission, the Government and any political party willing to think constructively, realistically and ambitiously about social care.

The report covers funding, both how to find the money and how to distribute it, as well as workforce issues and the use of technology. It also deals with how to manage proper integration with the NHS, the commissioning system and ways to reduce the need for formal care.

**There are 35 recommendations in total.** Some of the most important ones are:

## Funding

- Extra money is needed. The Government can choose a collective solution through a Health and Care Levy, and/or a more individual solution with a pension-style Care Supplement with insurance premiums paid either through long-term savings or a lump sum at the end of one's working life.
- The system of distribution through local authorities should end. There should be a National Care System with a standardised assessment of entitlement to care. Funding should follow the individual to their chosen provider.

## Workforce

- A Ten-Year Workforce Strategy to match the NHS. Parity with NHS pay for the same jobs.
- A College of Care, and a professional registration scheme for care workers.
- Reform of the Apprenticeship Levy.

## Technology

- A Ten-Year Technology Strategy to complement the Workforce Plan.
- A Technology Challenge Fund to support pilots and innovation.
- Digital skills training for care workers.

## Integration with the NHS

- Introduce joint budgeting, commissioning and service design, with money following the person.
- A national "My Care" portal to eliminate confusion in navigating the care system.
- "Care Connect Hubs" as one-stop community support centres signposting public, private and voluntary services.

## Commissioning and Regulation

- An Elder Care Commissioner to provide the sector with a strong public voice.
- Government to support the sector to access lower-cost capital through the British Business Bank.
- The CMA's regulatory powers in the sector should be complemented by a sector-specific economic regulator.

## Reduction of Need

- Increase massively the provision of housing designed for later life.
- Strengthen planning policies to introduce a presumption in favour of later-life housing.
- Encourage family and professional carers to keep their charges physically active and engaged with the wider community.

# 1. Adult Social Care

Adult Social Care in the UK has become one of those political issues which repeatedly falls through the cracks. It is too important and under too much pressure to be left alone by successive governments but has never quite (except during Covid) produced the kind of repeated horrific headlines, making it a case for 'crisis' action.

The current Labour Government has promised a new and serious approach to this, and the fruits of this will come from the Casey review. The first wave of comments on the Commission concentrated on the length of time it would take: a year to set out the problems and identify medium-term issues, and then another two to set out long-term options for solving them. Many in the sector think this does not meet the increasingly urgent need for decisions and action. One of the purposes of this report is to offer the Social Care Foundation's ideas on both the medium and long-term recommendations the Commission will make. We offer them in a constructive spirit to Baroness Casey, the Government and any opposition party willing to think constructively, realistically and ambitiously about social care.

The term "adult social care" covers a wide range of services needed by older people and some working age adults with physical or mental health challenges. The Casey Commission will need to segment its recommendations so that each group has a response that is appropriate to their particular needs. Some of the recommendations in this paper are specifically aimed at the care system for older people.

**many of these recommendations would lead to greater efficiencies and therefore better care and better use of taxpayers' money**

The terms of reference for the Commission are intriguing. The Commission's first task is to "set out how to implement a national care service." One can applaud the sentiment of making it a national service rather than social care depending on the strained resources of local government but will it be truly national or does it simply mean that the existing systems will remain in place and come under a new regulatory/governance arrangement? The name itself is problematic: its obvious echo of the NHS has the potential to mislead the public into thinking it will be a service which is free at the point of use for everyone.

Given the current state of the public finances, this is massively unlikely. Indeed the Terms of Reference themselves make clear to the Casey Commission that its recommendations must "remain affordable, operating within the fiscal constraints of the Spending Review settlements for the remainder of this Parliament." So free care for all would seem to be off the table.

What lies behind this is the most serious of the underlying challenges, namely the need to find more money for care from somewhere. All the previous Commissions and reports have been sunk on this rock. The Dilnot Report of 2011, which led directly to the 2014 Care Act, was implemented successfully, apart from the financial arrangements which were postponed because successive governments found them too expensive. Many of our own recommendations are designed to make the system more efficient and therefore would reduce the cost of individual acts of care. But this does not remove the need to increase the amount of money we spend as a society on this sector, a demand which demographics tell us will increase over time. However, it is worth remembering that many of these recommendations would lead to greater efficiencies and therefore better care and better use of taxpayers' money even if the amount of money allocated was not increased.

There is a problem about the quantum of money we spend, and a separate problem about the way we spend it. In recent years the distribution mechanism has been a hybrid of funding through Local Authorities and central top-ups such as the Better Care Fund. This model has been criticised from many quarters. Councils say that they are underfunded, providers say that some of the money disappears to shore up other budgets within the local authority, the Better Care Fund has not achieved one key aim of reducing unplanned hospital admissions, and overall the need for an annual top-up from central government makes long-term planning impossible.

As you might expect therefore funding and how it is distributed is one of the most difficult challenges facing Baroness Casey and her team. It is though not the only intractable problem. The Social Care Foundation has identified five other areas which need to be addressed before we can claim to have a stable system.

**in 2023-24 around 8.3% of adult social care roles were vacant, which is around 131,000 unfilled positions in England**

The **first** of these is staffing. According to Skills for Care in 2023-24 around 8.3% of adult social care roles were vacant, which is around 131,000 unfilled positions in England. This number is lower than the 9.9% in the previous year's survey but is still alarmingly high. To add to the pressures around a third of England's care workers are immigrants and at a time when pressure is mounting on Government to cut the amount of immigration the sector's dependence on migrant workers is a significant vulnerability.

As an attempt to encourage more UK workers to consider care as an option the first steps have been taken to provide a sense of career progression in care, but it still sticks in the public imagination as a low skilled job. This is manifestly unfair, but as long as it is seen as a low paid job it will be difficult to shift this stigma.

**Another** great challenge is the use of technology and how it can be integrated to make the care system both more efficient and more responsive to the needs of its clients. For years there has been a conventional response that says while technology should be used for systems improvement and greater integration among operators and commissioners, it is dangerous to try to replace the human touch in the delivery of care.

This piece of conventional wisdom is worth challenging. The use of robots in care is more common in Japan than in this country, and one visitor was told by a personal care client who needed his most basic needs met by others that he much preferred having a robot do it. It was not only reliable and efficient (and always available) but he felt it no longer violated his privacy.

It is only an anecdote but it illustrates the possibilities of current technology, let alone the likely breakthroughs that will come as AI becomes embedded in different systems.

The **third** non-financial issue which bedevils care is how to manage proper integration with the NHS. The Integrated Care Boards were meant quite clearly to manage this, but the most polite verdict possible on their performance so far is that it has been patchy. Many in the care sector were disappointed that the NHS 10-Year Plan published in July paid only scant attention to social care. The King's Fund review of the NHS plan says "it feels strange that the interface between social care and health is not more acknowledged.... Health care cannot be fixed without also fixing social care so it must be hoped that thinking about how the two can best work together happens sooner than 2028."

It is exactly right that there is an urgent and immediate challenge for both the NHS and the care sector. At times one in seven patients in hospitals need not be there if they could be placed in a care setting either at home or in a residential care home. This would of course help their recovery and free up vital hospital beds. Too often the reason is not a simple lack of capacity in the care system but a lack of coordination between the NHS, local authorities and local care providers.

The **fourth** serious problem we have identified is in the commissioning of care. There is currently no consistency across the country in the basic assessment of care need. For home-based support refusal rates vary from 12% to 85% among different local authorities. At the same time the short-term nature of the commissioning cycle makes it more difficult and expensive for those offering residential care to raise the capital necessary to build new homes and improve those that already exist.

Providers of care often feel that the commissioning process is something that simply happens to them and believe that it would be better for everyone if services were co-designed from the outset. This is one of the issues that arises because of the radically different funding models of the NHS and social care. If we assume that social care is not going to be funded entirely out of general taxation (and that the NHS is) then bringing together the commissioning process so that it recognises the different pressures on different parts of the system is crucial.

The **fifth** issue is the failure to be effective in moving as far as possible from treatment to prevention. This is one of the three pillars of the NHS Ten-Year Plan but needs to be applied rigorously and consistently in the field of care as well. Apart from using technology more creatively, the most significant gap is in the provision of housing which will enable people to live independently in their own home for longer.

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At one end of the needs spectrum we have about a tenth as much housing with care as other advanced societies such as the US or Australia, according to the Older People's Housing Taskforce which reported in 2024. But the problems are more widespread, as the options for older people to find properties and communities which will enable them to live in comfort in their own homes are smaller in this country than elsewhere and are particularly difficult for those facing the greatest economic need.

These are each large intractable problems. The rest of this report contains our recommendations for dealing with them.

# 2. Funding

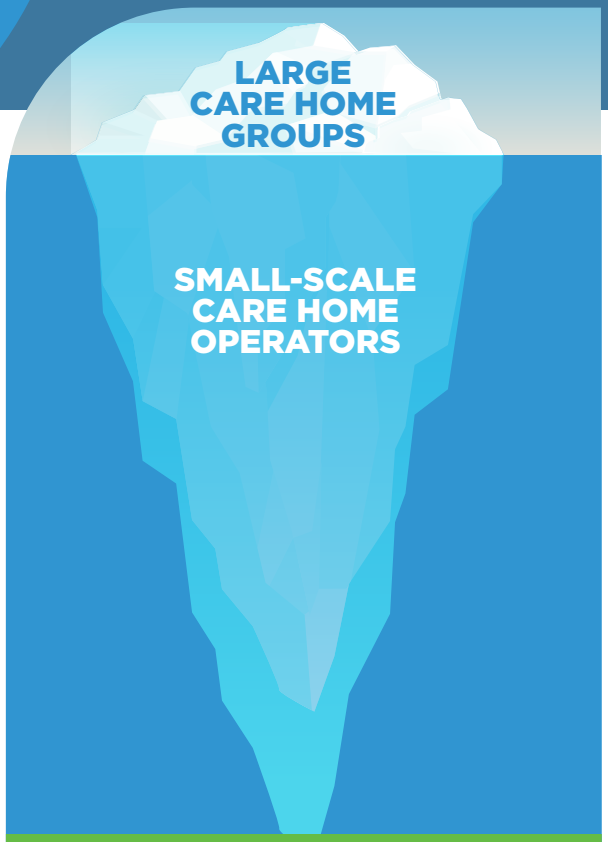
The one proposition agreed by everyone who has looked at social care in the last three decades is that the system needs more money to operate successfully. There are a number of reasons why this basic underlying difficulty has not been translated into effective political action.

The **first** is that it is desperately uncomfortable for politicians to confront the public with the fact that there is a whole new demand on their wallets which they almost certainly have not planned for. Most people only start thinking about care when an elderly parent begins to need it, and many are shocked to discover that it is not part of the NHS. So political discussion of social care never has it at the top of the agenda and that lack of a sense of urgency has meant that it has been left to be a grumbling problem which everyone knows is there but never hurts enough to demand immediate relief.

## More than 5 million people in England and Wales are unpaid carers

The **second** is that for all the complaints about the various inadequacies in the system, as set out in Chapter One, the system has never fallen over. To some extent this is due to the often-forgotten fact that the majority of care is provided unpaid by family members. More than 5 million people in England and Wales are unpaid carers, many of them not regarding themselves as carers at all but as willingly performing a duty for a loved one.

The system also survives because of the efforts of those providing care professionally, from domiciliary through to residential and nursing care, who have managed to make do and mend at every potential crisis. Operators will admit in private that the strain is taken too often in the quality of care. The appointments which are shorter than they should be, or the lack of continuity of care from individual carers who have established a relationship with the client. These are failings that will not show up on spreadsheets, but which are all too common, despite the efforts of operators to keep standards as high as possible.




**The trend is not towards consolidation into very large groups, but medium sized regional groups alongside many smaller-scale operators**

In other practical measures taken to keep the system running some operators have pivoted to the higher-fee privately funded care. This has resulted in 11,000 care home beds disappearing from the local authority market in the past decade. There have also been reductions in unit costs through more efficient processes and better staff deployment, but also through holding wage costs down.

The **third** is that economically the Treasury does not believe that the sector is in crisis. It is reinforced in that belief by evidence such as the Knight Frank annual review of the corporate providers, which in 2024 showed that for these larger operators fees had grown 11%, profitability had increased, and the average occupancy level was up from 86.4% to 88.3%. However this does not present the full picture. LaingBuisson research shows that in January 2025 the top ten providers held 18.8% of all UK registered bed capacity, which is 8.4 percentage points down on the peak of 27.2% reached in 2006. The trend is not towards consolidation into very large groups, but medium sized regional groups alongside many smaller-scale operators.

The **fourth** is a side-effect of this country's unusual capacity to concentrate wealth in property ownership. If a person is to take personal responsibility for paying for their care, they must either save extra throughout their working life or be prepared to put aside a lump sum in their later years. For the vast majority of those who can contemplate affording this (many have no property wealth) this will involve raising money from their home. Hence the fear of having to sell the family home to pay for care costs, avoiding which has at times been by far the biggest political imperative.

This is an issue restricted to care costs for older people, not working age adults who need care, and who are very often unable to work and therefore have no chance of contributing to their care costs. So the discussion in this paper is about the ways of paying for older recipients of care. As a practical assumption, the vast majority of working age adults needing care will be supported by the state.

The Casey Commission cannot suspend the laws of maths, and nor can it resolve the long-running problems with the public finances. So what it must do is present either a single option, or more likely a range of options, which will offer the sector financial stability. It is absolutely imperative that it takes the chance to set the stark facts before the public and politicians. If more money is to be put into social care then it either needs to come from individuals paying for themselves, or from the general taxpayer. Both options will be politically unpopular with some groups. The Casey Commission is the country's best bet to persuade political leaders to take that risk.

The advantage of this is that
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## Raising the money

Here are the options we recommend. Unlike other recommendations in this report we set out two broad approaches to raising the money, as there is such a divide between those who believe in the personal approach and those who believe in a collective approach. There is greater unanimity on the need for a radical change in the system of distribution.

For the "personal approach" I have drawn on ideas from "Fixing the Care Crisis" paper I produced with the Centre for Policy Studies in 2019. This advocated a model on the lines of the pension system we are all used to. There would be a Universal Care Entitlement, along the lines of the state pension, which would guarantee everyone a decent standard of care whatever their means.

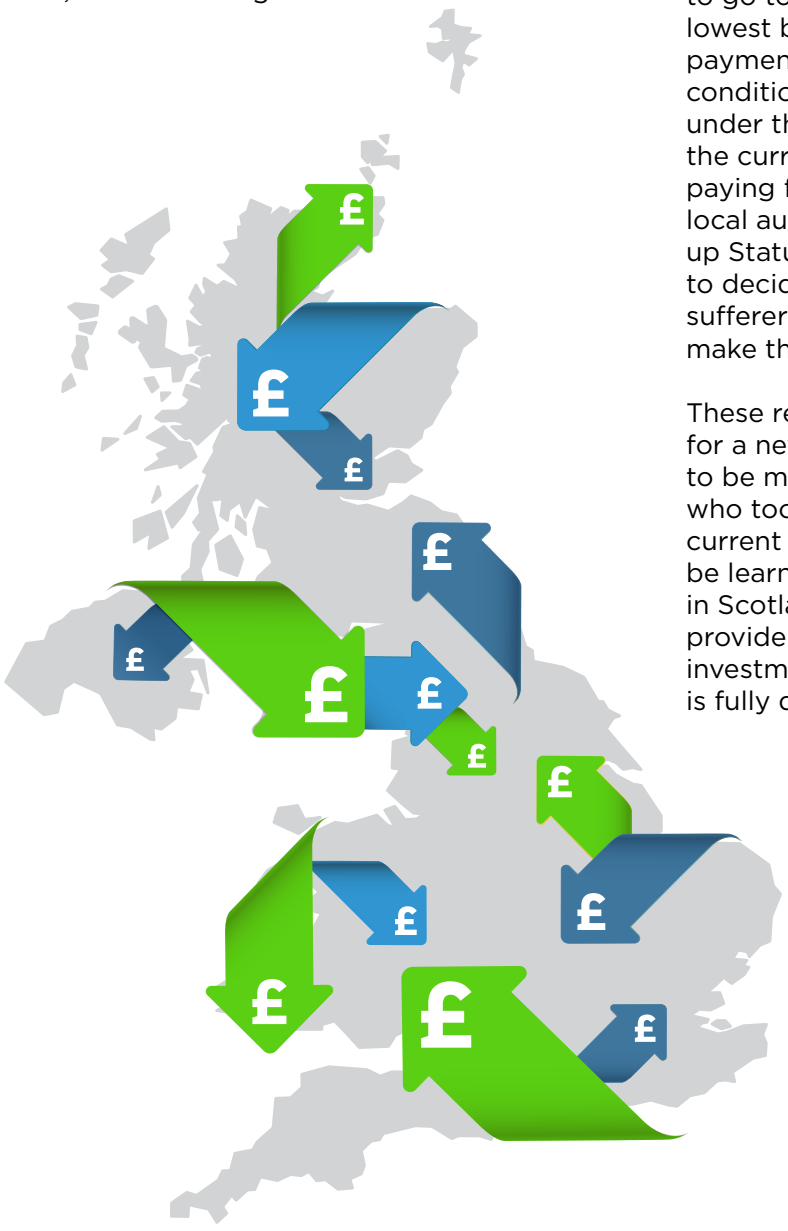
Those who wanted to top this up would be allowed to with a Care Supplement, something similar to an annuity or an insurance policy. This money could come from existing working age from saving small amounts throughout their working life and for those at the end of their working life through the payment of a lump sum. This could come from savings, existing pension pots or equity withdrawal from people's homes. The advantage of this is that no one would be forced to sell their family home to access care.

For those who prefer a purely collective approach there would be a Health and Care Levy to hypothecate at least some of the extra money needed to stabilise the system. This would contribute to the aim of integrating the whole health and care system. The lack of a joined up budget leads directly to a lack of joined up thinking. Even if the Commission adopts a more personal approach it could use a Health and Care Levy to help fund the Universal Care Entitlement at an appropriate level.

## Distributing the money

Whichever route we go down in finding ways to raise the necessary extra money, the Social Care Foundation believes that the system of distributing the funds through Local Authorities must go, in the interests of both people who draw on care and support and of the Councils themselves.

A National Care System must entail a standardised national assessment of the entitlement to care, with an Assessment Tool designed to grade the level of care required. As an international example, Australia is introducing legislation which creates eight need classifications with associated funding based on need, not local budgets.



This removal of regional disparities will be a great step forward, particularly for residents in the poorer council areas, which tend in themselves to have people in greater need than the average. This has given rise to “care deserts”: areas where local authority-funded care is unavailable because of providers leaving the market. This in turn leads to placement delays, out-of-area moves that separate residents from families and higher costs.

At the same time we need to shift to consumer-directed care where government funding follows the individual to their chosen provider. Everyone therefore becomes a self-funder, whatever the source of their funding. People select from quality assured providers rather than be forced to go to the preferred provider based on the lowest bid. Those who can afford to top up their payments, to allow them to access better “hotel” conditions, would be able to continue to do so under this system, which would therefore remove the current system of cross-subsidy from those paying for themselves to those funded by a local authority. There would need to be a back-up Statutory Commissioner for those unable to decide how to self-fund, such as dementia sufferers who do not have a family member to make the decisions.

These recommendations would be a fair basis for a new national care system, which will need to be more easily understood by potential users, who too often are completely confused by the current application process. There are lessons to be learned from some of the changes introduced in Scotland, where a national contract for care providers gives a more stable basis for future investment in capacity (Health and Social Care is fully devolved to the Scottish Government).

# 3. Workforce

There is a chronic shortfall in the number of care workers employed in the sector compared to the best estimates of what would be needed if every post were filled to provide a satisfactory service. For many years it has been a given that "British people" do not want to take the entry level jobs in social care which are seen as low paid and therefore low status, and that therefore the gaps have to be (partially) filled by immigrant workers.

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**By 2040**
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The current pressures on care work numbers will only be increased by the demographic pressures already happening in the UK. In 2025 there are around 13 million over-65s. By 2040 this number will have increased to nearly 17 million. However much we change society so that people's healthy lifespan is longer it is inconceivable that we will not need more care workers. The care workforce is older, predominantly female and largely part-time, so these factors will need to be taken into account as we try to expand the workforce.

This is therefore already an unstable position for the sector, and one which is likely to become significantly worse as the squeeze on immigration numbers continues. Since March 2024 applicants for a visa to work in care have not been allowed to bring dependants with them. Care providers applying for visas must be registered with the CQC, and hundreds of sponsorship licenses have been revoked.

Since April 2025 care providers must demonstrate attempts to recruit from care workers already in this country before seeking new recruits from overseas. Since July 2025 the minimum education level for Skilled Worker visas has increased from RQF Level 3 (A level) to RQF level 6 (graduate level) which effectively excludes most care worker roles. There is a transition period until July 2028 to allow care workers already in the UK to extend their visas, switch their employer or apply if eligible for Indefinite Leave to Remain.

The effect of these measures will clearly be to increase significantly the need for employers to attract UK workers into the care sector, as indeed is the government's intention. We make six recommendations to improve the chances of this happening.

The **first** is that the Government needs to develop its own 10-Year Workforce Strategy, along the lines it has for the NHS. This can build on the Workforce Strategy launched by Skills for Care, with the three pillars of Attract and Retain, Train, and Transform, but will need Ministers to own it much more publicly than they have up to now. In 2023 the previous Government introduced a national workforce pathway so there is a structure on which a strategy can be built, but there needs to be at least as much energy as there has been with the NHS if it is to succeed.

The **second** is that there needs to be a Fair Pay Structure. For example, as part of the greater integration between the NHS and care sectors equivalent jobs should be paid the same whether or not they are inside the NHS. The NHS pay rates are well established and it has been the case for some time that nurses working in care can move to do the same job for higher pay. Inevitably this makes retention rates in the care sector more challenging.

The early stages of negotiating a "Fair Pay Agreement" under new Employment legislation have shown the difficulties, not least because there are more than 18,000 different employers in care. The Fabian Society has pointed out that putting care workers on a par with healthcare assistants in the NHS, along with knock-on costs for pay progression, sick pay and pensions, would cost about £2bn a year. Others put the cost much higher. It is impossible to avoid the funding dilemmas addressed above, but fair pay is essential if the sector is to become more attractive.

The **third**, related, need is for clearer and obvious career progression. Other countries manage this, with Australia a prime example with its six job levels in homecare. This is a challenge for the sector as much as the Government, as it needs to sell itself more effectively than has happened in the past. Career pathways from entry level though to team leadership should be clear and well-advertised. There should also be proper professional recognition available, in the way that comparable professions manage.

**putting care workers on a par with healthcare assistants in the NHS,**
along with knock-on costs for pay progression, sick pay and pensions,
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The **fourth** need is for a College of Care, so that the profession is properly recognised like other professions in the health and care sector. This would be an important symbol of wider society recognising the value of social care and accepting it as a profession which will only become more important for the well-being of society as time progresses. It would also help in giving a voice to the various parts of the care sector, which have in the past found it difficult to break through to the forefront of public attention.

The **fifth** is that there should be a proper fully accredited professional registration scheme for care workers. This would help prevent scandals emerging which would damage the image of the profession and give greater confidence and status to those considering it as a career.

The **sixth** is that reform of the Apprenticeship Levy is essential if it to provide any worthwhile help to the care sector. Providers complain about having to pay the Levy but receiving nothing like enough training help in return. (The situation in Scotland is if anything worse.) Also, money was taken from employers during the Covid lock-downs, but, despite there being no possibility of using it appropriately at that time, it was still taken.

# 4. Technology

As we have seen, social care in the UK stands at a pivotal moment. As demographic pressures mount and workforce challenges persist, technology offers a powerful lever to reshape the sector by enhancing quality, efficiency, and accessibility. While individual innovations have shown promise, the real opportunity lies in developing a strategic, system-wide approach to technology adoption. This chapter outlines key areas where technology is already making a difference, identifies barriers to scale, and proposes a roadmap for future development. Although longer than many sections of the report, it merely scratches the surface of the range of technology which is already being used and of the potential for it to enhance people's lives.

The appendix to this section gives some examples of the technology in place which is already making a difference.

## 1. Technology for Person-Centred Care

Technology is increasingly enabling more personalised, responsive, and dignified care. Innovations in **smart monitoring, AI-driven analytics, and assistive devices** are helping individuals live more independently while allowing carers to intervene earlier and more effectively.
Examples of technology which, if adopted more widely, could have great benefits for people and for the health and care system include the following:

- **Ambient monitoring systems** which use discreet sensors and AI to detect deviations from routine, enabling proactive care without intruding on privacy.
- **Conversational AI wearables** and **voice assistants** which empower users to manage their own wellbeing, log moods, and communicate with carers thus reducing isolation and improving engagement.
- **Facial recognition tools** for pain detection are transforming care for non-verbal individuals, especially those with dementia, by improving comfort and clinical outcomes.

These technologies shift the model from reactive to preventive care, improving both quality of life and resource allocation.

## 2. Technology for Provider Efficiency and Workforce Support

Digital transformation is also streamlining operations for care providers, freeing up staff time and improving service delivery.

- **Digital Social Care Records (DSCRs)** have seen widespread adoption, and have demonstrated significant ROI through time savings, reduced errors, and better care planning.
- **Real-time tracking and bedside planning tools** allow staff to personalise care and respond quickly to changing needs.
- **Recruitment platforms** and **automated admin tools** are helping providers attract and retain staff more effectively, reducing reliance on costly agency support.

These tools not only improve operational efficiency but also support a more empowered and resilient workforce.

## 3. System-Level Integration and Data Sharing

Beyond individual providers, technology is enabling better coordination across the health and care system.

- **Shared Care Records** across ICSs are improving communication between sectors, enhancing safety and enabling population health planning.
- **Integrated prescribing and health data systems** allow care homes and home care agencies to work more closely with GPs and hospitals, reducing duplication and improving outcomes.
- **AI-driven health coaching** and predictive analytics are helping identify individuals at risk of hospitalisation, enabling targeted interventions that reduce pressure on acute services.

These developments point to a future where care is not only more personalised but also more connected and intelligent.

## 4. Challenges and Recommendations

Despite the promise, several barriers remain:

- **Fragmentation of systems** and lack of interoperability hinder scale and consistency.
- **Limited funding and support for innovators** restrict the diversity of solutions.
- **Unclear standards and regulatory pathways** create uncertainty for developers and providers.These technologies shift the model from reactive to preventive care, improving both quality of life and resource allocation.

To address these, we recommend:

1. **A Ten-Year Technology Strategy for Social Care,** aligned with the Workforce Plan, co-developed with tech companies, care providers, care workers and people who draw on care and support.
2. **Clear standards for safety, interoperability, and ethical use,** giving developers a roadmap for inclusion.
   In this area the work of the Oxford Project: The Responsible Use of Generative AI in Care should be highlighted as an example of how care providers, care workers, tech companies and people who draw on care and support are working with the DHSC, LGA and the CQC to develop technology that is based around people's needs and has a sound ethical foundation.
3. **A Technology Challenge Fund,** supporting pilot schemes and innovation partnerships, especially for SMEs.
4. **Ongoing evaluation and learning,** ensuring that technology enhances human care and does not aim to replace it.
5. **A programme of digital skills training for care workers.** This would enable those in the sector to adopt advanced tools to improve outcomes and reduce risk.

Technology is not a panacea: it is a powerful enabler which allows people and systems to function more effectively and efficiently. With the right strategy, investment, and safeguards, it can help build a social care system that is more humane, efficient, and sustainable. The Casey Commission has a unique opportunity to catalyse this transformation, not just by endorsing innovation, but by shaping the conditions in which it can thrive.

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# 5. Integration with the NHS

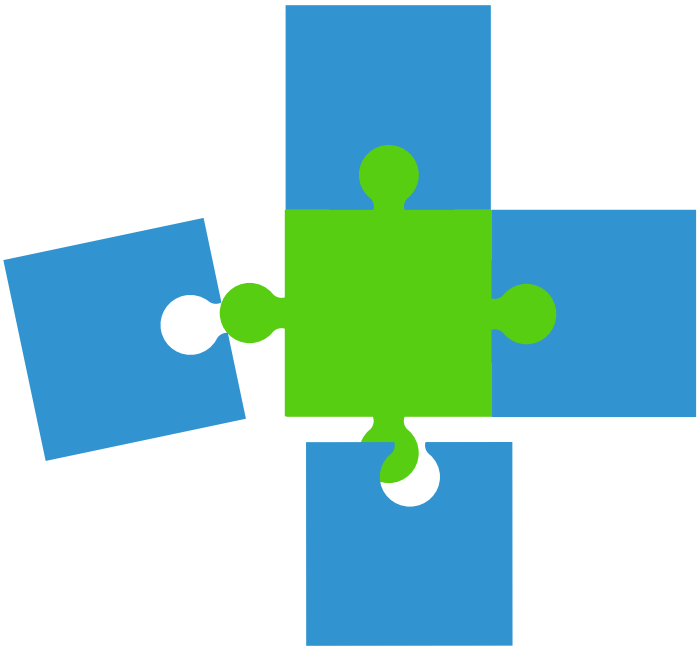
One of the biggest frustrations in the wider health and care sector in recent years has been the failure to set up systems which allow the NHS and care providers to work seamlessly together. There has been much rhetoric about patient-centred care, and indeed the creation of Integrated Care Boards to make the patient journey easier and less opaque, but there are few signs of improvement.

One of the specific problems with the ICBs is that while the commissioners of social care services are around the table in the form of the Local Authorities, the providers' voice is not often heard. This is not a simple bureaucratic mistake. It is often difficult to find a voice in each ICB area which can genuinely claim to speak for the different types of provider.

However, the current set-up bakes in the disadvantages of care providers as compared to hospitals and other parts of the NHS both in terms of access to money and of the ability to shape policy. It is never going to be easy to organise a properly planned system across one complicated public sector institution and thousands of private sector bodies, but moving towards this is essential, and therefore is one of the key tasks facing the Casey Commission.

**Our recommendations in this area are:**

Integration must go beyond simply enabling digital systems to talk to each other (though in many areas that would be an advance, shockingly in 2025) and encompass joint service design, joint commissioning and pooled budgeting, especially at the interface of health and care. Andy Burnham, as Mayor of Greater Manchester, has introduced a radical approach to integrate health and social care services across the region. His approach is rooted in a "whole-person, whole-place" philosophy, aiming to break down traditional silos in public service delivery and create a more preventative, person-centred system. There are aspects of this approach which could be applied more widely. A similar approach has been taken in the Highland area of Scotland with some success.



Funding should follow the person drawing on care and support. This will entail financial flows being restructured and simplified. Currently NHS and Local Authority funding is separate, often commissioning the same care at different rates. Simplifying and speeding up the funding would result in fewer people stuck unnecessarily in hospital beds while the appropriate care setting is identified. One pot of money to deliver a basket of services would allow services to be delivered in the most effective way by the state or private, community, voluntary or charitable contractors.

It will also be necessary to change the measures of success to move from activity levels to outcomes as the performance indicator which is monitored and rewarded. Health and social care will need to make this change together if the system is to be truly integrated. At the same time social care needs to have parity of esteem with health inside the Department. It does not and has never enjoyed this status, and until it does neither the NHS or social care will be able to perform their proper functions effectively.

In terms of practical delivery, we recommend the creation of **“Care Connect Hubs”**. These would be one-stop community support centres where older adults, disabled people, carers and families can access a mix of advice and services in one place. These hubs could be an extension of the neighbourhood services proposed in the NHS Ten-Year Plan and could offer advice and navigation support for care services, benefits and home adaptations.

They could also link to community resources as well as formal care services (care homes and homecare). This would support independent living and reduce hospital admissions and would itself facilitate better integration with the NHS. Over time these hubs would build community resilience and help reduce isolation.
Care providers would be a vitally important part of this initiative.

**we recommend the creation of Care Connect Hubs**

These hubs would be the visible sign of the existence of a National Care Service. Precisely because they would be pointing clients to services provided by the NHS, the voluntary sector, the community, private and/or charitable organisations they would be palpably different from the NHS model. This would help people gain the maximum way they can benefit from the mixture of provision from the public and private sectors.

As a further sign of a national service, we recommend massively simplifying access to care for individuals and families. At present those searching for advice and guidance have to cope with a variety of local authority websites. These should be replaced by a national **“My Care” portal**. This would allow one assessment and one pathway, eliminating navigation complexity for families and reducing the administrative burden. This portal would be useful for families and others approaching the care system for the first time, to be used in conjunction with the comparison websites for care homes and domiciliary providers which have sprung up in the private sector to help with the task of navigation.

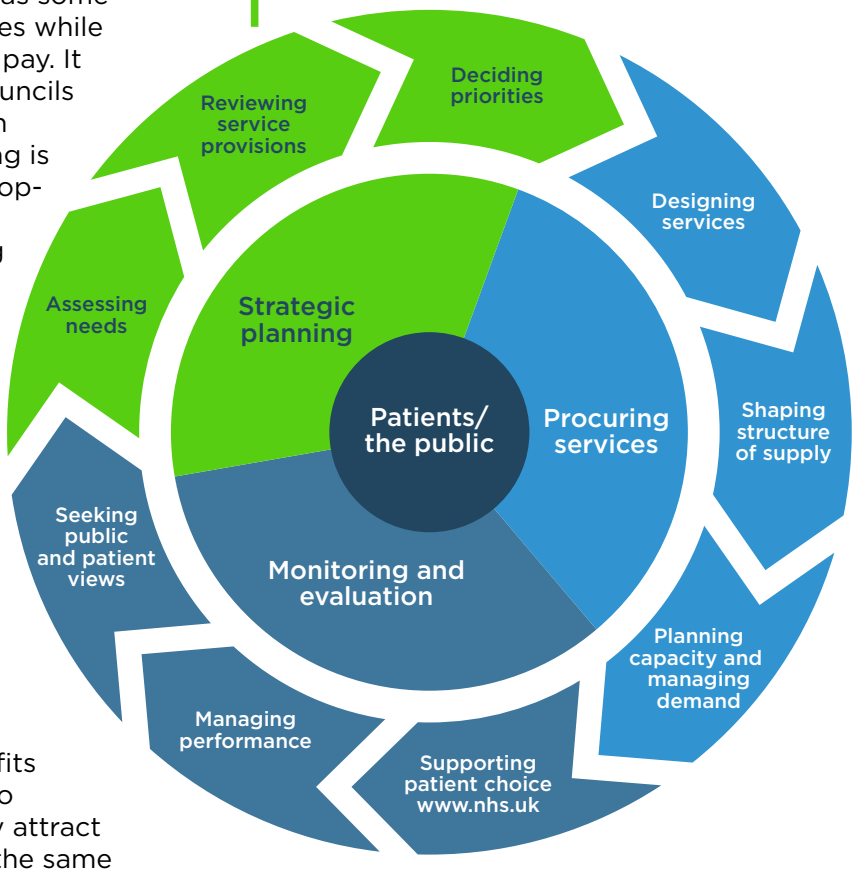
# 6. Commissioning and Regulation

The Commissioning system, where local councils offer contracts either to care home providers or agencies offering care in people's own homes, suffers from being complex and too short term. The complexity is partly unavoidable as some needing care will be paying themselves while others are dependent on the state to pay. It would also be wrong to blame the councils for the short-term nature of too much commissioning, as their overall funding is massively stretched, and the annual top-up they have received in recent years comes very late in the budget-setting process.

Even without apportioning blame it is clear that the system needs a radical overhaul, and many of the recommendations throughout this paper would lead to that. One purpose which the commissioning process should encompass is to promote structural stability in the care sector, to encourage more investment of capital where appropriate.

We recommend that the Casey Commission should explore the benefits of multi-year commissioning cycles, to provide greater certainty and thereby attract new long-term investors. It would at the same time be useful to create partnerships between commissioners and providers so that the services are co-designed and co-delivered. The effect of this would be to develop a clearer long-term vision of roles across the public-private-community care economy, and through that to create the conditions for sustainable growth. The market could be shaped in ways that would ultimately benefit all those receiving care.

## The Current Commissioning Cycle




Source: NHS England

We also recommend that the Government should actively support the sector to access lower-cost capital. The natural source for this would be the British Business Bank. In return the providers would have to use that capital to deliver approved outcomes including workforce pay and development, and the quality of care on offer. This change could also be used to encourage the building of care homes in the areas which most need them, and which currently find it difficult to sustain them because of a relative lack of clients able to meet the costs without public support.

Commissioning and regulation need to work together to promote a sustainable sector. So we recommend that the CQC and other relevant regulators have sufficient resources and real powers to ensure that quality is maintained at acceptable levels. This will involve surprise inspections, meaningful penalties and swift intervention. This is not just to protect the clients, although that is the main focus. It also helps responsible providers. In the homecare area 60% of providers lack a current rating, which is unacceptable and unfair to the good operators. We also recommend that the CQC should operate the same standards and punishments inside the NHS as it already does to social care. Up to now the CQC has closed social care services which are manifestly inadequate, but has allowed NHS services to continue under the same trusts for many years with inadequate services.

**In the homecare area**
**60% of providers lack a current rating, which is unacceptable and unfair to the good operators**

Both commissioners and regulators also need to combine to end the practice where contracts are essentially offered on price alone, with quality of service a secondary consideration. The focus on price has led to a crisis of confidence in the sector and often to unscrupulous employment practices. The aim must be that providers operate viable businesses which can legitimately compete on quality. We accept that this might mean a smaller number of providers, instead of the current system where more than 10,000 employers operating 14,000 registered locations are competing. There is much to learn from the Australian model in this regard.

The Casey Commission should also consider the merits of a sector-wide economic regulator for the social care sector. The social care sector may require more longer-term planning and more assertive management of the market than other sectors, and regulation more sensitive to the needs of the sector than that which can be offered by the economy-wide Competition and Markets Authority may be warranted.

To promote better regulation we need better data. We should move to a system which mandates provider reporting for state-funded work: financial statements, service delivery data, and consumer outcomes. This kind of public transparency will enable more informed choice among potential consumers and contribute to greater regulatory accountability.

To keep a permanent eye on the changes that are required we recommend the creation of an Elder Care Commissioner. This would give the sector a much-needed voice both inside Whitehall and more publicly to champion the interests of the increasing number of elderly people who need care.

# 7. Reduction of Need

The Government has stated its desire in the context of the NHS of moving from a model based on reactive treatment to one based on preventative care, with a stronger focus on public health initiatives, early detection and reducing the burden on the NHS caused by chronic disease.

## It is that rare event in public policy, a win-win

This is a worthy aim, and we would argue that it is at least as relevant for social care as it is for the NHS. Maximising the healthy lifespan of individuals and therefore increasing the amount of their life they can spend in their own homes, is an improvement in the quality of life for the individuals, and a reduction of the burden on the taxpayer. It is that rare event in public policy, a win-win.

Some of the building blocks for such a policy are already available. Particularly in the housing field, making homes user-friendly for older and frailer people was a key recommendation of the Older People's Housing Task Force which reported in 2024. We particularly endorse the recommendations to:

Develop more housing designed for later life. This would mean building homes that are not only designed to make life convenient for older people in traditional ways (plug sockets not at ground level, wider doorways for wheelchairs, eye level cookers etc.) but are digitally connected so that information can be gathered and transmitted to allow family and carers to stay connected.

Recognising that new homes will only form a small proportion of the total stock, support a wide range of later-life housing options such as retrofitting existing stock, raising accessibility standards and embracing community-led and more affordable housing models.

Strengthen national planning policies to introduce a presumption in favour of later-life housing, requiring the National Planning Policy Framework and local plans to embed the specific needs of older people.

There is also work to be done to encourage more building of retirement communities, which will have medical and care facilities on site to enable residents to have confidence that problems will be dealt with promptly. We build about a tenth of the number of retirement community homes of comparable countries and this option ought to be more widely available.

More widely, in terms of minimising the need for individuals to require care, there are interesting developments in geriatric medicine which suggest that problems which were previously put down simply to the ageing process are preventable by changes in lifestyle. To simplify hugely, if older people remain physically active and engaged in the wider community they will remain healthier for longer. Social care professionals and family carers can change their approach to meet this goal but will need support not just from care providers but housing departments, parks and libraries departments, leisure services and voluntary groups. Sir Muir Gray CBE and Associate Professor Yvalia Febrer at Kingston University are leading the way in this research.

It will still be the case that in the last 12-18 months of life most people will require complex care. This is particularly true for those living with dementia, whose needs often grow rapidly and require specialised support. Prevention and care should therefore go together. Investment in healthy housing, community engagement and early intervention is vital, but so is high-acuity social care, especially for people with complex dementia.

This area requires an agenda for the long-term and a recognition that improvements will come in small steps. But it is crucial both in reducing the aggregate need for care, and in addressing the social and geographical inequalities which lead to the length of healthy lifespans being so different in different areas of the country.

# 8. Recommendations

## Raising extra money

- **Collectively:** through a Health and Care Levy.
- **Individually:** through a pension-style Care Supplement, paid for either through savings during working age or a lump sum at the end of working life.

## Distributing money differently

- End the system of distribution through Local Authorities.
- Have a **National Care System** with a standardised assessment of entitlement to care. (Australia has eight needs classifications with funding based on need.)
- Government funding to follow the individual to their chosen provider.

## Workforce

- Introduce a **10-Year Workforce Strategy.**
- Introduce a **Fair Pay Strategy** with greater links to NHS rates.
- Have **clear and obvious career progression.**
- Start a **College of Care** to give parity of recognition with other health and care professionals.
- Introduce a **professional registration scheme** for care workers.
- Reform the **Apprenticeship Levy** to make it work for the care sector.

## Technology

- Introduce a **10-Year Technology Strategy** aligned with the Workforce Plan.
- Have **clear standards** for safety, interoperability and ethical use.
- Start a **Technology Challenge Fund** to support pilots and innovation.
- Ensure **continuous evaluation and learning** to make technology enhance care.
- A programme of **digital skills training** for care workers.

## Integration with the NHS

- Introduce **joint budgeting, commissioning and service design.**
- Personal budgets mean that financial flows follow the person, avoiding unnecessary time in hospital.
- **Change the measures of success** from activity levels to patient outcomes.
- **Keep parity of esteem** between health and social care with the Department.
- Introduce **"Care Connect Hubs"** as one-stop community support centres, as a visible sign of a National Care System.
- Replace current access to services with a **national "My Care" portal** to eliminate confusion in navigating the care system.

## Commissioning and Regulation

- Introduce **multi-year commissioning cycles.**
- Government to support the sector to access **lower-cost capital** through the British Business Bank.
- The **CQC** should have the resources and powers to enforce meaningful quality improvements and keep ratings up to date.
- **CQC standards** and punishments should be the same inside the NHS and the care system.
- **Competition should be on quality** as well as price.
- The **CMA's regulator powers** in the sector should be complemented by a sector-specific economic regulator.
- **Data provision** should be mandatory for state-funded work.
- There should be an **Elder Care Commissioner** to provide the sector with a voice.

## Reduction of Need

- Increase massively the **provision of housing** designed for later life.
- Support a wide range of later life housing options such as **retrofitting existing stock** and **raising accessibility standards.**
- Strengthen planning policies to introduce a presumption in favour of **later-life housing.**
- Build more **retirement communities.**
- Use recent research to encourage professional and family carers to keep their charges **physically active and engaged** with the wider community.

# Appendix of selected technology examples

## 1. Technology for Person-Centred Care

- **Acoustic Monitoring** (AI-driven infrared/ acoustic monitoring). Implemented by organisations such as AllyLabs, Earzz and Adaptive Care have numerous benefits such as:
  - Night-time monitoring for fall prevention
  - Monitoring for signs of distress or illness, e.g. restless nights, which may signal health issues
  - Behavioural monitoring for dementia care
  - Incident detection in private rooms
  - Activity pattern analysis
- Other solutions include pictorial representations to monitor people's activities where companies such as Sensio and Teton are making great strides.

- **PainChek** (Facial expression-based pain detection app)
  Especially useful for non-verbal dementia patients, the app uses smartphone cameras to spot micro-expressions indicating pain, improving assessment and comfort. This leads to benefits in falls reduction, medication reduction (where appropriate) and improved behavioural support for people.

- **TEC-enabled care**
  Home based sensors enhanced by AI analytics add value to personal care. Solutions like Access Assure, Just Checking, 2ic-Care offer solutions where discreet sensors in a person's home can monitor a person's activity, learning to recognise anything outside the normal routine.

- **Conversational AI wearables**
  In the UK companies such as MICA and Clinitouch have developed wristwatches and other wearables which support people's independence by enabling natural language interactions, logging moods, giving reminders, and synchronising real-time data with carers or clinicians, shifting care from reactive to proactive.

- **AI Chatbots & Robotics in Home Care**
  Organisations such as Sentai are developing listening and interactive devices specifically designed to support a person's independence. Some organisations such as Service Robotics (the robot Genie) have successfully installed robots that engage in conversation, deliver medication and nutrition reminders, offer video calling, log moods and also even offer entertainment. They can alert carers if someone is unresponsive. These increase a person's independence and help staff focus on more acute tasks while enhancing preventive care.

- **Adapted consumer tech**
  Consumer tech such as that developed by Amazon and Google is now being trained to remind people to take medication, manage routines, and even communicate with carers remotely to create a familiar, user-friendly experience that reduces social isolation.

## 2. Technology for Provider Efficiency and Workforce Support

- **Digital Social Care Records**
  The DHSC's DSCR programme and funding means that 80% of care providers now have DSCRs. This has been an unprecedented success. The Assured Suppliers list has helped organisations decide on which tech supplier to employ and there are many other DSCR providers which are not assured and are widely used in social care.

  These systems streamline record-keeping, save time, and involve residents in care plans. Time savings, reduction in errors and the improvement in the quality of life of people who draw on care and support translates into more effective and efficient care for people.

- **Worker support technology**
  Tools employing AI can now be used to create greater efficiencies, ensure carers are informed and plan care more effectively. Tools such as Access Evo, EmmaAI, and CareBrain ensure greater coordination of all tasks and should be increasingly used.

## 3. System-Level Integration and Data Sharing

- **Integrated Medical Info in Care Homes**
  GP Connect is now a standard part of the DSCRs. Developed by NHS England, it enables authorised health and care professionals to securely access and share patient GP records in real time. It enables care staff to access up-to-date medical information instantly, rather than waiting for faxes, phone calls, or discharge letters and ensures GP appointments can be made more efficiently.

- **Ambient Voice technology** (such as Access's Smart Notes and Magic Notes)
  Piloted by councils in England, these transcription and communication tools transcribe conversations, draft letters, and suggest follow-up actions, saving time and refocusing AI support on human-led decisions.

If you have any questions about the report, please get in touch with us at:
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