Adult Social Care - Delivery Design (implementation-ready)

The operational detail behind the Strategic Design: how the four delivery recommendations would actually be legislated, built, funded, governed, sequenced and - if the evidence does not hold - paused or reversed.

Discussion draft · version 1.0 · June 2026. Companion to the Strategic Design, the Evidence Annex, the costing model and its results, and the plain-language Public Choices. It answers, for each of the four **delivery** recommendations, the seven questions any implementation-ready policy must settle (Method B3): legislation, delivery body, funding, the first hundred days, measures of success and evaluator, sequencing and dependencies, and failure modes and exit conditions.

What this document does and does not decide. Following the Method's empirical/value split, this is the *delivery* design - the part that is largely an evidence question, and so is **recommended**. The *funding* question - who bears the uninsurable catastrophic tail of care costs - is a value choice and is **not** decided here; it is presented as a neutral costed menu in the Public Choices document and routed to the public. This plan describes how to build the capacity that *any* funding choice will need, and is written so it stands up whichever the public chooses.

The one organising principle: capacity before entitlement. Scotland legislated the *entitlement* to free personal care without building the *supply* to deliver it, and the result was a bottleneck transferred, not cleared (Audit Scotland, Jan 2026: ~720,000 unnecessary hospital bed-days in 2024/25, the top cause being the absence of a care package - Grade B). The whole sequence below is built so that workforce and provider capacity is in place *before* any entitlement is widened. A set of **no-regrets** measures (the funded pay deal, fair provider pricing, commencing s.18(3) - section 18, subsection 3 of the Care Act 2014, the never-switched-on provision that lets people paying for their own care ask their council to arrange it at the cheaper council rate - uprating the means test) can start now because they are needed under every option.

Evidence and grades. Every figure below inherits its grade from the Evidence Annex (A robust · B strong/official · C modelling · D contested). Costing figures are Grade C model outputs unless noted. The **eleven items previously flagged UNVERIFIED** in the annex were checked against primary sources in June 2026 - confirmed, corrected or removed; the figures used here reflect that check (residual caveats are recorded in the annex).

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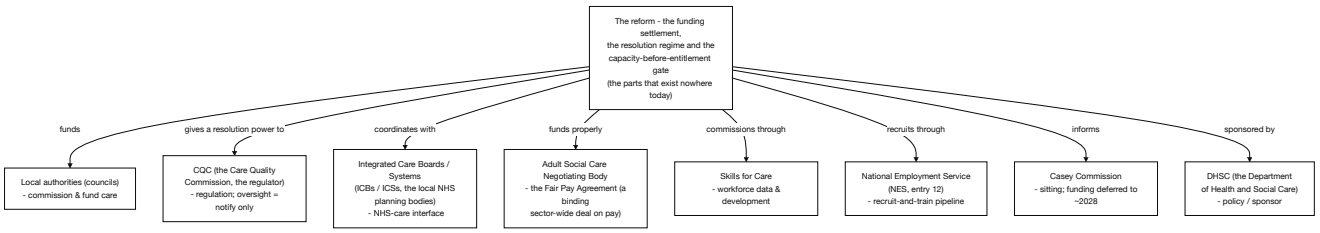
1. The institutional landscape - what the reform owns, uses and coordinates

The first delivery risk in social care is the opposite of NES's: not building a new coordinating layer, but **adding money and duties to a fragmented system without fixing the structures that waste them**. This reform therefore owns almost no new machinery. It owns four things that exist nowhere today - a *properly funded* pay settlement, a *commenced* s.18(3), a provider *resolution* regime, and the *capacity-before-entitlement* sequencing discipline - and uses the existing bodies for everything else.



Existing body	Its function	The reform's relationship
DHSC	Adult social care policy and funding	**Sponsors** - but with HMT (HM Treasury), MHCLG (the Ministry of Housing, Communities and Local Government, the councils' department), DWP (the Department for Work and Pensions) / the Home Office, and NHS England as co-sponsors (the cost and the savings land across all of them; §3).
Casey Commission	The live independent commission; Phase 1 reports 2026, **long-term funding deferred to Phase 2 ~2028**	**Informs, does not compete** - this product supplies *now* the costed, non-partisan funding options Casey has deferred, to inform the Commission and the public rather than pre-empt it.
Local authorities (~152 upper-tier councils)	Commission and fund care; ~42% of council service spend	**Funds** - the reform funds councils to pay the true cost of care; it does not take commissioning off them.
CQC	Regulation and quality; market oversight is **monitoring + notification only - no power to resolve a failing provider** (Grade A)	**Gives a new power to** - a statutory provider-resolution regime beyond today's notification (the Southern Cross gap).
ICBs / Integrated Care Systems	The NHS-social-care interface; the Better Care Fund	**Coordinates with** - on discharge and reablement capacity, sold honestly on coordination, not banked savings.
Adult Social Care Negotiating Body	The Fair Pay Agreement (Employment Rights Act 2025); first agreement **April 2028**	**Funds properly** - the £500m earmarked (≈20p/hr) is far below a real floor; the reform funds the agreement to actually move pay.
Skills for Care	Workforce intelligence and development	**Commissions through** - for the funded career structure, qualifications and the Care Certificate pipeline.
National Employment Service (White Paper · Implementation Plan, Register entry 12)	Domestic recruit-and-train pipeline	**Recruits through** - NES is the natural domestic replacement for the closed overseas route (synergy shown, **not banked**; §5.1).

The single thing the reform *owns* is the bottom of the stack: the money that lets councils pay true cost and providers pay a real wage, the legal power to resolve a failing provider, and the discipline that no entitlement widens ahead of the capacity to honour it.

2. Legislation

2.1 Primary legislation - a Care Reform Act (or targeted amendments to the Care Act 2014)

- **Commence Care Act 2014, s.18(3).** This already exists in statute and was **never commenced**; its commencement (cancelled, with the £1.36bn fair-cost-of-care fund, on 29 Jul 2024 - Grade A) would let self-funders ask their council to arrange care at council rates, ending the self-funder cross-subsidy as a structural matter. This is a **commencement order**, not new primary law - the fastest structural fix available.
- **A provider-resolution regime.** New primary power so that the regulator (CQC) can do more than *notify* when a "difficult to replace" provider fails - it can compel continuity, restructuring or managed transfer (the Southern Cross lesson: >750 homes / ~37,000 beds, no power to act - Grade A). Today there is statutory monitoring and notification but **no resolution regime**.
- **A statutory, ring-fenced evaluation and capacity-gate duty.** So that (a) the evidence base survives a spending review (the discipline NES adopted after the Future Jobs Fund was cancelled before it reported), and (b) no entitlement expansion can be commenced until the named capacity test is met.
- **The chosen funding mechanism is legislated separately, after the public choice.** Whichever option the public chooses (Public Choices §A) carries its own legislation - restoring the cap framework (the Care Act 2014 cap architecture was cancelled Jul 2024 and can be re-enacted un-diluted), a free-personal-care entitlement, or a social-insurance Act. This is **logically separable** and is not on the critical path for the no-regrets capacity work.

2.2 Secondary legislation and statutory instruments

- **Means-test threshold uprating** - by regulation (the Care and Support (Charging and Assessment of Resources) Regulations 2014), no primary law needed. Restoring the £23,250 / £14,250 thresholds frozen since 2010/11 (a ~56% real uplift - Grade B).
- **Fair Pay Agreement scope and funding** - regulations under the Employment Rights Act 2025 setting the Negotiating Body's coverage and the funded settlement (the Body exists; the gap is funding, not powers).
- **Provider-resolution and fair-cost-of-care regulations** - the operating detail of the s.18(3) commencement and the resolution power.

2.3 Critical-path legal dependencies

The s.18(3) commencement and the FPA funding regulations are on the critical path: provider stability and a stabilised workforce are the capacity that *any* entitlement expansion depends on (the Scotland lesson). The funding-mechanism legislation is **not** on the critical path - it follows the public choice and can proceed on its own track once capacity is being built.

3. Delivery body and governance

- **No large new body.** Unlike NES, social care already has its delivery institutions - councils commission, CQC regulates, ICBs coordinate, the Negotiating Body sets pay, Skills for Care develops the workforce. The reform funds and re-wires them rather than building a parallel structure. The only genuinely new function is the **provider-resolution unit** (housed in or alongside CQC), and it is deliberately small.

- **Cross-departmental sponsorship from the outset.** The cost lands on DHSC and councils; the savings land in the NHS (delayed discharges), in council finance (entry 1) and in the Exchequer (the workforce tax base). So the sponsorship should too: **DHSC lead, with HM Treasury, MHCLG (councils), DWP and the Home Office (workforce and the closed migration route), and NHS England as co-sponsors.** This is how the wrong-pocket problem (the body that spends is not the body that saves) is solved in practice - the same device NES uses.
- **Local delivery, national standards.** Councils keep commissioning; the centre sets the funded fair-cost-of-care methodology, the pay settlement and the capacity gate. The reform provides the money and the standards; councils and providers provide the care.
- **Governance of the capacity gate.** A named authority (the evaluation duty in §2.1) owns the test that gates entitlement expansion, reporting independently of delivery pressure, so "we're ready to widen entitlement" is an evidenced finding, not a political assertion.

4. What changes for the three people who matter

The design is built around the people in the system, not the institutions behind it:

- **The person who needs care** - care is available when needed (capacity built before entitlement widens), the catastrophic-cost question is answered honestly by the public choice rather than left as a private lottery, and the means test stops trapping people frozen thresholds set in 2010.
- **The unpaid carer and the family** - fewer of the ~720,000-bed-day situations where care simply is not there; an end to the self-funder cross-subsidy that makes the same care cost ~41% more (~£236/week, over £12,000/yr) if you pay privately (the Competition and Markets Authority (CMA) 2017, Grade B).
- **The care worker** - a real wage materially above the floor, a funded career structure and qualifications, redesigned jobs (the evidence from Buurtzorg, a Dutch home-care provider built around self-managing teams), and a domestic recruitment route (via NES) to replace the migration route closed on 22 Jul 2025. Pay alone retains; pay plus structure plus quality plus a pipeline is what *recruits* (the Organisation for Economic Co-operation and Development (OECD, the club of mostly wealthier nations), *Who Cares?*, Grade B on direction).

5. The four delivery workstreams to B3 specificity

Each workstream is recommended on the evidence and specified to implementation-readiness. The figures are the costing model outputs; the workforce figure is presented as the **ambition ladder** (a public choice on *how far*, see Public Choices §B), not a single number.

5.1 Workforce - fix it properly, not the bare floor

What. The four-part package the evidence says is needed to *recruit* and not merely *retain*: (i) a real **Fair Pay Agreement materially above the Band-3 floor** (Band 3 is an entry-level rung on the NHS pay scale, the natural comparison job; benchmark: Australia's 2022-23 work-value 15% rise - Grade B/C); (ii) a **funded career ladder, qualifications and CPD** (continuing professional development - ongoing on-the-job training, ~2% of payroll, against today's near-zero - Grade C); (iii) **job-quality and autonomy redesign** (the Netherlands Buurtzorg self-managed-team model - Grade B/C); and (iv) a **domestic recruit-and-train pipeline** to replace the overseas route closed 22 Jul 2025 (Grade C). The bare Band-3 pay floor alone (~£1.5bn, Grade B) is **not** a fix - pay alone retains the existing workforce but does not recruit (Australia, Grade B), and overseas recruitment, the only lever that had cut vacancies, is now closed.

Legislation. Employment Rights Act 2025 (the Negotiating Body exists); FPA scope and funding by regulation (§2.2).

Delivery body. The Adult Social Care Negotiating Body (pay), Skills for Care (career structure, qualifications, the Care Certificate), and NES (the recruitment pipeline).

Funding. The **ambition ladder**: slow-the-decline ~£1.5bn (the bare floor, labelled honestly as *not a fix*) · fix-it ~£6.1bn (the full four-part package, central) · fix-it-faster ~£8.7bn (high). Components at the central rung: pay-above-floor ~£4.9bn, career/training ~£0.65bn, job-quality ~£0.12bn, recruit-and-train ~£0.49bn (all Grade C). The FPA's earmarked £500m (≈20p/hr) is below even the bare floor.

The NES synergy - shown, not banked. The recruit-and-train pipeline runs naturally through the National Employment Service (entry 12 - White Paper, Implementation Plan, Public Summary): NES supplies care its domestic workers, care gives NES a large, growing source of real jobs (entries 3↔12, Method A6 centrality). Per the model's discipline, **no NES cost-sharing is netted off** the £0.49bn - it is a directional synergy, treated like the NHS/council savings: real, but not banked.

First hundred days. Fund the FPA settlement to a real floor; commission Skills for Care to design the funded career framework and qualifications; stand up the NES adult-social-care recruitment pathway; publish the workforce-capacity baseline (vacancies, turnover, recruitment) against which the capacity gate is judged.

Measures + evaluator. Vacancy rate (7.0% is a floor under the closed-migration scenario - A), turnover (23.1% - A), domestic recruitment volume vs the lost overseas intake (~50-105k/yr), retention at 12 months. Independent evaluator (Skills for Care data + an academic partner).

Sequencing. The pay deal is a **no-regrets** item - start now; the career structure and pipeline ramp over 2-3 years; recruitment is the slowest lever and gates entitlement expansion.

Failure modes / exit. *Pay without the rest* → retention but not recruitment (Australia); mitigation is funding all four parts. *Pipeline fails to replace migration* → vacancies stay at the 7% floor; mitigation is the NES route and, if it underperforms, a paused entitlement expansion rather than an unstaffed promise.

5.2 Provider market - fund true cost, end the cross-subsidy, gain a resolution power

What. True-cost pricing with councils funded to pay it; **end the self-funder cross-subsidy** (self-funders pay ~41% more - ~£236/week, over £12,000/yr - for the same care, Grade B, CMA 2017) by **commencing Care Act s.18(3)**; and a **provider-resolution regime** beyond CQC's notification-only oversight.

Legislation. A commencement order for s.18(3) (already in statute); new primary power for the resolution regime; fair-cost-of-care regulations.

Delivery body. Councils (commissioning and the fair-cost methodology), CQC (oversight + the new resolution unit).

Funding. ~£1.98bn/yr to fund councils to the true cost of domiciliary care, at the National Living Wage (NLW, the legal minimum wage for workers aged 21 and over) benchmark (Homecare Association, *The Homecare Deficit 2025*: £1.64bn councils + £0.345bn NHS - Grade B, primary-confirmed; the report's £2.64bn England figure is at the higher NHS Band-3 pay benchmark, which the workforce package covers separately). The cancelled £1.36bn fair-cost-of-care fund is the policy anchor.

First hundred days. Lay the s.18(3) commencement order; restart the fair-cost-of-care exercise on the cancelled-fund methodology; introduce the resolution-regime power; publish the share of councils paying below the cost of provision as the baseline.

Measures + evaluator. Share of councils paying domiciliary rates below the cost of employing workers (rose 8% in 2023 → 29% in 2025 - A/B; target: reverse); the self-funder differential (41% / ~£236 per week - target: narrow toward zero); provider exits and unplanned closures. Independent evaluator.

Sequencing. Fair pricing and s.18(3) are **no-regrets** - start now. The resolution regime needs primary law and follows.

Failure modes / exit. *Ending the cross-subsidy without funding councils* → providers lose the self-funder subsidy and exit; mitigation is to **fund councils first, commence s.18(3) second**. *A large provider fails with no power to act* → the Southern Cross repeat; mitigation is the resolution regime. Exit: if true-cost funding is not sustained, s.18(3) commencement is held rather than collapsing the market.

5.3 NHS integration - coordination and capacity, sold honestly

What. Investment in **coordination and capacity at the discharge interface** (discharge-to-assess, reablement, intermediate care) - and **no banked emergency-admission or cost savings**. The integration evidence is over-promised: the Better Care Fund was judged "not value for money" by the National Audit Office (NAO), Parliament's independent public-spending auditor, with "no compelling evidence" of savings (Grade B); ICS benefits are slow, partial and place-specific; discharge-to-assess and reablement are sound but **capacity-constrained**, so without workforce they recycle the same bottleneck (Grade C).

Legislation. Largely none new - uses the ICS framework and a reformed Better Care Fund.

Delivery body. ICBs with councils (the Better Care Fund as the joint vehicle, reformed away from a savings-target framing).

Funding. ~£0.5bn/yr for coordination and capacity (a cost, not a saving estimate - Grade C).

First hundred days. Re-base the Better Care Fund on coordination and capacity outcomes (not assumed savings); expand discharge-to-assess and reablement capacity *as workforce allows*.

Measures + evaluator. Delayed discharges (~12,000-14,000 patients/day; ~13,750/day in January 2026, NHS England via Nuffield Trust); bed-days lost to absence of a care package; reablement outcomes. **Savings are tracked but never banked** (the share of delayed discharge attributable to social care is contested, 20-45% by framework - do not present as settled). Independent evaluator.

Sequencing. This workstream is **downstream of workforce** - without staff, more discharge capacity simply moves the bottleneck (Scotland). It ramps as capacity is built.

Failure modes / exit. *Selling integration on savings* → the Better Care Fund (BCF) repeat; mitigation is the honest coordination-and-capacity framing with savings graded C. *Capacity added ahead of workforce* → recycled bottleneck; mitigation is the sequencing in §7.

5.4 Quality and unmet need - clear the backlog as a capacity problem, paced by capacity

What. Prevention, reablement and personalisation for outcomes (the outcome gains are reasonably evidenced - B; the cost-offset claims are **C and not banked**), and clearing the waiting lists (~418,029 waiting, ADASS Mar 2024 - a self-reported snapshot, B) and unmet need (~2m older people, ~1 in 5 of those aged 65+ - Age UK, C) as **capacity-and-funding** problems, not process ones - paced by the workforce and provider capacity built in 5.1-5.2.

Legislation. The Care Act 2014 duties (ss.18-19) already exist; the gap is funding and capacity, plus the means-test uprating by regulation.

Delivery body. Councils.

Funding. **~£6.4bn/yr** to meet demand and improve access (the Health Foundation (HF), an independent health charity and think-tank, Scenario 2 gap: demand + ~90,000 additional packages - primary-confirmed, Grade B/C). Means-test uprating (~56%) is modest and a **no-regrets** start.

First hundred days. Uprate the means-test thresholds by regulation; publish a capacity-paced plan to clear the waiting-list backlog (no entitlement widened ahead of the workforce to deliver it); commission reablement/prevention expansion as capacity allows.

Measures + evaluator. Waiting list and time-to-assessment; unmet-need prevalence; CQC quality (82% Good/Outstanding, as at 1 August 2024 - B); reablement outcomes. Independent evaluator.

Sequencing. Means-test uprating is **no-regrets** - start now. Entitlement expansion (the access improvement) is **gated on capacity** (the Scotland lesson is the whole reason for the gate).

Failure modes / exit. *Entitlement widened without supply* → Scotland's 720,000 bed-days; mitigation is the capacity gate. *Reablement sold as a saving* → unbanked claim banked; mitigation is grading C and not netting it off.

6. Funding - whole-life cost of the delivery package, and who pays

6.1 The cost of good care (the delivery package)

The model computes the cost of provision **once** and does not sum the workstreams (they interact - non-additive). The **total** cost of good-care provision is **~£38.3bn/yr** in the base year at the full (fix-it) workforce rung (~£33.3bn at the floor, slow-the-decline rung) - shared between the state and individuals according to whichever funding option is chosen (§6.2; under the status quo the state covers ~£26.7bn of the total and individuals ~£11.6bn). The delivery package is what lifts the system from managed decline to good care, and its largest single lever is the workforce ambition ladder:

Component	Central cost / yr	Grade	Note
Workforce (full four-part package)	~£6.1bn (ladder £1.5-8.7bn)	C	The ambition ladder - a public choice on *how far* (Public Choices §B)
Provider true-cost gap	~£1.98bn	B	Homecare Association 2025 (confirmed; NLW benchmark)
Meeting demand + access	~£6.4bn	B/C	HF Scenario 2 gap (primary-confirmed)
NHS coordination & capacity	~£0.5bn	C	A cost, not a saving

These are the costed components, not an additive total - the model's integrated provision figure (£33.3bn floor / £38.3bn full) is the single source of truth; the components overlap and must not be summed.

6.2 Who pays - the menu, not a recommendation

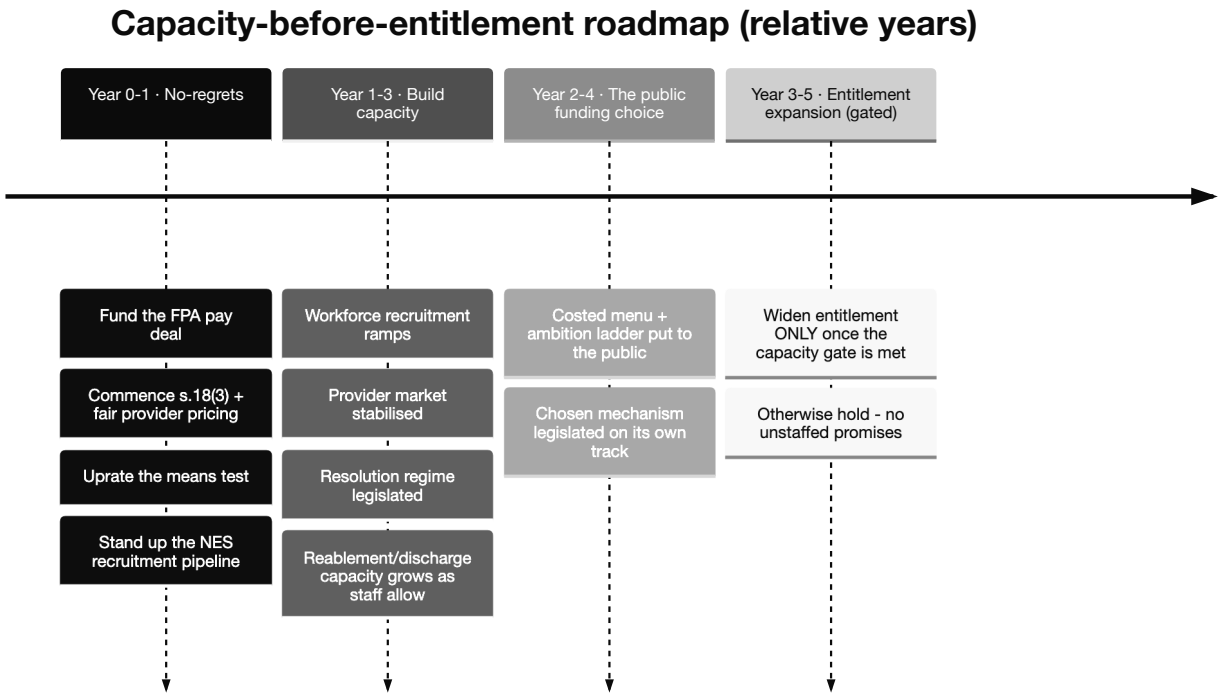
Who bears that cost is the value question, and is not decided here. The Public Choices document presents the six neutral, costed funding options (social insurance; hypothecated NI; free personal care; the un-diluted cap; means-test reform; status-quo-plus), each with its track record, its state/individual split, its incremental new money, and whether it addresses the catastrophic tail - with private insurance available

only as a top-up on whichever public base is chosen. Only the **un-diluted cap** addresses the catastrophic tail; the model surfaces this, it does not recommend it. The choice is routed to the public.

6.3 Centrality - real, directional, not banked

Adequate social care relieves council finance (entry 1; ~42% of council service spend) and the NHS (delayed discharges). Both effects are **directionally strong but Grade C in magnitude**, and **no numeric saving is netted off any cost figure** - the same discipline NES applied to its ROI (return on investment). The reform is **never** presented as self-funding.

7. Sequencing, dependencies and the capacity-before-entitlement critical path



The rule: no entitlement is widened ahead of the workforce and provider capacity to honour it. The **no-regrets** items (the funded pay deal, fair provider pricing + s.18(3), means-test uprating, the NES pipeline) start now because they are needed under *every* funding option and improve the system regardless of the public's choice. The **gates**:

- **Gate 1 - no-regrets delivered:** the pay settlement funded; s.18(3) commenced; means test uprated; the recruitment pipeline live; the capacity baseline published.
- **Gate 2 - capacity proven:** vacancy and turnover improving on a measured trajectory; provider exits down; the workforce able to staff a wider entitlement. *Evidenced, not asserted.*
- **Gate 3 - the funding choice made and legislated:** the public has chosen who bears the tail and at what ambition; the chosen mechanism is enacted; entitlement expansion commences **only** once Gate 2 is met.

Critical-path dependencies: s.18(3) commencement (provider stability) and the FPA funding (workforce) block Gate 2; the funding-mechanism legislation follows the public choice and is *off* the critical path; the cross-departmental settlement (so the departments that save contribute) should be pre-built through day-one co-sponsorship (§3).

8. The first hundred days

A concrete list for the period immediately after the commitment:

1. **Formalise cross-departmental sponsorship** (DHSC lead; HMT, MHCLG, DWP, Home Office, NHS England co-sponsors) and the protected evaluation/capacity-gate mandate.
2. **Fund the Fair Pay Agreement** to a real floor and commission the Negotiating Body to settle materially above Band-3 entry.
3. **Lay the commencement order for Care Act s.18(3)** and restart the fair-cost-of-care exercise on the cancelled-fund methodology.
4. **Uprate the means-test thresholds** by regulation (~56%, restoring the 2010 real value).
5. **Commission Skills for Care** to design the funded career structure and qualifications, and **stand up the NES adult-social-care recruitment pathway**.
6. **Introduce the provider-resolution regime** power and publish the provider-market and workforce baselines.
7. **Commission independent evaluators** and publish the capacity-gate test before any entitlement change.

9. Measures of success and the evaluators

System-level, evidence-graded, and adjusted so that no single number can be gamed:

- **Workforce:** vacancy rate, turnover, domestic recruitment vs the lost overseas intake, 12-month retention.
- **Provider market:** share of councils paying below cost (reverse the 8%→29% trend), the self-funder differential (narrow), provider exits.
- **NHS interface:** delayed discharges and bed-days lost to absent care packages - **tracked, savings not banked**.
- **Quality / unmet need:** waiting list and time-to-assessment, unmet-need prevalence, CQC quality, reablement outcomes.
- **The centrality effects** (council-finance and NHS relief) are measured as directional context, **never** netted off cost.

Each workstream has an **independent evaluator** reporting to the cross-departmental board independently of delivery, with a statutory protected budget - so a future spending review cannot quietly defund the evidence (the Future Jobs Fund lesson).

10. Failure modes and exit conditions

10.1 Risks and mitigations

Risk	Mitigation
Entitlement widened ahead of supply (the Scotland trap)	The capacity-before-entitlement gate (§7); no entitlement commenced before Gate 2.
Pay rises retain but do not recruit (the Australia finding)	The full four-part workforce package, not the bare floor; the NES pipeline; entitlement paced to recruitment.
Provider exit when the cross-subsidy ends	Fund councils to true cost **first**, commence s.18(3) **second**; the resolution regime for failures.
A large provider collapses with no power to act (Southern Cross)	The statutory provider-resolution regime (§5.2).
Integration sold on savings that do not materialise (the BCF "not value for money")	Coordination-and-capacity framing; savings graded C and never banked.
The funding mechanism unwound by a later government (the 2021 Health and Social Care, HSC, Levy)	Funding legislated as an entrenched standing settlement, not a line a Chancellor can lift; the public choice gives it a mandate.
The cardinal error - a value choice dressed as a technical necessity (the 2021 diluted cap)	Funding presented as a neutral costed menu and routed to the public (§6.2); the cap option is the *un-diluted* version.
Defaulting to the most expensive ambition as if it were the only fix	The ambition ladder is itself a public choice (Public Choices §B); the bare floor is labelled honestly as *not a fix*, but how far to go is the public's call.
The evidence base defunded before it reports	Statutory ring-fenced evaluation duty (§2.1, §9).

10.2 Exit conditions

Named in advance, not left to political weather:

- **If Gate 2 fails** - workforce and provider capacity not on a sufficient trajectory - entitlement expansion is **held**, not commenced. The no-regrets improvements remain in place; the system is better than the status quo regardless.
- **If Gate 3's public choice is "do less"** - the public chooses a lower ambition rung or status-quo-plus - that choice is honoured; the reform delivers the capacity for what was chosen, no more.
- **In every case the no-regrets work stands alone**: a funded workforce, fairly-paid providers, a commenced s.18(3), an uprated means test and a domestic recruitment pipeline all retain their value whatever happens to the larger funding settlement. This is what makes the reform a staged, reversible programme rather than an all-or-nothing gamble.

Sources and companions

Strategic Design · Evidence Annex (grades and full citations; the 11 previously-flagged items were primary-checked in June 2026) · Evidence Verification · costing model and results · Public Choices (plain-language funding menu + ambition ladder). Cross-references: Problem Register entries 1 (local government finance), 6 (SEND - special educational needs and disabilities), 12 - the National Employment Service (White Paper · Implementation Plan · Public Summary). All figures inherit the Evidence Annex grades.