Adult Social Care - Evidence Base (verified draft, 2026-06-06)

Gathered 2026-05-29 via five parallel research agents; Phase-2 primary-source verification applied 2026-06-06. Register entry 3 (adult social care - the care and support, such as help with washing, dressing, eating and daily living, provided to older and disabled adults), whole-system reform. England unless noted.

How to read the evidence grades (A to D). Every factual claim in this document carries a grade describing how strong the evidence behind it is - not whether the claim is important, but how confident we can be that it is true:

- **Grade A** - robust evidence that one thing actually causes another (the strongest).
- **Grade B** - strong evidence from careful observation or official statistics.
- **Grade C** - weaker, indirect, or modelled evidence (a calculation or projection rather than a direct measurement).
- **Grade D** - contested or absent evidence (the weakest).

UNVERIFIED items are explicitly flagged below. Do not publish or cite those figures without a fresh primary-source check (that is, checking the original official document yourself).

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1. Funding - risk-pooling models (and their track record)

("Risk-pooling" means everyone pays in - through taxes or insurance contributions - so that the heavy costs that fall on the unlucky few are shared across the whole population, rather than each individual facing the full bill alone.)

- **Social insurance (a compulsory national scheme funded by contributions from wages, like a dedicated tax for care) - Germany (Pflegeversicherung, the German long-term care insurance scheme, 1995):** the contribution rose from 1.0% to **3.6% of gross wage (1 Jan 2025)** (4.2% for childless people aged 23 and over) - confirmed by the German Federal Ministry of Health (the Bundesgesundheitsministerium, or BMG), BMG; it is explicitly a *partial* benefit (in German, "Teilkasko", meaning part-cover - like an insurance policy that only pays some of the bill, not all of it); the number of people needing care rose **from about 3.3 million to 5.0 million (2017 to 2021)**; there were **130 care-home insolvencies (businesses going bust) in 2023 (compared with 26 in 2022). The annual deficit (the amount by which the scheme's spending exceeds its income) is now CONFIRMED from the original source:** the German social long-term care insurance scheme (the Soziale Pflegeversicherung) ran a **1.54 billion euro deficit in 2024** (the National Association of Statutory Health Insurance Funds, the GKV-Spitzenverband, 14 Mar 2025), with the scheme's reserve fund (the Ausgleichsfonds, its financial buffer or rainy-day fund) falling from about 1.8 billion euros (start of 2024) to about 1.0 billion euros (end of 2024); a deficit of about 0.5 billion euros is projected for 2025. **Grade B (from the original source). The projected path of the contribution rate (from WIP-PKV, the research institute of the German private-health-insurers' association, May 2024) - CORRECTED:** the *average* contribution rate reaches about 4.93% (2030) and about 7.70% (2040) under the worst-case trend (which the German source labels "RETRO20"); the *childless* rate reaches about 5.9% (2030) and about 9.2% (2040). The earlier "about 5.2% by 2030 / about 7.9% by 2040" was a garbled blend of the two figures - **do not use it**; cite the childless path or the worst-case ("RETRO20") average, each clearly labelled. *Verdict: this scheme has WORKED for 30 years and is durably popular, but is now structurally STRAINED - because it is "pay-as-you-go" (PAYG), meaning today's contributions pay today's care bills with nothing set aside, an ageing population feeds straight through into rising contribution rates; and it never covered the full cost by design.*
- **Japan (LTCI, the Long-Term Care Insurance scheme, 2000):** funded half from taxes and half from premiums (paid by people aged 40 and over); spending grew from 3.6 trillion yen to 11.7 trillion yen (2019), and to more than 15 trillion yen by 2025; premiums for the over-65s roughly doubled; the cost was controlled by raising the share users pay themselves (the "co-payment", from 10% up to 20% or 30%) and by tightening who qualifies. **Grade B.** *WORKED, but STRAINED.*
- **South Korea (2008):** the long-term care premium is a surcharge added on top of the national health-insurance contribution; the rate is **12.95% of the national health-insurance premium in 2025** (about 0.9182% of income) - CORRECTED: the freshly-decided **13.14% applies to 2026, not 2025** (Ministry of Health and Welfare long-term care committee, 4 Nov 2025), and the previously cited 12.27% was wrong. **Grade B.** Reserve trajectory (how the scheme's savings buffer has changed over time): the fund ran a **surplus from 2008 to 2011** (per the Korea Institute for Health and Social Affairs, KIHASA, and the National Health Insurance Service, NHIS, yearbook) and a deterioration is **projected** (government data: reserves exhausted around 2026, large deficits thereafter) - the earlier "36% falling to about 1.7% by 2015" figures are **NOT supported by any original source and are contradicted by the records of the time; they have been removed. Grade B (directional; the trillion-won deficit projections are government data reported via the press - re-source from the original before citing).** *WORKED at launch, but straining fastest of all.*

- **Netherlands (Wlz, the Long-Term Care Act, the Dutch law funding long-term care):** funded by an income-based premium of about 9.65% plus a top-up from general taxes; it costs **about 4.4% of GDP** (gross domestic product - the total value of everything the country produces in a year; the share of GDP shows how big the cost is relative to the whole economy), against an average of 1.8% across the OECD (the Organisation for Economic Co-operation and Development, a club of 38 mostly-wealthy countries that publishes comparable statistics) - making it the costliest long-term care system; reforms in 2015 split out home care on affordability grounds. **Grade B.** *WORKED on coverage; costliest in the world.*
- **Cross-cutting pattern (Grade A):** every social-insurance long-term care scheme has needed rising contributions or co-payments; none has collapsed; all are pay-as-you-go (PAYG). *Design lesson: build in automatic rate-adjustment, partial-benefit expectations (be honest from the start that it will not cover everything), and institutional entrenchment (making it hard to abolish) from day one.*
- **Private long-term care insurance (cover you buy individually from a commercial insurer): USA** - suffered a "death-spiral" (insurers mispriced the long-run liabilities, that is, they badly underestimated how much they would eventually have to pay out, so they stopped selling new policies; take-up fell to about 3 to 4% of people); the widely-cited **Genworth "about 97% premium hike" (a near-doubling of what policyholders pay) is CONFIRMED but state-specific** - it was an average 97% increase imposed on about 2,000 policyholders in the US state of Connecticut in 2022 (the increases ranged from 79% to 173%), per Connecticut Insurance Department data - it was **not** a sector-wide or company-wide figure; cite it only with that caveat. **Grade A.** *FAILED.* **France** (the "assurance dépendance", or dependency insurance) - the number of policyholders peaked at about **5.7 million (2012)** then shrank to **about 1.5 million (2024)** as the market contracted; it operates as a **fixed-sum top-up** (a set cash amount) **on top of the tax-funded APA floor** (the APA, "Allocation Personnalisée d'Autonomie", is France's tax-funded personal-independence allowance - the basic public payment everyone can fall back on). **Grade B.** *Works only as a limited supplement, and the market is demonstrably shrinking.* **Germany's Pflege-Bahr** (a government-subsidised voluntary top-up policy) - had a small and diminishing effect. **Grade C. UK** - the last standalone insurer left the market in 2010; this is a "missing market" (a product that simply is not offered); even the proposed Dilnot cap (see Section 2) did not spark one. **Grade A.** *FAILED to ever develop. *Synthesis (Grade A): standalone private long-term care insurance has failed everywhere as a main way of funding care; it is viable only as a fixed-sum top-up sitting on top of a compulsory public base - and even those supplementary markets shrink when the public base is weak (as in France).*
- **Hypothecated levy (a tax legally earmarked for one specific purpose):** the **UK Health and Social Care Levy (2021 to 2022)** - 1.25 percentage points added to National Insurance contributions (NICs, the payroll tax paid by workers and employers that funds the NHS and pensions), raising about **£12.4 billion a year** (per the OBR, the Office for Budget Responsibility, the government's independent fiscal watchdog), but regressive (it fell on earned income and on working-age people, so it took a bigger share from those less able to pay), and it was **repealed within about 13 months (25 Oct 2022)** before any of the money reached care. **Grade A.** *FAILED on politics.* Earmarking only endures when it becomes an entrenched standing fund (as in Japan and Germany).

Sources: House of Commons Library CBP-9310 and CBP-9626 (CBP = Commons Briefing Paper, the Library's numbered research notes for MPs); National Bureau of Economic Research (NBER, a US economics research body) papers w31870 (Germany) and w31829 (Japan); KFF (the Kaiser Family Foundation, a US health-policy charity) - US long-term care insurance; PMC (PubMed Central, a free archive of medical and scientific papers) - France long-term care financing; Strategic Society Centre - UK pre-funded insurance; OECD Health at a Glance 2023 - long-term care. *Resolved (2026-06-07 primary check): German social-care-insurance deficit 1.54 billion euros (2024, GKV-Spitzenverband, Grade B);*

German WIP-PKV rate path corrected (average about 4.93%/2030 to 7.70%/2040 worst-case; childless 5.9%/2030 to 9.2%/2040); Korea rate 12.95% (2025) / 13.14% (2026); Korea "36% to 1.7%" removed (unfounded, contradicted by the 2008 to 2011 surplus record); Genworth 97% confirmed but Connecticut-2022 state-specific only. Still press-reported / secondary: Korea forward deficit projections - re-source before citing.

2. Funding - entitlement, cap and means-test models

(A "means-test" is a check on someone's income and savings to decide whether the state pays for their care, and how much; a "cap" is a legal ceiling on how much any individual can be made to pay over their lifetime.)

- **Free personal care - Scotland (2002 onwards):** free personal and nursing care for people aged 65 and over (the everyday living costs - food, heating and accommodation, which someone would have to pay for anyway and which are referred to as "hotel costs" - are still means-tested; the scheme was extended to under-65s in 2019). Cost: Audit Scotland (the Scottish public-spending auditor) found in 2007 it cost about £1.8 billion over 2002 to 2006 (about £600 million of that being additional spending); it rose from about £500 million (2018) to **£915 million (2023/24)**; care-at-home spending rose from £739 million to £841 million (2024/25); central government funding lagged behind councils' actual costs (and the gap is widening). **Grade B. Critical nuance:** free care does NOT relieve the NHS (the National Health Service) by itself - Audit Scotland (Jan 2026) found **720,000 unnecessary hospital bed-days in 2024/25 (costing about £440 million a year; 1 in 9 hospital beds)**, the top cause being the absence of a social-care package to discharge the patient into. In other words, a free *entitlement* on paper is not the same as actual *supply* of care. **Grade B** (for the delayed-discharge figures); the claim that it "delays admission to a care home" is modelling **Grade C**. England cost: the Health Foundation (a major independent health charity and think-tank) estimates **about £6 billion (2026/27) rising to about £7 billion (2035/36)** for an equivalent scheme. **Grade C.** The Nordic countries (Sweden and Denmark) spend more than 3% of GDP on this and it works only at very high tax levels (tax-to-GDP ratios - total tax as a share of the whole economy - of 45.2% in Denmark and 41.4% in Sweden). **Grade B.** *Verdict: WORKED as an entitlement but FAILED on capacity without matched supply of care and a matched workforce.*
- **Dilnot cap-and-floor (England, never implemented):** named after the economist Sir Andrew Dilnot, this was a proposed £86,000 lifetime cap on how much anyone pays for *personal care* (with the everyday living "hotel costs" excluded), plus a "floor" (a savings level below which the state pays in full) set somewhere between £20,000 and £100,000. Cost: the OBR estimated about a quarter of one percent of GDP a year; the Department of Health and Social Care (DHSC, the government department responsible for the NHS and care in England) estimated about £1.42 billion (2023/24) rising to £4.74 billion (2031/32). **Distributional point (Grade A)** (that is, a point about who gains and who loses): the **November 2021 change** (under which only the individual's own spending counts towards the cap, not the contributions the council also makes) made it regressive - someone with about £90,000 in assets could end up paying roughly double, while a £500,000 estate is largely protected; people with less than £186,000 are worse off than under the original Dilnot design; the wealthy reach the cap in about 3 years 4 months, against about 6 years 5 months for others. History: Care Act 2014 (£72,000 cap) then delayed in 2015, then revived in 2021 (£86,000, to start Oct 2023), then delayed to Oct 2025, then **cancelled in July 2024. Grade A.** *Verdict: FAILED politically and never tested in practice; the 2021 version is a value choice (to protect family estates) dressed up as protection against catastrophic care costs - exactly the kind of disguised value choice the Pragma Method exists to prevent.*

- **Means-test reform:** the thresholds are an **upper limit of £23,250 (about £36,400 in 2026 prices) and a lower limit of £14,250 (about £22,300 in 2026 prices)** - above the upper limit you pay for all your care; below the lower limit the state pays in full; in between you contribute on a sliding scale. These have been **frozen since 2010/11 (16 years)**. The gap caused by not uprating them for inflation is approximately **56%** - uprating them in line with CPI (the Consumer Prices Index, the standard official measure of inflation) would require roughly doubling the real value of the threshold. **Grade B.** Uprating is cheap, but it does NOT touch the catastrophic tail (the upper limit of £23,250 is tiny next to care bills that can run to £50,000 to £60,000 a year). *Verdict: a cheap palliative (it eases the symptom without curing the problem).*
- **Catastrophic-cost problem:** care costs have a "right-skewed, uninsurable tail" - meaning a small minority of people face enormously high lifetime costs that no commercial insurer will cover; only **universal tax-funding** or an **un-diluted cap that also includes the everyday "hotel costs"** meaningfully addresses this. *The value question for the public to decide: who should bear that catastrophic tail - the individual's estate or the taxpayer - and how progressively (that is, how much more should the better-off pay)?*

Sources: Audit Scotland 2007 and delayed discharges Jan 2026; Free Personal and Nursing Care Scotland 2024-25; Health Foundation - free personal care in England; OBR - cost of cap and floor; IFS (the Institute for Fiscal Studies, an independent economics research institute) - Does the cap fit?; King's Fund (an independent health and care think-tank) - Labour abandons the cap; House of Commons Library CBP-9315.

3. Workforce (Skills for Care 2024/25)

(Skills for Care is the official body that collects and publishes workforce data for adult social care in England.)

There are about **1.60 million filled posts**; the vacancy rate is **7.0%** (about 111,000 unfilled posts; down from a 10.5% peak, but *only* because of international recruitment); the turnover rate (the share of staff leaving each year) is **23.1%** (about 335,000 people a year); the median (typical) care-worker pay is **£12.00 an hour** - above the *then-current* National Living Wage (the NLW, the legal minimum wage for workers aged 21 and over, which was £11.44 in Dec 2024) but below the *incoming* April 2025 National Living Wage of £12.21; and **65% of care workers were paid below the April 2025 National Living Wage rate as at Dec 2024** (not 66% - this is the Skills for Care 2025 figure); care-worker pay is about 31p an hour less than a newly-started NHS Band 3 healthcare assistant (a Band-3 healthcare assistant, or HCA, is an entry-level clinical-support role on the NHS pay scale - a natural comparison job that care workers can move to) (confirmed Grade **A**, Skills for Care 2025). **Grade A.** Workforce funding gap: the Homecare Association (the membership body for home-care providers in England) puts the England gap for domiciliary care (care delivered in people's own homes) at **£1.98 billion (2025-26: £1.64 billion from councils plus £0.345 billion from the NHS / Integrated Care Boards)** - now **CONFIRMED from the original source** (*The Homecare Deficit 2025*, Homecare Association, 21 Nov 2025, Figure 33), Grade **B.** (An Integrated Care Board, or ICB, is the local NHS body that plans and pays for health services in an area.) Note that this £1.98 billion is measured at the **National Living Wage** benchmark; the same report's headline England figure is **£2.64 billion** if measured at the NHS Band-3 healthcare-assistant pay benchmark (£3.25 billion across the whole UK). The model uses the National-Living-Wage-benchmark £1.98 billion for the provider true-cost component, because the extra cost of paying above Band 3 sits separately in the workforce package - using the Band-3 figure here would double-count that pay uplift. Health Foundation modelling is covered in Section 5. **Grade A/B.** International recruitment: fell from about 105,000 (2023/24) to **about 50,000**

(2024/25) after the 11 Mar 2024 ban on care workers bringing dependants (family members); the **overseas care-worker recruitment route was closed on 22 July 2025** - CONFIRMED from the original source (GOV.UK Statement of Changes to the Immigration Rules, HC 997): it closes entry-clearance (overseas) applications for the care-worker occupation codes 6135 and 6136; people already in the UK can continue switching into the route transitionally until 22 July 2028; this is distinct from the earlier March 2024 dependants ban - it removes the only lever that was cutting vacancies, with no domestic (home-grown) replacement. The 7% vacancy rate should be treated as a floor (a best case that is likely to worsen) under this scenario. **Grade A.**

- **Fair Pay Agreement** (under the Employment Rights Act 2025 - to be negotiated by an Adult Social Care Negotiating Body): the first agreement is due in **April 2028**; but only **£500 million is earmarked, equivalent to about 20p an hour** (confirmed Grade **A**), which covers only about two-thirds of even the bare minimum floor; council and NHS staff may be excluded. **Grade A.** *Evidence from where similar things have been tried:* Australia's 2022-23 "work-value" pay rise of 15% improved **retention (keeping staff) but not recruitment (attracting new staff)** (Grade B); New Zealand's 2017 pay settlement was not embedded in law and so proved fragile (Grade C); Austria and Germany have near-universal sector-wide pay agreements that raise the floor, but shortages persist anyway (Grade B/C). *Verdict: a Fair Pay Agreement stabilises the existing workforce but does NOT recruit new workers; it delivers only what it is actually funded for. The Fair Pay Agreement plus £500 million alone does not close the pay gap.*
- **Registration (requiring care workers to be on an official register):** England has none; Scotland and Wales register the whole workforce and pay the Real Living Wage (a voluntary, higher minimum wage rate calculated to meet the cost of living), which plausibly lowers turnover, but the effect is **confounded by pay** (that is, you cannot tell how much is down to registration and how much to the higher wage). **Grade C.**
- **What works (OECD *Who Cares?* 2020):** pay rises help but have only a small effect unless properly funded (Grade B); improving job quality and giving workers more autonomy (as in the Dutch model **Buurtzorg**, a nurse-led home-care provider known for self-managing teams) cuts turnover (Grade B); Japan's wage-supplement plus funded training lifted its workforce by about 20% (Grade B/C); migration (overseas recruitment) is a stopgap, not a long-term stabiliser (Grade B). *Conclusion: pay, plus a funded career structure, plus job quality, all together; with migration only as a stopgap.*

Sources: Skills for Care - State of the Adult Social Care Workforce 2025; House of Commons Library CBP-9615; Nuffield Trust (an independent health think-tank) - implementing a Fair Pay Agreement; GOV.UK - Fair Pay Agreement consultation; OECD - Who Cares? (2020); Australian Fair Work Commission - aged-care work value; Homecare Association - homecare funding gap 2025. *Resolved (2026-06-07 primary check): Homecare Association £1.98 billion CONFIRMED (The Homecare Deficit 2025, National-Living-Wage benchmark; £2.64 billion at Band-3); overseas route closure CONFIRMED 22 July 2025 (GOV.UK HC 997).*

4. Provider market and NHS integration

- **Self-funder cross-subsidy:** the CMA (the Competition and Markets Authority, the UK's competition regulator) found in 2017 that self-funders (people paying for their own care because they are above the means-test threshold) pay **about 41% more (about £236 a week, over £12,000 a year)** for the same care than councils pay - CONFIRMED from the original source (CMA *Care homes market study* final report, 30 Nov 2017, paragraph 2.40: self-payers average about £846 a week against about £621 a week for council-funded residents). This means self-funders effectively subsidise council-funded residents - a "cross-subsidy". The precise "£12,982 a year" figure was over-precise and is **not** actually in the CMA report - it has been corrected to the CMA's own wording of "£236 a week / over £12,000 a year". **Grade B (2017).** This amounts to a sector-wide shortfall of about **£1 billion a year (UK-wide, 2017).** No verified 2024/25 version of this differential was found in the primary sources from LaingBuisson (a care-sector market analyst) or the Health Foundation - the CMA's 2017 figure of 41% / £236 a week remains the standard citation; a fresher figure needs a dedicated check. *This is a distributional choice (about who pays for whom) disguised as a price.*
- **Cancelled fix:** the **£1.36 billion "fair cost of care" fund** plus the commencement of **section 18(3) of the Care Act 2014** (a legal provision that would have let self-funders ask their council to arrange care for them at the cheaper council rates) - both **cancelled on 29 July 2024**. **Grade A.** *The only legislated structural fix was abandoned.*
- **Fragility:** Southern Cross collapsed in 2011 (it had used a "sale-and-leaseback" model - selling its care-home buildings and renting them back, which left it with rents it could not afford - and ran **more than 750 homes / about 37,000 beds**); about 80 to 85% of small providers operate on thin profit margins; the share of councils paying home-care rates that are **below the cost of actually employing the workers rose from 8% (2023) to 29% (2025). Grade A/B.** Market oversight by the CQC (the Care Quality Commission, the independent regulator of health and care services in England): it has a **statutory duty to monitor, and to give notice about, providers that would be "difficult to replace" if they failed; but there is no statutory rescue regime** - the CQC can flag financial distress but cannot compel a rescue or restructuring. **Grade A.**
- **Delayed discharges (patients who are medically fit to leave hospital but cannot, often because no care is available at home):** approximately **12,000 to 14,000 patients a day** are ready for discharge but delayed - CONFIRMED as a range (Nuffield Trust, compiling NHS England data): about 12,201 a day (Jan 2022) rising to about 13,750 a day (Jan 2026), with a peak of about 14,096 (Jan 2024). The precise "12,663 a day" figure is **not** in any NHS England release - it has been **removed as spurious**; the "about 12% of general-and-acute beds" figure was **unsourced and has been removed** pending a primary check. Cost of delayed discharge: NHS England's first costing put it at **about £220 million a month (a September 2025 figure), implying more than £2 billion a year** - treat this as **Grade C** (the method is contested and varies depending on how costs are attributed). Social care as a *cause* of delayed discharge is **a major but contested contributor**. Estimates vary substantially depending on the attribution framework (the method used to assign blame) and the reference period - NHS England (using its post-May 2024 framework) puts it at about 23%; the CQC (April 2024) at about 45%; the Nuffield Trust (using an older framework) at about 42%. **The previously cited "social care = largest single cause (about 33%)" figure overstates how certain this is - do not present it as an established fact. Grade C** (the attribution method is contested). The "about 33%" figure attributed to NHS internal processes is similarly framework-dependent.

- **Integration evidence (over-promised):** the **Better Care Fund** (a pooled budget meant to join up health and social care) - the NAO (the National Audit Office, Parliament's independent public-spending auditor) judged it "not value for money"; emergency hospital admissions **rose by 87,000** against a *planned cut* of 106,000; and there was "no compelling evidence that integration delivers savings." **Grade B. Integrated Care Systems** (the structural merger of local NHS and council planning introduced in 2022) - the benefits are slow, partial and place-specific; the advice is to "set realistic expectations." **Grade B. Discharge-to-assess and reablement** (sending patients home with support to recover, rather than assessing their long-term needs in hospital) - sound in principle, and cost-saving at the level of the whole system, but **capacity-constrained** (it just recycles the same bottleneck). **Grade C.** *Sell integration on the basis of better coordination and capacity, NOT on the promise of emergency-admission savings.*

Sources: CMA via House of Commons Library CBP-8003; NAO - health and social care integration; Health Foundation - delayed discharges and intermediate care; CQC - market oversight; LSE (the London School of Economics) - corporate care homes; NHS England delayed discharge statistics. *Resolved (2026-06-07 primary check): "12,663 a day" removed (spurious); range about 12,000 to 14,000 a day CONFIRMED (current about 13,750 a day, Jan 2026, NHS England via Nuffield Trust); self-funder differential CONFIRMED at CMA 2017 (41% / £236 a week). Still standing (genuinely contested, not a verification gap): delayed-discharge social-care attribution is framework-dependent (20 to 45%) - do not present "largest single cause about 33%" as fact; £220 million a month is a Sept 2025 NHS England figure (Grade C). No verified 2024/25 self-funder differential found - CMA 2017 remains the citation.*

5. Unmet need, cost, demographics, official process, centrality

- **Unmet need and quality: 418,029 people waiting (as at 31 Mar 2024, per ADASS, the Association of Directors of Adult Social Services - a self-reported snapshot, Grade B)**; **about 2 million older people with some unmet need - approximately 1 in 5 of people aged 65 and over (and 1 in 4 of those aged 80 and over)** (Age UK, modelled using ELSA, the English Longitudinal Study of Ageing - a long-running survey that tracks the health and circumstances of older people over time; Grade **C**); the CQC rates **82% of services Good or Outstanding** (as at **1 August 2024**, CQC State of Care 2023/24 - CONFIRMED from the original source; the date is corrected from "Aug 2023"). The **"47% of Requires-Improvement providers re-inspected failed to improve" claim is a MISATTRIBUTION and is permanently removed** - the only 47% figure in CQC State of Care 2023/24 actually refers to *maternity* services rated requires-improvement or inadequate, and the CQC publishes no year-on-year re-inspection improvement comparison for this edition (because it was a ratings transition period). **Do not cite it.** There is a "postcode lottery" (a sharp variation in what care you get depending on where you live; Grade B). Reablement and personalisation (support to regain independence, and care tailored to the individual): the gains in people's outcomes are reasonably evidenced; but the claim that they "save money" is only Grade **C** - do not bank on it.
- **Cost and demographics:** local authorities' (councils') net current spending on adult social care is **£23.3 billion (2023/24)**, with gross spend of £27.1 billion (**Grade B**, confirmed); adult social care is **about 42% of councils' service spending** (up from about 35% in 2010/11, per the IFS; Grade **B**); dementia: **about 982,000 people in the UK (2024, Alzheimer's Society)**, projected to reach about **1.4 million by 2040** - not 650,000 (the 650,000 figure is outdated and incorrect; the figure in the prior draft was wrong). The over-85s and dementia are the principal demographic drivers of rising demand (these projections are Grade **C**).

- **Health Foundation funding scenarios (in 2024-25 prices; against a baseline of about £28.4 billion in 2025/26) - now CONFIRMED from the original source** (the Health Foundation's own datasheet and press release; the live website blocks automated agents with a 403 error, so these were obtained via cached copies of the Health Foundation's own files). The scenarios are **cumulative** (each one builds on the one before), and the figures the Health Foundation actually publishes are the **annual funding gaps** (how much extra is needed each year), not totals:
    - **Scenario 1 - Stand still** (just keeping pace with rising demand plus the cost pressures of the National Living Wage and National Insurance contributions): gap of **+£3.4 billion a year (2028/29)**, rising to +£9.1 billion by 2034/35.
    - **Scenario 2 - Improve access** (the above plus about 90,000 extra care packages): gap of **+£6.4 billion a year (2028/29)**, rising to +£12.7 billion by 2034/35.
    - **Scenario 3 - plus Band-3 pay parity** (the above plus raising care-worker pay to match the NHS Band-3 healthcare-assistant rate): gap of **+£8.7 billion a year (2028/29)**, rising to **+£15.4 billion a year by 2034/35.** The three gap figures, the £15.4 billion, and the £28.4 billion baseline are all **primary-confirmed, so Grade B** (Grade **C** is retained only for the Health Foundation's own stated uncertainty about its projections). The corresponding **2028/29 total spending** figures in the Health Foundation's datasheet are Scenario 1 £31.8 billion / Scenario 2 £34.8 billion / Scenario 3 **£37.1 billion. CORRECTION: the earlier "£36.5 billion" for Scenario 3 was the wrong cell in the datasheet (it is actually Scenario 1's 2033/34 total); the correct Scenario 3 figure for 2028/29 is £37.1 billion.** These totals are **2028/29** figures - do **not** present them against the 2025/26 baseline. They are three separate (cumulative) scenarios, not one figure with optional add-ons.
- **Official process / 25 years of failure:** Royal Commission 1999 (its recommendation rejected in England) then Wanless 2006 (not implemented) then Dilnot 2011 (legislated in 2014, then shelved) then the 2017 "dementia tax" U-turn (a proposed care-funding policy abandoned mid-election after a public backlash) then the 2021 White Paper "People at the Heart of Care" (which contained the £86,000 cap, cancelled in July 2024) and now, **LIVE: the Casey Commission** (the current independent review of adult social care, led by Baroness Louise Casey) **- Phase 1 reports in 2026; the long-term FUNDING question is deferred to Phase 2, around 2028** (the Institute for Government, IfG, an independent think-tank on how government works, warns that this reproduces the very sequencing that sank earlier efforts).
- **Systemic centrality (quantified, honestly):** adult social care is about 42% of councils' service spending and a primary driver of section 114 notices (a section 114 notice is the formal declaration a council issues when it cannot balance its books - effectively local-government bankruptcy) (Grade **B**); NHS delayed discharges run at about 12,000 to 14,000 a day, with an attributed cost of about £1.7 to 2 billion a year (Grade **C** - the method is contested; see Section 4); and the share of those delays attributable to social-care availability is a **major but contested** figure (a 20 to 45% range depending on the framework used - see Section 4). *It is directionally strong (the broad direction is well-founded) that fixing social care relieves both council finances and the NHS - but the MAGNITUDE of the savings is Grade C, so do not overclaim it.*

Sources: ADASS Spring Survey 2024; Age UK - 2 million unmet need; CQC State of Care 2023/24; House of Commons Library CBP-7903; IFS - council funding 2010 to 2024; Health Foundation - funding scenarios press release and datasheet *(primary CONFIRMED 2026-06-07 via the Health Foundation's own files; gaps Grade B)*; Alzheimer's Society - dementia statistics; Casey Commission terms of reference; Nuffield Trust - delayed discharges.

Caveats (updated 2026-06-07 after the 11-item primary-source check):

VERIFIED AND CONFIRMED: ADASS 418,000 waiting (self-reported snapshot, Grade B); £23.3 billion baseline and adult social care about 42% of council spend (Grade B); 31p Band-3 gap (Grade A); Fair Pay Agreement £500 million about 20p an hour, first agreement April 2028 (Grade A); vacancy 7.0% / 111,000 and turnover 23.1% / 335,000 (Grade A); Scotland free personal care £915 million (Grade B); OBR cap about a quarter of one percent of GDP (Grade B); private long-term care insurance failed everywhere (Grade A); Better Care Fund "not value for money" (Grade B).

CORRECTED IN THIS DRAFT: Health Foundation figures rewritten as three separate scenarios (not one figure); means-test uprating gap updated to about 56% (not 45 to 50%); thresholds stated in current-price equivalents; dementia baseline corrected to about 982,000 UK (not 650,000); CQC Good/Outstanding corrected to 82% (not 83%); Age UK unmet need corrected to "1 in 5 of those aged 65 and over" (not "1 in 4"); self-funder premium corrected to 41% / £236 a week (CMA 2017) - the "£12,982" was over-precise and is not in the CMA report; £1 billion shortfall clarified as UK-wide; Southern Cross corrected to more than 750 homes / about 37,000 beds; CQC oversight reframed as monitoring-and-notification with no rescue regime; international recruitment corrected to about 50,000 (not about 44,000); National Living Wage framing corrected (65% below the incoming April 2025 National Living Wage; the median was above the prevailing rate but below the incoming one); Germany insolvencies corrected to 130 in 2023 (not "about 2 a day"); German rate path now corrected to the WIP-PKV primary source (childless 5.9%/2030 to 9.2%/2040; average worst-case 4.93%/2030 to 7.70%/2040 - the earlier "5.2%/7.9%" was a blend); France insurance market corrected (5.7 million falling to about 1.5 million, contracting).

PRIMARY CHECK COMPLETE (2026-06-07) - all 11 previously-flagged items resolved: German social-care-insurance deficit 1.54 billion euros (2024) CONFIRMED; German WIP-PKV rate path corrected; Korea rate 12.95% (2025) / 13.14% (2026) corrected; Korea "36% to 1.7%" REMOVED (unfounded, contradicted by the 2008 to 2011 surplus record); Genworth 97% confirmed but Connecticut-2022 state-specific only; Homecare Association £1.98 billion CONFIRMED (National-Living-Wage benchmark); overseas route closure 22 July 2025 CONFIRMED (GOV.UK HC 997); "47% Requires-Improvement failed to improve" REMOVED (CQC maternity misattribution); delayed-discharge "12,663 a day" REMOVED (range confirmed; about 13,750 a day Jan 2026); Health Foundation gaps plus £15.4 billion plus £28.4 billion baseline CONFIRMED (Grade B), £36.5 billion corrected to £37.1 billion; self-funder "£12,982" corrected to the CMA's £236 a week. ***Residual items that still need a fresh source before citing (and are NOT used in the public artefacts): Korea's forward deficit projections (government data reported via the press); a 2024/25 self-funder differential (none found - CMA 2017 stands). Genuinely contested (not a verification gap): the delayed-discharge social-care attribution share (20 to 45% depending on framework).***

Treat "social care saves money downstream" as Grade C; demographic projections (Grade C); refresh all 2025 figures before the next publication cycle.