Adult Social Care - White Paper

A proposal to fix adult social care in England as a whole system - the workforce, the provider market, the NHS interface and unmet need together - and to put the one genuinely contested question, who pays for ruinous care, honestly to the public.

Discussion draft · version 1.0 · June 2026. Prepared under *The Pragma Method* - an approach for turning long-unsolved problems into implementation-ready policy on graded evidence and across the political spectrum. It is presented for development and public deliberation, not as a finished government position: it **sets out options and the evidence for them, and does not advocate their adoption.** It is offered to inform the independent Casey Commission and the public, not to pre-empt them. Whether the country wants this, how good a service it is willing to pay for, and who should bear the cost, are decisions for the public and Parliament.

How to read the evidence grades. Each factual claim below is graded for the strength of the evidence behind it: **A** robust causal · **B** strong observational / official statistics · **C** weak, indirect or modelling · **D** contested or absent. Every claim carries a grade and a source; full citations are in the Evidence Annex. **Eleven figures were flagged UNVERIFIED in earlier drafts** (their primary sources had been inaccessible); they have since been checked against primary sources (June 2026) and the figures used here are primary-confirmed, corrected or removed accordingly, with any residual caveats recorded in the annex.

Executive summary

Adult social care in England is failing on five fronts at once, and they are causally linked. The **workforce** is underpaid and unstable - around 1.6 million posts, a vacancy rate of 7.0% (held down only by overseas recruitment, now closed), turnover of 23.1%, and median pay that sits below the incoming National Living Wage (the legal minimum wage for workers aged 21 and over) (Skills for Care 2025, Grade A). The **provider market** is fragile, with the share of councils paying domiciliary rates below the cost of employing workers rising from 8% (2023) to 29% (2025) (A/B). The **funding system** leaves a minority facing ruinous, uninsurable costs while a private insurance market has never developed (A). The **NHS interface** has ~12,000-14,000 patients a day medically fit to leave hospital but unable to be discharged, a major and contested share of them for want of a care package (B/C). And **unmet need** is large - ~418,000 people waiting (the Association of Directors of Adult Social Services (ADASS), Mar 2024, a self-reported snapshot, B) and ~2 million older people with some unmet need, roughly one in five of those aged 65+ (Age UK, C). Reform has been promised and abandoned for twenty-five years.

This is a **whole-system** reform, because every previous attempt that touched only one strand - funding alone; the workforce alone - failed for want of the others. It follows the Method's central discipline: **settle the empirical questions with evidence, and route the value question honestly to the public.** So the four *delivery* strands (workforce, provider market, NHS integration, quality and unmet need) are designed to implementation-readiness on the evidence, while the *funding* question - who bears the cost - is presented as a neutral, costed **menu** and decided by the public, not by us.

It is honest about three hard things.

First, this reform is not self-funding, and this paper never claims it is. Good-quality provision costs about **£38.3 billion a year** (central, full-workforce scenario; ~£33.3 billion at the floor scenario) against today's ~£26.7 billion of state coverage. Better social care does relieve council finance and the NHS - but

those savings are **Grade C in magnitude and are never banked or netted off** the cost. The cost is the cost.

Second, who pays is a value question, not a technical one - and pretending otherwise is the cardinal error that has killed every reform. The 2021 version of the Dilnot cap is the cleanest British example: it was sold as protection against catastrophic costs but in substance protected large estates while a person with a ~£90,000 home could lose almost all of it - a *distributional* choice dressed as a *technical* safeguard. We present **six neutral, costed funding options** and recommend none; only one of them (the un-diluted cap) actually addresses the catastrophic tail, and we say so plainly without saying it is therefore the right answer.

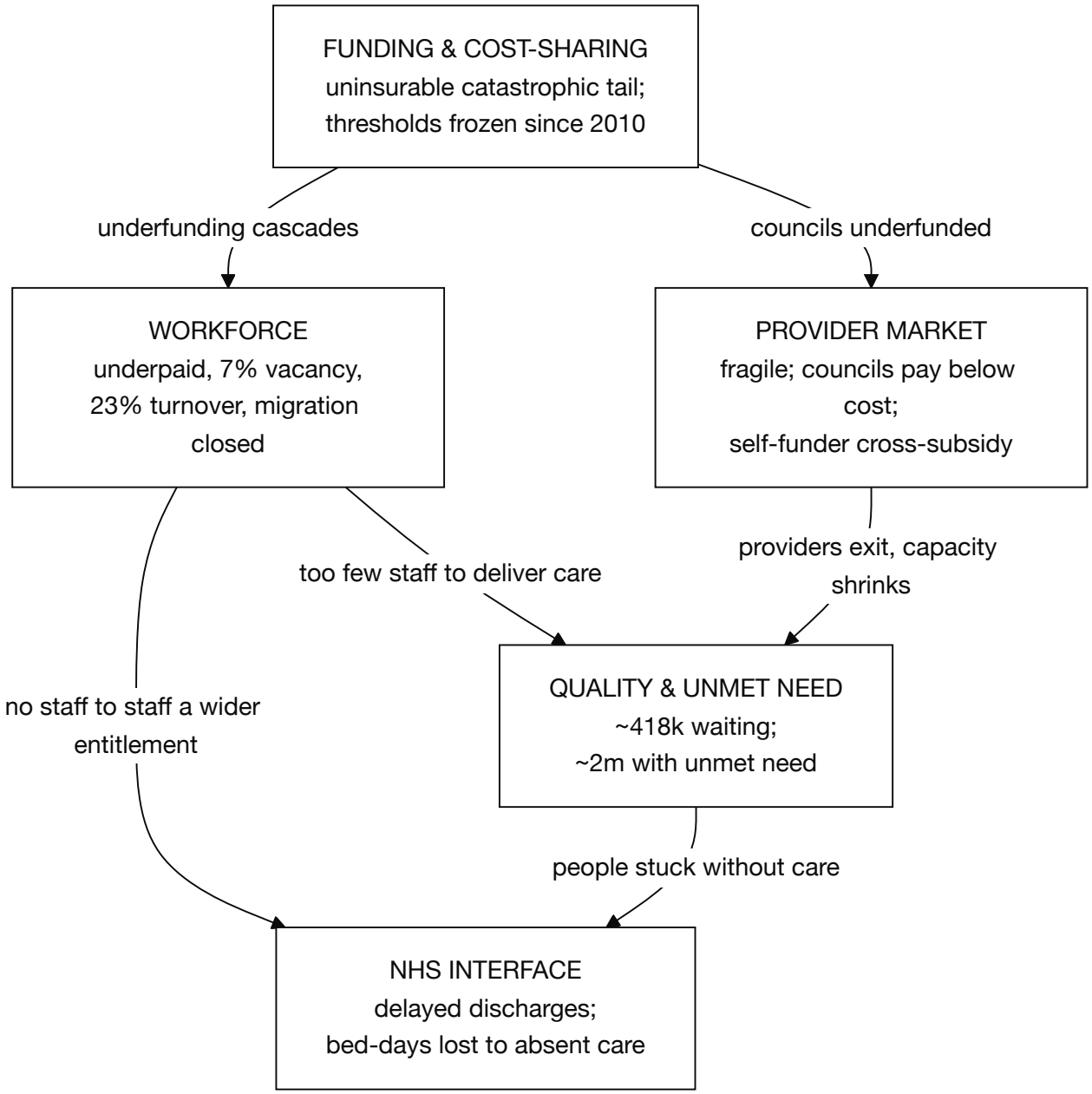
Third, capacity must come before entitlement. Scotland legislated free personal care without building the staff and providers to deliver it, and the result was a bottleneck moved, not cleared - ~720,000 unnecessary hospital bed-days in 2024/25, the top cause being the absence of a care package (Audit Scotland, Jan 2026, B). So this reform builds workforce and provider capacity *first*, through a set of **no-regrets measures needed under every funding option**, and widens entitlement only once the capacity to honour it exists.

The result is **two questions for the public**: *who should bear the cost of ruinous care* (the funding menu), and *how good a service we build and how fast* (an honest ambition ladder). The rest of this paper sets out the problem, why it has persisted, the whole-system design, the evidence, the honest cost, the two choices, the institutional and sequencing model, the measures of success, an adversarial three-perspective review, and the route to implementation.

---

1. The problem - five interlocking failures

Social care's failures are usually treated as separate problems. They are not: they are one system failing in five linked places, which is why single-strand fixes have never held.



The numbers (full grades and citations in the Evidence Annex):

- **Workforce:** ~1.6 million filled posts; vacancy 7.0% (~111,000, held down only by overseas recruitment); turnover 23.1% (~335,000/yr); median pay £12.00/hr, with **65% of care workers paid below the April 2025 National Living Wage** at the end of 2024, and pay ~31p/hr below a new NHS Band-3 healthcare assistant (Band 3 is an entry-level rung on the NHS pay scale - a job care workers can readily move to) (Skills for Care 2025, **A**). The overseas recruitment route - the only lever that had cut vacancies - was **closed on 22 July 2025** with no domestic replacement (B).
- **Provider market:** the share of councils paying domiciliary rates below the cost of employing workers rose **8% (2023) → 29% (2025)** (A/B); self-funders pay ~**41% more (~£236/week, over £12,000/yr)** for the same care (the Competition and Markets Authority (CMA) 2017, **B**); the regulator has monitoring and notification powers but **no power to resolve a failing provider** (the Southern Cross gap: >750 homes / ~37,000 beds, **A**).

- **Funding:** the means-test thresholds (£23,250 / £14,250) have been **frozen since 2010/11** (B); the £86,000 lifetime cap was legislated and then **cancelled in July 2024** alongside the £1.36bn fair-cost-of-care fund (A).
- **NHS interface:** ~**12,000-14,000 patients a day** ready for discharge but delayed (~13,750/day in January 2026, NHS England via Nuffield Trust); the share attributable to social care is a major but **contested** figure (20-45% by framework - do not present as settled) (B/C).
- **Unmet need and cost:** ~**418,000 waiting** (ADASS Mar 2024, snapshot, **B**); ~**2 million** older people with some unmet need (~1 in 5 of those aged 65+, Age UK, **C**); local-authority net spend **£23.3bn** (23/24), **~42% of council service spend** (B).

2. Why markets and government have not resolved it

Why the market does not solve it (the Method's market-insufficiency taxonomy):

- **A missing market (category 6).** Standalone private long-term-care insurance has **failed everywhere** as a primary mechanism - the US death-spiral, the UK's last insurer exiting in 2010, the French market contracting from ~5.7m policies (2012) to ~1.5m (2024), and no market reappearing even when the Dilnot cap was legislated (**A**). The risk is hard to price, the need may be decades away, and the costs can be open-ended. Private insurance works only as a **fixed-sum top-up on a compulsory public base** (France). "Let a private market develop" is therefore not an available option.
- **A distributional failure (category 9).** Care costs are right-skewed and uninsurable: a minority face open-ended, ruinous bills, and you cannot predict who. Without collective pooling the burden falls catastrophically and arbitrarily on whoever happens to need years of care. This is explicitly **not** a classic efficiency failure - it is a question of who should bear an unfair risk, which is a value choice and is labelled as one.
- **A coordination failure (with the NHS).** Underfunded social care raises hospital costs through delayed discharges - but the integration evidence is over-promised, so this is a real cost to relieve, not a saving to bank (§5).

Why government has not fixed it is structural, not accidental. Twenty-five years of attempts - the Royal Commission (1999), Wanless (2006), Dilnot (2011, legislated 2014, shelved), the 2017 "dementia tax" U-turn, the 2021 White Paper (cap cancelled Jul 2024) - failed for the same reasons each time: the costs are large and immediate while the beneficiaries are diffuse; the politics (the "death tax" and "dementia tax" attacks) have punished every party that tried; and each attempt embedded a contestable funding mechanism and called it settled. The live vehicle, the **independent Casey Commission**, reports its first phase in 2026 but has **deferred long-term funding to a second phase around 2028** - reproducing the very deferral that sank its predecessors. This paper exists to supply, now, the costed and non-partisan funding options Casey has deferred.

3. What the reform is - whole-system, five strands

A **whole-system reform of adult social care in England**: a single, costed, evidence-graded product that treats the five interlocking failures together. Its founding discipline is the empirical/value split: **the delivery is designed on the evidence and recommended; the funding is presented as neutral costed options and routed to the public.**

The five strands:

- **Funding and cost-sharing** - how the risk of care costs is pooled, and who bears the uninsurable catastrophic tail. *Presented as a neutral costed menu* (§6.3).
- **Workforce** - pay, career structure, job quality, and a domestic recruitment route to replace the closed migration stopgap. *Evidence-led recommendation* (§4).
- **Provider market** - true-cost pricing, ending the self-funder cross-subsidy, and a resolution regime for failing providers. *Evidence-led recommendation* (§4).
- **NHS-care integration** - coordination and capacity at the interface, sold honestly. *Evidence-led recommendation* (§4).
- **Quality and unmet need** - prevention, reablement, personalisation and clearing the waits, paced by capacity. *Evidence-led recommendation* (§4).

Geography: England-led (adult social care is devolved). Scotland (free personal care), Wales and the major international systems (Germany, Japan, the Netherlands) are used as **comparators and as live options**, not models to import wholesale. The reform **complements the Casey Commission** rather than competing with it.

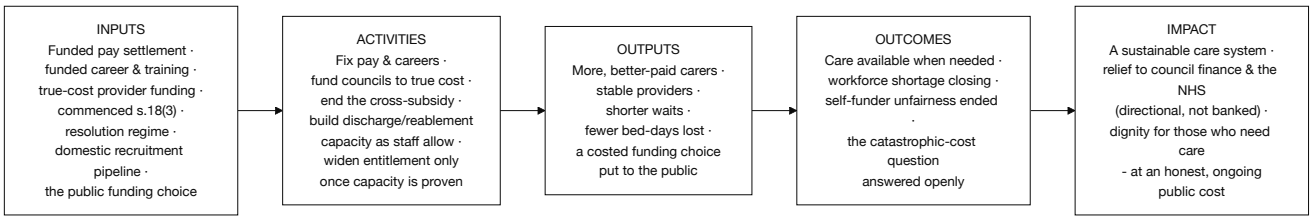
4. How it works - the delivery design

The four delivery strands are recommended on the evidence and specified to implementation-readiness in the companion Delivery Design, which answers, for each, the seven questions any implementation-ready policy must settle (legislation, delivery body, funding, first hundred days, measures and evaluator, sequencing, failure modes and exit). In outline:

- **Workforce** - the four-part package the evidence says is needed to *recruit* and not merely *retain*: a real Fair Pay Agreement (a legally binding, sector-wide deal on pay and conditions) materially above the Band-3 floor; a funded career ladder and qualifications; job-quality redesign (the Netherlands Buurtzorg evidence); and a domestic recruit-and-train pipeline to replace the closed overseas route. The bare pay floor alone does **not** fix the shortage - pay alone retains but does not recruit (Australia, **B**).
- **Provider market** - true-cost pricing with councils funded to pay it; ending the self-funder cross-subsidy by **commencing Care Act s.18(3)** (section 18, subsection 3 of the Care Act 2014, a legal provision that lets people paying for their own care ask their council to arrange it at the cheaper council rate - already in statute, never commenced, cancelled with the £1.36bn fund in Jul 2024); and a **provider-resolution regime** beyond the regulator's notification-only oversight.
- **NHS integration** - investment in coordination and capacity at the discharge interface, **sold honestly** with no banked emergency-admission savings (the Better Care Fund was judged "not value for money" by the National Audit Office (NAO), Parliament's independent public-spending auditor, **B**).
- **Quality and unmet need** - prevention, reablement and personalisation for outcomes (cost-offsets graded **C** and not banked), and clearing the waits as a capacity-and-funding problem, **paced by the workforce and provider capacity built in the first two strands**.

The organising rule is capacity before entitlement. A set of **no-regrets measures** - funding the pay deal, fair provider pricing and commencing s.18(3), uprating the means test, and standing up the domestic recruitment pipeline - can start now because they are needed under *every* funding option and improve the system regardless of the public's choice. Entitlement is widened only once the capacity to honour it exists.

4.1 Theory of change (logic model)



5. The evidence base

The reform rests on a deep comparative and official-statistics base. The headline lessons, graded:

- **Private insurance cannot be the primary mechanism.** It has failed everywhere as a standalone product; it works only as a fixed-sum top-up on a compulsory public base (**A**).
- **Entitlement without capacity backfires.** Scotland delivered the *right* to free personal care but not the *supply*; ~720,000 unnecessary hospital bed-days in 2024/25, top cause the absence of a care package (Audit Scotland Jan 2026, **B**). Free at the point of use ≠ available.
- **Social insurance works but strains.** Germany (since 1995, contribution risen 1.0% → 3.6%), Japan, Korea and the Netherlands have all *worked* and stayed popular, and none has collapsed - but all are pay-as-you-go, all have needed rising contributions and co-pays, and all are explicitly *partial* (**B**). A credible social-insurance option must build in automatic rate-adjustment and institutional entrenchment from day one.
- **Hypothecation only endures if entrenched.** The UK's 2021 Health & Social Care Levy - a tax legally earmarked for one purpose - (~£12.4bn/yr) was repealed within ~13 months, before any care money flowed (**A**). Earmarking survives only as a standing, entrenched fund (the Japan/Germany pattern).
- **The catastrophic tail is the crux.** Only universal tax-funding or an un-diluted, hotel-cost-aware cap meaningfully addresses the uninsurable tail; means-test uprating is a cheap palliative that does not touch it (**A/B**).
- **Pay alone retains, it does not recruit.** Australia's 2022-23 work-value 15% rise improved retention not recruitment (**B**); the international evidence (the Organisation for Economic Co-operation and Development (OECD, the club of mostly wealthier nations), *Who Cares?*) is that pay must be paired with funded career structure and job quality, and that migration is a stopgap not a stabiliser (B).
- **The provider funding gap is real and measured.** ~£1.98bn England domiciliary gap at the National Living Wage benchmark (Homecare Association, *The Homecare Deficit 2025*, **B** - primary-confirmed).
- **Integration is over-promised.** The Better Care Fund was "not value for money" with "no compelling evidence" of savings (NAO, **B**); discharge-to-assess and reablement are sound but capacity-constrained (C). Sell integration on coordination and capacity, not savings.
- **Centrality is directional, not bankable.** Adequate social care relieves council finance (~42% of council service spend) and the NHS, but the savings **magnitude is Grade C** and is never banked.

6. The honest cost, and the value question

This section should be read most carefully. The full model, its assumptions and grades are published openly (see the costing model and its results). It is deliberately conservative; most figures are Grade C modelling.

6.1 The cost of good care (the delivery package)

The model computes the cost of provision **once** and does **not** sum the strands (they interact - it is non-additive). Good-care provision costs about **£38.3bn a year** in the base year at the full-workforce rung (~£33.3bn at the floor rung), shared between the state and individuals according to whichever funding option is chosen (§6.3). The largest single lever is the workforce, presented as an **ambition ladder** rather than a single number:

Component	Central cost / yr	Grade	Note
Workforce (full four-part package)	~£6.1bn (ladder £1.5-8.7bn)	C	The ambition ladder (§6.2)
Provider true-cost gap	~£1.98bn	B	Homecare Association 2025 (confirmed; NLW benchmark)
Meeting demand + access	~£6.4bn	B/C	Health Foundation Scenario 2 gap (primary-confirmed)
NHS coordination & capacity	~£0.5bn	C	A cost, not a saving

These are 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 How good a service - the ambition ladder

It is a **fact** that the cheapest workforce option does not fix the shortage; it is a **value choice** how far and how fast to go. Defaulting to the most expensive option would itself be a version of the cardinal error - dressing an affordability/ambition choice as a technical necessity. So the workforce is presented as a ladder, each rung with honest consequences:

- **Slow the decline (~£1.5bn):** a modest pay rise - enough to slow people leaving. Labelled honestly: this does **not** fix the shortage.
- **Fix it (~£6.1bn):** the full four-part package the evidence says actually closes the shortage.
- **Fix it faster (~£8.7bn):** the same, larger and quicker.

6.3 Who pays - the funding menu (neutral, no recommendation)

Six costed options, each with its real-world track record, its split between the state and individuals, the **incremental new public money** it requires, and whether it addresses the catastrophic tail. We recommend none. Private insurance appears only as a top-up on whichever base is chosen.

Option	State share	Individual share	New public money	Tail addressed	Grade
Social insurance (new contribution)	£34.1bn	£4.2bn	+£7.4bn	No	C
Earmarked National Insurance, NI (re-label existing)	£26.7bn	£11.6bn	£0 new (£7.4bn reallocation)	No	C
Free personal care	£33.2bn	£5.1bn	+£6.5bn	No	C
Un-diluted cap (£86k)	£28.5bn	£9.8bn	+£1.9bn (rising)	**Yes**	C
Means-test reform	£31.0bn	£7.3bn	+£4.3bn	No	C
Status-quo-plus	£26.7bn	£11.6bn	+£3.4bn	No	C

*Shares are the distributional view from a common status-quo baseline (Grade C coverage shifts); "new public money" is the better-evidenced incremental lever. The cap and social insurance are **back-loaded** - their cost rises over the horizon (a single-year snapshot understates them). Only the un-diluted cap addresses the catastrophic tail; the model surfaces this, it does not recommend it.*

The cardinal-error guard, stated openly. The 2021 Dilnot variant - where only the individual's own spend counted toward the cap - protected large estates while a person with a ~£90,000 estate could lose almost all of it: a regressive distributional choice dressed as a technical safeguard. Option C is the **un-diluted** version precisely so the product never repeats it, and the menu exists so the distributional choice is made in the open.

6.4 Never self-funding

Better social care relieves council finance (entry 1) and the NHS, but both effects are **directionally strong and Grade C in magnitude**, and **no numeric saving is netted off any cost figure**. This reform is never presented as paying for itself.

6.5 The value question, surfaced honestly

The empirical questions - what good care costs, what each option does - are answered above, with their uncertainty. What the appraisal **cannot** settle is who should bear the cost:

> *Who should bear the uninsurable catastrophic tail of care costs - the individual's estate or the taxpayer - and how progressively across income, wealth and generations?*

This is the question twenty-five years of reform has answered implicitly and then lost on. It is a value question, and it belongs to the public and their representatives, not to the appraisal.

7. The two choices for the public

This reform puts **two** questions to the public, and pre-judges neither:

1. **Who pays for ruinous care?** - the funding menu of §6.3, each option costed and with its honest catch.
2. **How good a service, and how fast?** - the ambition ladder of §6.2.

Both are set out in plain language in the Public Choices companion. They will be put to the public on a **Pragma-hosted** deliberation platform, with the detailed evidence published alongside; the intention is to **publish the costed choice now and wire the deliberation in as the platform is built.**

8. Institutional form and sequencing

No large new body. Social care already has its delivery institutions - councils commission, the regulator oversees, the NHS systems coordinate, the Negotiating Body sets pay, Skills for Care develops the workforce. The reform funds and re-wires them; the only genuinely new function is a small provider-resolution unit. The cost lands on one set of budgets and the savings on others, so sponsorship is **cross-departmental** from day one (Health lead, with the Treasury, the councils' department, the work-and-pensions and migration departments, and the NHS).

Sequencing - capacity before entitlement. Three evidence-gated steps: Gate 1, the no-regrets measures delivered; Gate 2, capacity proven (vacancies and turnover improving on a measured trajectory, provider exits down); Gate 3, the public's funding choice made and the chosen mechanism legislated - with entitlement widened **only** once Gate 2 is met. The full sequencing, legislation, first hundred days and exit conditions are in the Delivery Design.

9. Measures of success

System-level, evidence-graded, and built so no single number can be gamed: workforce (vacancy, turnover, domestic recruitment, retention); provider market (share of councils paying below cost, the self-funder differential, provider exits); the NHS interface (delayed discharges and bed-days lost - tracked, **savings not banked**); and quality and unmet need (waiting list, time-to-assessment, unmet-need prevalence, quality ratings, reablement outcomes). Each strand has an **independent evaluator** with a statutory protected budget, reporting independently of delivery so the evidence survives a spending review.

10. Adversarial review - three perspectives and the strongest case against

The proposal is stress-tested from three political perspectives, reporting where they agree (robust) and where they disagree (shown, not dropped), and the strongest case against it is set out as forcefully as a serious opponent would put it.

Fiscal-conservative reading. Objections: a large permanent cost (potentially £10bn+ of new annual money depending on the option and ambition rung); the fear of a bottomless pit; reluctance to create open-ended entitlements. Reassurances it values: **no big new quango** (no big new arm's-length public body - the reform funds existing bodies); **capacity-before-entitlement**, so no unfunded promises; the menu **prescribes no tax**; ending the self-funder cross-subsidy is a market-fairness fix; the means-test uprating returns money to savers; the un-diluted cap limits the state's open-ended liability *and* protects property and inheritance; and private insurance is preserved as a top-up. Its steelman: *the state cannot afford to nationalise the catastrophic tail; better to target the poorest and let families and estates carry the rest.*

Social-democratic reading. It values collective risk-pooling, fair pay for a workforce that is overwhelmingly women and underpaid, ending the cross-subsidy, and meeting unmet need with dignity. Its objections push the *other* way: that "status-quo-plus" and means-test reform are too thin to count as

reform; that the just answer is universal tax-funding or free personal care; and that the cap protects wealthy estates. Its steelman: *free personal care or universal tax-funding is the fair answer, and presenting under-provision as a legitimate menu option normalises a system that fails the poorest.*

Libertarian reading. Objections: compulsory social insurance or new taxes; state expansion; crowding out family and private provision. Reassurances it values: **no tax is prescribed**; private insurance is preserved as a top-up; the cap limits state liability and preserves individual responsibility up to the cap; the means-test uprating lets people keep more of their own money; and the choice is **routed to the public, not imposed**. Its steelman: *care is in the first place a family and individual responsibility; the state should provide a safety net for the destitute, not pool everyone's risk.*

Where the three agree (robust): the workforce is underpaid and short-staffed and must be fixed; providers are fragile and the self-funder cross-subsidy is unfair; private insurance cannot be the primary mechanism; entitlement without capacity backfires; NHS and council savings must not be banked; and any funding mechanism must be entrenched to endure. These are the load-bearing commitments, and all three perspectives can sign them.

Where they disagree (the live questions): who bears the catastrophic tail (the value question of §6.5); how far and fast on ambition (§6.2); and whether the cap's protection of estates is fair. The menu deliberately removes the *mechanism* disagreement by not prescribing one.

The strongest case against the whole reform. *This is £10bn+ of new annual spending on a devolved service, with only Grade-C evidence that money fixes it and Grade-C, unbankable savings; every attempt for twenty-five years has failed; the politics are toxic; better to wait for Casey to report in 2028 and meanwhile do only the cheap, incremental means-test and provider fixes.* The answer is in the design, not a deflection: the **no-regrets items are precisely those incremental fixes**, and they start now; **capacity-before-entitlement** de-risks the larger spend by refusing to fund an entitlement before the capacity to deliver it; the **menu and the routed value question** are how a reform survives the politics that killed its predecessors; and Casey's deferral of funding to 2028 *is itself* the twenty-five-year deferral pattern - which is why Pragma supplies the costed options now, to inform that choice rather than pre-empt it. What the case correctly establishes is that the country should not commit to the largest, most expensive version on present evidence - which is exactly why the ambition is a public choice and the entitlement is gated on proven capacity.

11. Implementation summary

The full operational detail - legislation, delivery body and boundary map, funding, the first hundred days, the critical path, the gates and the explicit exit conditions - is in the Delivery Design. In outline:

- **Legislation:** commence Care Act s.18(3) by order; a Care Reform Act for the provider-resolution regime and a statutory evaluation/capacity-gate duty; the chosen **funding mechanism legislated separately** after the public choice (off the critical path).
- **Delivery body:** no large new body - fund and re-wire councils, the regulator, the NHS systems, the Negotiating Body and Skills for Care, with cross-departmental sponsorship and a small provider-resolution unit.
- **Funding:** the costed delivery package (§6.1) plus the public's choice from the menu (§6.3); never self-funding.
- **Sequencing:** the no-regrets measures now; the three capacity gates; entitlement widened only once capacity is proven.

- **Exit conditions:** if capacity is not on track, entitlement expansion is held, not commenced; the no-regrets improvements stand alone whatever the larger funding settlement.

12. Open questions

Honesty requires naming what is not yet settled:

- **Legal structure is undecided** and is the founder's call; nothing here presumes charitable status, and the "present options, do not advocate" posture is what keeps that route open.
- **The eleven previously-flagged evidence items have now been checked against primary sources (June 2026)** - confirmed (e.g. the Health Foundation gaps, the Homecare Association £1.98bn, the 22 July 2025 route closure), corrected (e.g. the self-funder figure, the Health Foundation £37.1bn total), or removed (the "47% of Requires-Improvement failed to improve" claim, a misattribution). Two residual items - South Korea's forward deficit projections and a 2024/25 self-funder differential - still need a fresh source, but neither is used in these public artefacts.
- **The value-question channel** - a Pragma-hosted deliberation platform with auto-wonk users able to vote - is the intended route, but its build timing is a dependency (publish now, wire later).
- **How far to model the devolved and international comparators** as live options versus evidence is a judgement to settle as the menu is finalised.

Annexes and sources

- **Evidence Annex** - every claim above, with A-D grades and full citations (the 11 previously-flagged items were primary-checked in June 2026).
- **Delivery Design** - the implementation-ready (B3) detail behind §4, §8 and §11.
- **Public Choices** - the plain-language funding menu and ambition ladder.
- **Strategic Design** and the **costing model** and its **results** - the approved direction and the re-runnable appraisal.

Key sources (full list in the Evidence Annex): Skills for Care, State of the Adult Social Care Sector and Workforce (2025); Commons Library briefings CBP-9310/9315/9615/9626/7903/8003; Health Foundation funding scenarios; Homecare Association homecare funding gap (2025); CMA market study; the Office for Budget Responsibility (OBR) cost of the cap and floor; Audit Scotland (free personal care; delayed discharges, 2026); OECD Who Cares? (2020) and Health at a Glance (2023); NAO health and social care integration; ADASS Spring Survey (2024); Age UK; the Care Quality Commission (CQC), the regulator for health and care services, State of Care; Casey Commission terms of reference. Cross-references: Problem Register entries 1 (local government finance), 6 (SEND - special educational needs and disabilities), and 12 - the National Employment Service, the domestic recruitment route for the care workforce.