



CARE ENGLAND
The voice of care

Priced to fail

*The growing funding crisis in adult social care
2022–2026*

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Acknowledgements



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ABOUT CARE ENGLAND

Care England is the largest and most diverse representative body for independent providers of adult social care in England. A registered charity, it works collaboratively with its members, stakeholders, and government to build the foundations of a sustainable future for the sector. Its membership spans small, medium, and large providers, from single care homes and local groups to national operators and not-for-profit voluntary organisations. Care England works to improve the quality of care and to safeguard the health and safety of both staff and residents in care settings, and it advocates for sustainable policies and practices that address the workforce challenges facing the sector.

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FOREWORD

From the Chief Executive



In nearly forty years working alongside adult social care, I have never known the sector to be more stretched, or more determined.

I have visited care homes where staff are delivering extraordinary care under conditions that should, frankly, not exist in a country with our resources. I have spoken to providers who have absorbed year after year of inadequate fee uplifts, drawing on reserves that are now exhausted, making decisions about staffing and investment that no operator should be forced to make. And I have spoken with families who trusted the system to be there for them and found it constrained by years of underinvestment.

This report documents something that many of us in the sector have known for years but have struggled to quantify with sufficient clarity to force the national conversation we need. The gap between what local authorities pay for care and what it genuinely costs to deliver is structural, it is worsening, and by 2025/26 it has reached £2.36 billion.

This figure reflects a shortfall that is absorbed year after year by providers operating on unsustainable margins, by a workforce that cannot be paid or developed as it should be because funding does not allow it, and by a system that continues to be asked to do more with less.

And yet, I am not without hope. Every time I visit a service, I encounter staff and leaders who refuse to be defined by the constraints placed upon them; people who are finding ways to support residents with dignity and creativity despite everything working against them. That determination cannot be manufactured, and it cannot be replaced. It is the human foundation on which this sector stands. But it is not a substitute for proper funding, and it cannot carry the weight of a structural failure indefinitely. If government gives this sector the financial foundations it needs, that determination becomes the basis for something genuinely transformative rather than simply the reason the system has not yet broken.

Social care is not a burden on the public finances. It is one of the foundations on which everything else rests. It contributes positively to economic growth, supports the functioning of the NHS, sustains labour market participation, and enables families to continue working and living their lives. When it is properly funded, it pays for itself many times over. When it is not, the costs do not disappear. They are redistributed onto hospitals, onto families, onto communities, and they compound.

The evidence in this report is clear. The recommendations are specific and achievable. What is needed now is the political will to act on them. This sector has carried on through extraordinary adversity. But endurance has a limit, and that limit is closer than government may realise. ”



Professor Martin Green OBE

Chief Executive, Care England

OVERVIEW

Executive summary

This report maps the funding gap between local authority fees and the true cost of older people's residential and nursing care on a per-resident basis, year by year, from 2022 to 2026. It draws on the government's own Fair Cost of Care exercise (conducted in 2021/22) as its benchmark, applies minimum inflationary uplifts to track divergence over time, and uses client-level data to distinguish between the effects of rising demand and the effects of a funding model that is structurally failing.

By 2025/26, the gap between what local authorities pay for older people's residential and nursing care and what it genuinely costs to deliver it has reached £2.36 billion. That figure represents our best conservative estimate of the structural reality of how care is currently funded in England, and the measurable consequence of a funding model that has consistently failed to keep pace with the true cost of delivery.

The gap has widened by 49% in cash terms since 2022/23, and by 35% in real terms. Critically, this widening cannot be explained by rising demand alone. Holding the number of residents constant across the period, the shortfall grows regardless, confirming that the funding attached to each individual placement is becoming less sufficient over time. By 2025/26, the average residential placement carries an annual shortfall of over £10,000. For nursing care, that figure exceeds £23,000. These figures represent a substantial and growing deficit that providers are expected to absorb across every publicly funded resident they support, regardless of where they are located or how efficiently they operate. It represents resource that would otherwise be directed toward the workforce, toward the infrastructure of care settings, and toward the quality of care that residents receive. Every pound absorbed by the deficit is a pound diverted from building a sector capable of meeting future demand.

£2.36bn

Total funding gap in 2025/26, up from £1.59bn in 2022/23

£10,000+

Annual shortfall on the average residential placement by 2025/26

£23,000+

Annual shortfall on the average nursing placement by 2025/26

That said, the deficit is not felt evenly across the country. In nursing care alone, the weekly shortfall per resident ranges from £278 to £639 depending on where a person lives; a postcode lottery in financial sustainability that shapes whether services remain viable, whether capacity is maintained, and whether care is available at all.

The consequences of a gap of this scale do not remain contained within social care. Simply put, underfunding displaces cost rather than removing it: to the NHS, where delayed discharges occupy beds that cannot be freed, to families who reduce working hours or leave employment altogether to fill gaps in formal care, and to financially restricted local authorities who are legally required to commission services they cannot afford to fund at sustainable rates; all of which act as a detriment to economic growth. A system

that is expected to be central to the NHS's 10 Year Plan, and the Government's ambition to bring care into the community, is being systematically defunded at the moment it is most needed.

The impact on service quality reflects the same pattern. The share of published Good and Outstanding ratings remains below its pre-pandemic level. An improvement in ratings coincided with the year the estimated funding gap narrowed, although ratings improved further the following year and changes in inspection practice limit what can be concluded. The CQC's own operational challenges, combined with a period during which risk-based inspection concentrated activity on already-struggling services, mean that the published data increasingly reflects what has been inspected rather than the sector as a whole. These findings should be interpreted with appropriate caution, but they should not be dismissed.

The recommendations that follow address three interconnected areas where government action could begin to close the gap:

- the level and structure of funding,
- the consistency of how care is commissioned and costed,
- and the rights of individuals when the system falls short of its statutory duties.

The recommendations that follow are grounded in the analysis and proportionate to the scale of what it reveals. They do not require the system to be rebuilt, but they require government to fund it properly, commission it fairly, and hold it accountable to ensure those drawing on care and support are receiving high quality care, and pressure on the NHS is reduced.

The question this report poses is not whether the system is under pressure, that much is beyond dispute. The question is whether government will act before the gap between what care costs and what the system pays becomes impossible to close, and before the social care infrastructure on which the NHS 10-Year Plan depends is too diminished to support the ambitions placed upon it. The analysis presented here suggests that point is not far away.

THE SEVEN RECOMMENDATIONS AT A GLANCE

RECOMMENDATION 1

Provide an immediate funding injection to bridge the gap

RECOMMENDATION 3

Develop a reduced VAT rate for social care

RECOMMENDATION 5

Agree a standard national model for calculating the cost of care and a minimum uplift floor

RECOMMENDATION 7

Commission a system-level review of the relationship between funding and quality

RECOMMENDATION 2

Commit to multi-year, ringfenced funding linked to actual care costs

RECOMMENDATION 4

Embed national commissioning standards ahead of the National Care Service

RECOMMENDATION 6

Implement Section 72 of the Care Act 2014

CHAPTER 01

Moving away from the fair cost of care

The challenge of funding adult social care fairly is long standing. For many years, the fees paid by local authorities have fallen short of the actual cost of delivering care, steadily eroding providers' reserves, reducing their ability to invest in staff or improve services, and leaving the sector operating on increasingly fragile margins.

In 2021/22, the government sought to address this for older persons residential and home care services through the Fair Cost of Care (FCoC) exercise. Its aim was to establish an evidence-based benchmark for the real cost of care and to inform reforms under Section 18(3) of the Care Act 2014, under which both state and self-funded residents would have been able to access care at equitable and sustainable rates. As part of the exercise, every local authority worked with providers to assess costs and publish a Market Sustainability Plan, setting out current fee levels, the fair cost of care, and a strategy for closing the gap between them.

To support progress, government introduced the Market Sustainability and Improvement Fund (MSIF), which by 2025/26 had grown to £1.05 billion. Councils were also required to report the average fees they paid, creating for the first time a consistent national dataset. Although the implementation of Section 18(3) was delayed, and then ultimately abandoned, the FCoC exercise marked the first official acknowledgement of the real cost of delivering care. Based on data supplied directly by providers, its figures continue to underpin national debates about funding adequacy and market sustainability, though the majority of local authorities have declined to treat them as the basis for their fee-setting in practice.

To ensure the benchmark remains relevant beyond its original year, Care England developed a forecasted FCoC model, applying minimum inflationary uplifts to the original 2021/22 figures. The required uplifts are set out below, with further detail on how they were calculated in the methodology.

YEAR	NURSING (STANDARD)	RESIDENTIAL (STANDARD)	NURSING (DEMENTIA)	RESIDENTIAL (DEMENTIA)
2023/24	8.9%	9.8%	8.9%	9.8%
2024/25	8.3%	8.6%	8.4%	8.7%
2025/26	7.8%	8.0%	7.9%	8.1%

By comparing this forecast with the fees reported through MSIF, this report produces a consistent, year-on-year measure of the gap between what local authorities pay and what care genuinely costs to deliver.

Although councils have increased fees since 2021/22, uplifts have consistently lagged behind real cost pressures. For example, in 2024/25, local authority uplifts averaged around 6% against a 9.8% increase in

the National Living Wage. In 2025/26, with employment costs rising by 10.6% from combined National Living Wage and National Insurance changes, councils delivered less than 5.5% on average.

The evidence points to a persistent, structural shortfall between the rising cost of provision and the fees paid, one that the Fair Cost of Care exercise was designed to address, and that this report finds has instead grown substantially since that exercise was conducted.

CHAPTER 02

The scale of the funding gap

The evidence in this chapter documents a funding gap that has developed over several years into a structural failure at the heart of how England funds and delivers care for its oldest and most vulnerable citizens. Six findings emerge from the analysis, each covering a distinct dimension of that failure and together building a picture that is, in its totality, more troubling than any single finding considered alone.

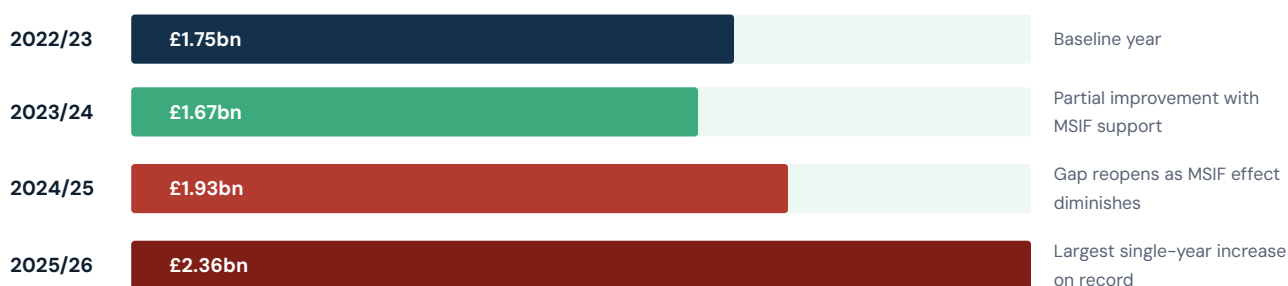
They address, in turn, the persistent and structural nature of the shortfall and the absence of any self-correcting mechanism within the current funding model; the widening of the gap at placement level independently of changes in demand; the role of specific unfunded policy decisions in accelerating the deterioration observed in 2025/26; the disproportionate impact on nursing care and what that means for the NHS services that depend on it; the significant regional variation in the size of the shortfall and the uneven distribution of financial risk it creates across the country; and the distance the system has travelled away from the Fair Cost of Care benchmark since that exercise was first conducted. Together, they describe the scale, character, and consequences of a funding crisis that is deepening with every year that passes.

The findings point collectively to a funding model that has moved progressively further from the cost of the services it is meant to sustain. That distance has grown in every year but one since 2022/23, and the rate at which it is growing has increased with each passing year. The gap is wider than it was, it is widening faster than it was, and the mechanisms that were designed to correct it have proven insufficient to do so. What the evidence shows is not a system that has encountered a period of difficulty and is finding its way back to stability. It is a system whose structural misalignment between cost and funding has deepened year on year, and which, without sustained intervention, will continue to do so.

The headline position

In 2022/23, the baseline year for this analysis, the funding gap stood at £1.59 billion in cash terms, or £1.75 billion in real terms. By 2025/26, those figures had reached £2.36 billion on both measures, having passed through a period of partial improvement in 2023/24 before widening sharply in the two years that followed. The trajectory of the gap over this period is set out below.

FUNDING GAP (REAL TERMS), 2022/23 TO 2025/26



The movement of the gap across these four years is not uniform, and its shape contains important information about the dynamics of the funding model. In 2023/24, the introduction of MSIF provided meaningful additional support to local authorities, and the gap narrowed in real terms by £80.4 million, or 4.6%. That improvement was real, but it was the product of a one-year intervention rather than a change in the underlying funding model, and its effects did not persist. By 2024/25, as MSIF-supported spend growth slowed to 7.4% against cost growth of 9.1%, the gap had reopened and expanded beyond its 2022/23 level. In 2025/26, with funding growth falling further to 5.7% against cost growth of 8.0%, the gap widened by £443 million in real terms, the largest single-year deterioration in the period reviewed.

The significance of the 2023/24 improvement should not be read as evidence that the problem is manageable within existing structures. Rather, it demonstrates that the direction of travel is not fixed and that, where funding increases are sufficient to match or modestly exceed cost growth, the gap can be stabilised. What it also demonstrates is that stabilisation requires a sustained commitment to that level of funding, not a single injection followed by a return to previous patterns. The absence of that commitment is precisely what the data for 2024/25 and 2025/26 reflects, and the result is a gap that has now reached its highest recorded level with no mechanism in place to slow its further growth.

The six findings that follow examine the different dimensions of that failure in detail.

FINDING 1
The gap has never been adequately closed

The most fundamental finding of this analysis is that, across the full period reviewed, the funding attached to adult social care has not kept pace with the real cost of delivering it on any sustained basis. The gap has never been closed. In the three years in which cost growth has exceeded funding growth, it has widened. In the single year in which that relationship was temporarily reversed through additional central government support, it narrowed modestly before reopening at pace once that support was not sustained. The consequence is an accumulated shortfall that grows progressively larger and progressively harder to correct, because each year in which the gap is not addressed becomes part of the baseline from which the following year's underfunding is calculated.

The relationship between funding and cost growth across the period is set out in the table below. In each year, the comparison between these two rates of change determines whether the gap narrows or widens, and by how much.

YEAR AND FUNDING GROWTH	COST GROWTH AND GAP MOVEMENT
2023/24: Funding growth 13.1% (MSIF-supported)	Cost growth 9.0%. Gap narrows by 4.6% in real terms.
2024/25: Funding growth 7.4%	Cost growth 9.1%. Gap widens by 15.2% in real terms.
2025/26: Funding growth 5.7%	Cost growth 8.0%. Gap widens by 23.0% in real terms.

What this table makes plain is that the pattern of funding growth across these years has been inconsistent in both level and direction, while cost growth has remained elevated throughout. The cost pressures facing providers are largely structural and predictable: workforce costs driven by National Living Wage uplifts,

non-pay costs including energy, food, and insurance, and the increasing complexity of need among people entering residential and nursing care. These pressures are the unavoidable costs of running regulated care services, and they require funding growth that consistently meets or exceeds them if the gap is to be held at its current level, let alone reduced.

The current funding model does not provide that consistency. Fee uplifts are determined through annual negotiations between local authorities and providers, shaped by the funding available to councils from central government and the competing demands on local authority budgets. Where that funding is insufficient, councils face an impossible position: they are legally required to commission sustainable services, but the resources available to them do not support the fee rates that sustainability requires. The result is that uplifts often fall short of cost growth, not because local authorities are unwilling to fund care adequately, but because they do not have the means to do so within their existing settlements.

Faced with these constraints, local authorities have limited means of managing the gap between their statutory obligations and the resources available to meet them. In practice, many respond by tightening eligibility thresholds, restricting the commissioning of care to those presenting with the highest levels of assessed need. This approach reduces immediate expenditure, but it does not reduce need, it simply defers it. People who would have benefited from timely, lower-level support instead deteriorate without intervention, ultimately presenting in crisis at a cost to the NHS that substantially exceeds what earlier social care provision would have required. The short-term saving to the local authority is achieved at the expense of a larger, less visible cost displaced onto the health system.

The effect is cumulative in a way that is often underappreciated in policy discussions about the sector. Each year of insufficient uplift does not simply mean that the gap in that year is larger than it should be. It means that the baseline from which the following year's gap is calculated is already too low, so that even a fee uplift that would have been adequate in a previous year is no longer sufficient to close the distance that has accumulated. This compounding dynamic is central to understanding why the gap has grown so substantially over a relatively short period, and why the cost of addressing it increases with every year in which it is not addressed.

FINDING 2

The gap is widening at the level of individual placements

One of the most important analytical questions raised by evidence of a growing aggregate funding gap is whether that growth is principally a consequence of rising demand, with more people entering the care system creating a larger total shortfall even if the funding attached to each individual placement is broadly adequate, or whether the per-placement position is itself deteriorating. The distinction matters considerably for policy, because the appropriate response to a demand-driven gap is different from the appropriate response to a funding adequacy problem at placement level. The data examined in this chapter addresses that question directly, and the answer it provides is unambiguous.

To separate the effects of demand from the effects of funding inadequacy, the analysis holds the number of residents constant at 2025/26 levels across all four years and recalculates the gap on that basis. Under this scenario, any growth in the gap reflects changes in the per-placement funding position rather than changes in the volume of people being supported. The results are presented below.

2022/23 (DEMAND HELD CONSTANT)	2023/24	2024/25	2025/26
£1.86bn	£1.77bn	£1.97bn	£2.36bn
Baseline	Modest improvement	Gap expands	Largest on record

The trajectory under constant demand conditions closely mirrors the headline figures, confirming that the growth of the aggregate gap is driven primarily by the deterioration of the per-placement funding position rather than by increased activity. Even with the number of residents held constant, the gap grows by approximately £500 million between 2022/23 and 2025/26, reflecting the progressive insufficiency of the funding attached to each individual placement over time.

The per-resident figures make this concrete. By 2025/26, the weighted annual shortfall stands at £14,415 per resident. At a weekly level, the position by care type has developed as follows across the four-year period:

RESIDENTIAL CARE		NURSING CARE	
2022/23	£158	2022/23	£345
2023/24	£142	2023/24	£341
2024/25	£159	2024/25	£388
2025/26	£198	2025/26	£452

Weekly shortfall per resident. Residential care rose from £158 in 2022/23 to £198 in 2025/26; nursing care from £345 to £452 over the same period.

In annual terms, these figures translate into a deficit of over £10,000 per residential placement and over £23,000 per nursing placement by 2025/26. The nursing figure is especially striking, given the figure approximately equates to [the annual salary of a full-time care worker](#), meaning that the publicly funded income attached to each nursing placement falls short of the true cost of delivery by roughly the equivalent of one full-time member of staff.

The implications of this for provider finances are significant and have become more so as the per-placement shortfall has grown. Care is commissioned and delivered on a placement-by-placement basis, and financial viability is determined at that level. Where a service is predominantly publicly funded, each additional placement carries a growing deficit rather than contributing to financial stability, investment in staff, or infrastructure. In that context, higher occupancy does not improve a provider's financial position in the way the conventional model of care home economics would suggest. Filling beds scales the shortfall rather than reducing it; a dynamic that fundamentally undermines the assumption that occupancy and financial sustainability move in the same direction.

This incentive structure has a further consequence that compounds over time. Where providers accept placements at rates below the cost of delivery, a decision often driven by the need to maintain occupancy and financial stability, those accepted rates feed into the evidence base on which commissioning decisions rest. Under the Care Act framework, local authorities are able to draw on the rates at which care is demonstrably being secured when setting Personal Budgets and evidencing what constitutes a sustainable

fee. Individual provider decisions, each rational in isolation, therefore, contribute to a system-level dynamic in which below-cost pricing becomes progressively normalised. Providers do not endorse inadequate rates by accepting them, but the cumulative effect of those acceptances is that suppressed fees are treated as achievable, making the case for correction harder to sustain with each passing year.

FINDING 3

Unfunded policy decisions have materially accelerated the deterioration

While the widening of the funding gap across the period reviewed is the product of structural factors that have been accumulating over many years, the sharp deterioration observed in 2025/26 cannot be understood without reference to specific policy decisions that took effect in that year and that had an immediate and substantial impact on the cost of delivering care. The most significant of these was the change to Employer National Insurance Contributions, which combined an increase in the contribution rate with a reduction in the earnings threshold from £9,100 to £5,000. In most sectors of the economy, this represents a large, but manageable additional overhead, but adult social care is not most sectors. It is among the most labour-intensive industries in the country, with staffing costs typically accounting for between 55% and 70% of total provider expenditure. The reduction in the earnings threshold alone brought a substantial proportion of the part-time and lower-paid workforce within scope of employer contributions for the first time, creating an immediate and non-negotiable increase in payroll costs across the sector.

55–70%

Share of total provider expenditure accounted for by staffing costs

10.6%

Combined employment cost increase in 2025/26 from NLW and NI changes

Under 5.5%

Average local authority fee uplift in 2025/26, less than half that increase

The timing compounded its impact considerably. It took effect alongside the second consecutive year of significant National Living Wage increases, meaning providers faced multiple simultaneous upward pressures on their largest cost line within a single settlement period, at precisely the moment when their financial reserves were most depleted from years of accumulated underfunding. Neither the National Insurance change nor the National Living Wage increase is a discretionary cost that providers can manage over time. Both apply immediately, in full, across the entire workforce, and neither can be offset through changes to operational practice that would not themselves compromise the quality and continuity of care.

Local authority fee uplifts in 2025/26 averaged less than 5.5%, a figure shaped by the funding settlements available to councils from central government rather than by any assessment of what adequate funding for provider cost growth would require. The combined employment cost pressures facing providers in that year required an uplift considerably in excess of that figure simply to hold the existing position, and the gap between what was needed and what was provided is reflected in the 26.7% widening of the shortfall in cash terms that the data records for 2025/26.

The sector's acute sensitivity to employment policy decisions, combined with a funding model that does not adjust to reflect them, means that each such decision adds to the accumulated shortfall.

FINDING 4

Nursing care is underfunded more severely and the gap is widening at a faster rate

The analysis reveals that the funding gap is distributed unequally across different types of provision, with nursing care carrying a substantially larger and faster-growing shortfall than residential care throughout the period reviewed.

The weekly per-resident shortfall in nursing care has grown from £345 in 2022/23 to £452 in 2025/26, an increase of £107 per week over four years, representing growth of over 30%. In residential care, the equivalent figures are £158 and £198, an increase of £40 per week, or approximately 25%. The nursing gap is therefore not only larger in absolute terms at every point in the period but is also widening at a proportionately faster rate. By 2025/26, the annual per-placement deficit in nursing care exceeds £23,000, compared to just over £10,000 in residential care.

YEAR	RESIDENTIAL CARE (WEEKLY SHORTFALL PER RESIDENT)	NURSING CARE (WEEKLY SHORTFALL PER RESIDENT)
2022/23	£158	£345
2023/24	£142	£341
2024/25	£159	£388
2025/26	£198	£452

The reasons for this divergence are rooted in the cost structure of nursing care. These services support individuals with greater levels of clinical complexity and dependency than residential care, requiring the employment of registered nurses who attract higher salaries than care workers and whose regulatory requirements impose additional costs in terms of training, supervision, and professional registration. The ratio of staffing to residents tends to be higher, and the clinical governance requirements more demanding. As a result, nursing care is disproportionately exposed to the employment cost pressures that have been the primary driver of the funding gap throughout the period reviewed, and the gap between the cost of delivery and the fees paid to deliver it has widened accordingly.

There is a further dimension to the nursing care position that connects it directly to NHS performance and the government's ambitions for integrated, community-based health and care. Nursing homes provide the step-down capacity that enables discharge from acute hospital settings for people who require ongoing clinical input but who do not need to remain in an inpatient bed. This capacity is central to the NHS's ability to manage patient flow, reduce length of stay, and free up acute beds for people who genuinely need them.

A further dimension of this problem concerns the boundary between health and social care funding. Local authorities have no legal power to fund healthcare, yet the growing expectation that clinical tasks will be delivered in community and residential settings creates pressure on councils to absorb costs that fall, in statutory terms, outside their remit. As the NHS 10-Year Plan accelerates the shift of care out of hospital and into the community, the volume of health activity expected to take place within social care settings will increase. That expectation cannot be met by a system that this report demonstrates is already unable

to fund its existing obligations, and the gap between what is asked of the sector and what it is resourced to deliver will widen further unless the funding framework is reformed to reflect it.

The NHS 10-Year Plan and successive iterations of integrated care strategy have emphasised the importance of nursing capacity and the need to strengthen it as part of a broader shift toward care closer to home. What the data in this chapter shows is that this capacity is not being strengthened. This creates a significant risk for NHS flow: where nursing home capacity becomes financially unviable and providers reduce beds or withdraw from the market, the pathway from acute hospital to community-based care narrows, delayed discharges increase, and the pressure on inpatient beds intensifies. The funding gap in nursing care is therefore not solely a social care problem. It is a problem for the health system as a whole, and it is one that the current funding model is making worse with each passing year.

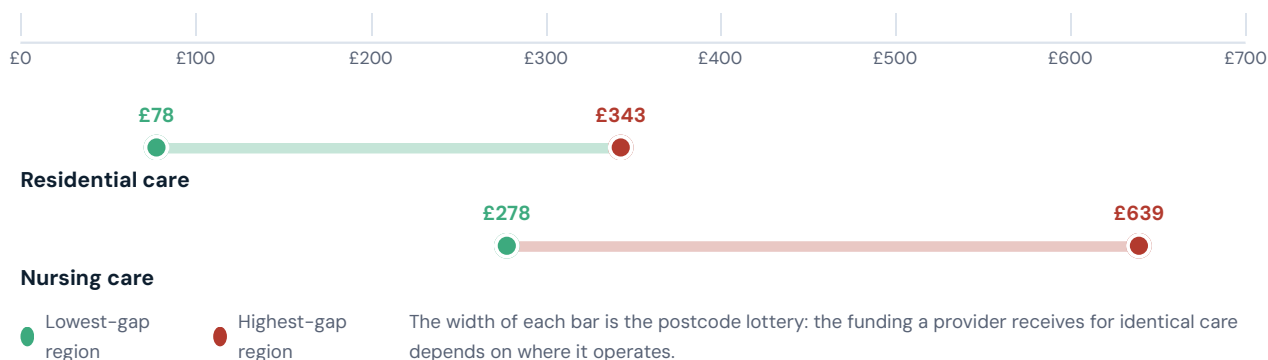
FINDING 5

Regional variation creates a postcode lottery in provider sustainability

The national funding gap of £2.36 billion represents an aggregate measure of a problem that is experienced very differently across different parts of England. There is substantial regional variation in the size of the per-resident shortfall, and that variation does not primarily reflect differences in the underlying cost of delivering care. It reflects differences in how local authorities have approached fee-setting and commissioning, in the availability and prioritisation of local resources, and in the extent to which individual councils have been able or willing to move their fee rates toward the Fair Cost of Care benchmark since that exercise was conducted.

By 2025/26, the weekly per-resident gap ranges from £78 to £343 in residential care and from £278 to £639 in nursing care. The figures below illustrate the scale of this variation.

WEEKLY SHORTFALL PER RESIDENT: LOWEST TO HIGHEST REGION, 2025/26



In nursing care, the spread between the lowest and highest regional figures exceeds £350 per resident per week, equivalent to more than £18,000 per year for a single placement. That is a difference of a magnitude large enough to determine whether a provider operating in the higher-gap regions can sustain its services over time. Two nursing homes delivering equivalent care to residents with equivalent levels of need can face funding gaps that differ by this amount simply because of where they happen to be located, a disparity that reflects neither the quality of what is being delivered nor the efficiency with which it is being delivered, but solely the commissioning approach of the local authority responsible for setting the fee.

The consequences of this regional variation accumulate over time in ways that are difficult to reverse. In areas where the shortfall is largest, providers face more constrained margins and are more likely to make

difficult decisions about capacity, investment, and the continued viability of publicly funded services. Communities in the highest-gap regions therefore face a growing risk not only of worse financial conditions for existing providers but of reduced availability of provision over time, with consequences for both the people who need care in those areas and the NHS services that depend on social care capacity to manage patient flow.

Regional variation of this scale is not the result of a deliberate policy choice about where resources should be directed. It is the product of 153 local authorities making independent decisions about fee-setting, each against a backdrop of different budgetary pressures and commissioning priorities, within a national funding framework that has never been sufficient to begin with. The consequence is an uneven distribution of financial risk across the country that has no principled basis and that is largely invisible to policymakers working at the national level.

FINDING 6

The system has moved nearly 50% further from the fair cost of care since the benchmark was established

The Fair Cost of Care exercise was designed with a specific purpose: to establish a credible, evidence-based benchmark for what residential and nursing care actually costs, and to create the conditions for local authority fee-setting to converge toward that benchmark over time. The intention was not to achieve immediate alignment but to set a direction of travel and provide the infrastructure for progressive improvement. The evidence in this chapter documents what has happened to that direction of travel since the benchmark was established.

£1.59bn

Gap in 2022/23, when the benchmark was established

£2.36bn

Gap in 2025/26, the system has moved further away, not closer

+49%

Growth in cash terms since the benchmark year

Since 2022/23, the gap between average local authority fee rates and the forecasted Fair Cost of Care has grown by 49% in cash terms, from £1.59 billion to £2.36 billion. In real terms, adjusted for the inflation and sector-specific cost pressures that providers have faced over the period, the gap has grown by 35%. The system is, by this measure, substantially further from the benchmark than it was when the benchmark was created, and the trajectory of the data provides no basis for expecting that position to improve under current arrangements.

The same directional finding holds at every level of analysis in this chapter: the aggregate gap is larger, the per-resident shortfall is larger, the gap is larger even when demand is held constant, nursing care is further behind than residential care, and regional variation has become more pronounced. There is no dimension of the data that suggests convergence toward the Fair Cost of Care is occurring.

The temporary improvement in 2023/24 demonstrates that progress toward the benchmark is possible where funding growth is sufficient to match cost growth. But it was not sustained, and the gap has since grown beyond the level it had reached before that improvement took effect. What the data shows, across every measure examined in this chapter, is a system moving away from the commitment the Fair Cost of

Care exercise represented, not toward it. Without a fundamental change in how care is funded, that will remain the direction of travel.

What the evidence establishes

The six findings set out in this chapter are analytically distinct but reinforce a common conclusion. The funding model for older people's residential and nursing care in England is structurally misaligned with the cost of providing those services, and that misalignment has deepened in every year but one since the Fair Cost of Care benchmark was established. It is felt at every level of the system, in aggregate, at the level of individual placements, across care types, and across regions, and it has left the sector nearly 50% further from the government's own benchmark than when that benchmark was created. The consequences of that misalignment, for the quality of care that older people receive, for the providers asked to deliver it, for the NHS that depends on a functioning social care system, and for the families and communities that carry the burden when it fails, are examined in the chapters that follow.

CHAPTER 03

Quality in a system under strain

Behind the financial figures in the preceding chapter are real services, real staff, and real people receiving care. This chapter examines what CQC inspection ratings for care homes in England from 2017 to September 2025 reveal about how those services are performing under sustained financial pressure, and whether the pattern of quality outcomes across that period reflects the conditions that the funding data would lead us to expect.

This analysis does not seek to establish a causal relationship between the funding gap and changes in CQC ratings. The inspection landscape has its own complexities, with changes to methodology, shifts in the CQC's inspection strategy and frequency, and the long-tail effects of the pandemic, and these must be acknowledged. What the data does show is a series of trends that align closely with the period of widening financial strain. These trends cannot be assumed to be driven solely by funding, but neither can they be dismissed as unrelated to it. The purpose of this chapter is to consider what those patterns, viewed alongside the financial and workforce pressures documented elsewhere in this report, reveal about how the funding environment is shaping the delivery and sustainability of care.

Interpreting the evidence

Any reading of CQC ratings over this period must account for three changes to the inspection environment that materially affect what the data can and cannot show.

From 2021 onwards, the CQC moved away from routine inspection cycles toward a risk-based approach, a shift that is now itself under review, directing resources toward services where concerns had already been raised or where existing ratings indicated lower performance. This concentrated inspection activity on services already suspected of underperforming. Because inspections increasingly focused on services where concerns had been raised, changes in published ratings cannot be assumed to reflect changes across all care homes.

Inspection volumes also fell considerably as the CQC implemented the Single Assessment Framework, with the number of care home ratings published annually down sharply from pre-pandemic levels. With so few inspections, concentrated on higher-risk services, the published ratings increasingly reflect a small and unrepresentative part of the sector. Services not recently inspected, including some that may have deteriorated since their last assessment, are absent from the current picture entirely. The CQC has since confirmed that it is now looking to extend its prioritisation beyond urgent and very high-risk services to include those that have never been assessed or that hold ratings more than six years old. That is a welcome development, but it means a significant portion of the sector remains without a current, validated rating, and the published picture should be read with that in mind.

The Single Assessment Framework also introduced new evidence categories, changed how assessment domains are weighted, and altered how ongoing evidence contributes to ratings, meaning year-on-year com-

parisons are not straightforward. A further revision to the framework, consulted on between March and June 2026 and expected to take effect from late 2026, will add another level of complexity to interpretation in the years to come. These factors limit what can be inferred about the sector as a whole. Both deterioration and improvement in published ratings should be read with caution, particularly when inspection volumes were low.

Annual inspection outcomes, 2017/18 to 2025/26

The table below sets out the annual distribution of CQC inspection ratings for care homes alongside the national funding shortfall for years in which that data is available. It should be read in light of the interpretive caveats above, and in particular the significant reduction in inspection volumes from 2023/24 onwards.

YEAR	FUNDING SHORTFALL	OUTSTANDING (%)	GOOD (%)	REQ. IMPROVEMENT (%)	INADEQUATE (%)	OTHER (%)
2017/18	—	3.78	95.01	1.14	0.07	0.00
2018/19	—	3.24	67.38	27.69	1.69	0.00
2019/20	—	3.58	59.42	30.47	6.54	0.00
2020/21	—	2.03	35.85	46.31	15.72	0.09
2021/22	—	0.58	40.92	41.93	16.47	0.09
2022/23	£1.59bn	0.78	46.09	40.91	12.11	0.12
2023/24	£1.58bn	1.37	48.86	38.26	11.51	0.00
2024/25	£1.87bn	1.33	57.86	32.96	7.86	0.00
2025/26	£2.36bn	1.68	56.54	32.62	8.97	0.19

Year-on-year comparisons should be read with caution given changes to inspection methodology and volumes. The 2025/26 row reflects data to September 2025 only, a partial year, and is not directly comparable in scale to the full-year rows above it. The funding shortfall shown for 2025/26 is the full-year figure from Chapter 2, so this row pairs a full-year funding figure with a partial-year quality figure. The share of published Good and Outstanding ratings remains below its pre-2020 level, although these figures cannot establish a like-for-like change in quality across all care homes.

Key findings from the quality data

The data, read with those caveats in mind, reveals four clear and consistent patterns.

QUALITY FINDING 1

The share of Good and Outstanding ratings fell before the pandemic

The table shows that the proportion of published Good and Outstanding ratings fell from 98.79% in 2017/18 to 70.62% in 2018/19, before the pandemic, and then to 63.00% in 2019/20. The fall in the share of pub-

lished Good and Outstanding ratings began before the pandemic and became more pronounced during it. Changes in inspection practice mean this cannot, on its own, establish an equivalent change across all care homes. Good and Outstanding ratings accounted for 41.50% of published outcomes in 2021/22 and 46.87% in 2022/23. The share subsequently rose to 59.19% in 2024/25 and stood at 58.22% in the partial 2025/26 year, below the 63.00% recorded in 2019/20. Outstanding ratings tell a sharper version of the same story. Before the pandemic they accounted for around 3.2% to 3.8% of all inspections. By 2021/22 it had fallen to 0.58%, and stood at 0.78% in 2022/23, and by the partial 2025/26 year had recovered only to 1.7%, around half the pre-pandemic level. Achieving Outstanding requires sustained excellence across leadership, workforce development and quality improvement. Inadequate fee income can constrain providers' ability to invest in the staff, time and stability that support those outcomes.

QUALITY FINDING 2

Requires Improvement and Inadequate ratings remain above their 2019/20 share

Among homes assessed, the proportion rated Requires Improvement or Inadequate was 37.01% in 2019/20 and reached 58.40% in 2021/22. It subsequently fell to 40.82% in 2024/25 and stood at 41.59% in the partial 2025/26 year. These figures describe the homes assessed in each period, rather than all care homes. When fee rates do not cover the real cost of delivery, providers face difficult choices: reducing staffing levels, deferring recruitment, or allowing turnover to go unaddressed. Each is a rational response to financial constraint. Each also produces the conditions (reduced staffing continuity, lower institutional knowledge, weakened leadership capacity) that inspection identifies as barriers to safe, well-led and responsive care. The sustained elevation of Requires Improvement and Inadequate outcomes across this period is consistent with those pressures operating at scale.

QUALITY FINDING 3

Published ratings remain below their pre-pandemic profile

The share of published Good and Outstanding ratings fell during the pandemic and has since improved, but remains below the share recorded in 2019/20. Changes in which homes were inspected limit what this tells us about the sector as a whole. The pandemic exposed and deepened structural vulnerabilities that were already present, rooted in years of fee rates failing to keep pace with the cost of delivering care. The financial pressures facing providers make the relationship between funding and care quality an important subject for further investigation.

QUALITY FINDING 4

An improvement in published ratings coincided with a narrowing funding gap

In 2022/23, over half of inspected homes were rated below Good. In 2023/24, the single year in which the estimated national funding gap narrowed, the Good and Outstanding proportion rose and the below-Good proportion fell. The improvement in published ratings continued in 2024/25, even as the estimated funding gap widened. This does not prove causation, and the improvement also reflects a partial normalisation of inspection patterns. The timing raises an important question about whether greater financial headroom contributed to better care, but the ratings cannot establish that relationship. Changes in inspection practice and the further improvement in 2024/25 must also be accounted for.

The published data for 2024 and 2025 shows a further apparent improvement in ratings. This should be read carefully: inspection volumes have fallen sharply from pre-pandemic levels, and the services being assessed are a small and risk-selected subset of the sector. The improvement is real for those services. As a measure of where the sector stands overall, it is incomplete.

Conclusions

The data reviewed in this chapter does not support definitive causal claims, and this analysis does not make them. What it does show is that the share of published Good and Outstanding ratings fell markedly and has only partly recovered during a period of sustained financial pressure.

The share of published Good and Outstanding ratings fell before the pandemic and remains below its 2019/20 level. This makes it important to examine the financial and operational pressures facing care homes, while recognising that published ratings do not measure changes across the whole sector on a like-for-like basis. Behind those trends are older people in homes that are finding it harder to meet the standards they should.

Published ratings improved in 2023/24, when the estimated funding gap narrowed, but improved further in 2024/25 despite the gap widening. Changes in inspection practice also affect comparisons over time. The ratings cannot establish the effect of funding on quality, but they show why that relationship needs to be examined properly.

These findings underline the need for a clearer national understanding of how financial conditions shape care quality. Without it, decisions on fee uplifts, employment costs, and inspection frameworks risk being made without full appreciation of their consequences for the people receiving care.

CHAPTER 04

How underfunding shapes care, communities, and the NHS

The preceding chapters have documented the funding gap in quantitative terms and considered its relationship to quality outcomes. This chapter examines what a gap of this scale and duration means in practice for the people, organisations, and systems that adult social care is expected to support. The consequences extend across the health and social care system, into the labour market, and into the lives of families who expected the care system to be there when they needed it. Understanding the breadth of those consequences is necessary context for the recommendations that follow, because it establishes that the cost of inaction is not borne by the sector alone.

A care market under structural strain

The most immediate consequence of sustained underfunding is its effect on the financial viability of the providers on whom the entire system depends. These are not margins that can be managed through operational efficiency or absorbed through good financial housekeeping. They represent a structural gap between income and cost that has widened every year but one since 2022/23, and that a growing number of providers no longer have the reserves to bridge.

The consequences of this manifest in ways that do not always appear in national data but are well understood by commissioners and by the families affected by them. Providers facing structural deficits on publicly funded placements make a predictable set of decisions: they reduce or freeze capital investment in the fabric and infrastructure of their services, they constrain staffing to the minimum required by regulation, they become more selective about which placements they will accept and on what terms, and in the most difficult cases they reduce their capacity or withdraw from publicly funded care altogether. Each of these decisions is individually rational given the financial position providers are in. Collectively, however, their effects extend well beyond the immediate financial position of individual services.

The availability, stability, and quality of provision across the market deteriorates. Unmet need grows as capacity contracts and eligibility thresholds tighten. Investment in the workforce, in training, in career development, and in the conditions needed to recruit and retain staff at scale becomes impossible to sustain at the level the sector requires. The long-term investment in infrastructure and buildings needed to modernise and future-proof the estate is deferred year after year. Progress toward decarbonisation, which requires capital that providers operating on structural deficits simply do not have, stalls. And the economic consequences extend outward: to unpaid carers who reduce their working hours or leave employment altogether, to communities that lose local provision and the employment it sustains, and to a national economy that bears the compounding cost of needs unmet until they reach crisis point.

Where care is secured at a given rate, and providers bear responsibility for the rates they accept, local authorities are able to draw on that as evidence of what provision can be purchased for when determining

Personal Budgets under the Care Act. Budgets anchored in this way carry the assumptions of below-cost commissioning forward, embedding them into the framework through which future need is assessed and funded. The result is that the rates providers accept in order to maintain occupancy and financial stability do not simply reflect the conditions of the market at a given point in time; they shape the conditions of the market going forward. It is through this mechanism that the financial pressure on providers is not only sustained but structurally reproduced, independent of any deliberate decision to underfund, and increasingly difficult to correct the longer it persists.

When that pressure becomes unsustainable, the withdrawal of capacity from the publicly funded market is significant because it is largely irreversible in the short term. Where beds are lost, they are not always replaced within the publicly funded segment; new capacity may emerge aimed at self-funders, but this shifts the composition of supply rather than restoring it. While that shift may ease immediate pressure on public budgets, it narrows the options available to commissioners and families of limited means, and constrains what the market can offer them for a considerable time afterward.

The position of local authorities

Local authorities occupy a position of particular difficulty within this picture. Under the Care Act 2014, they carry a legal responsibility to ensure the availability of sustainable, high-quality care services in their areas. That duty is not qualified by the level of funding available to them. It is a statutory obligation, and it sits in direct and growing tension with the financial reality that most councils face: fee rates that do not meet the Fair Cost of Care, budgets that are already overspent, and a central government funding settlement that does not provide the headroom required to close the gap, and a local tax base that gives councils no meaningful capacity to make up the difference themselves. [The ADASS Spring Survey 2026](#) confirms the scale of that pressure, finding that councils overspent their adult social care budgets by £715 million in 2025/26 and that Directors report diminishing confidence in their ability to meet their legal duties.

The practical consequence is that local authority commissioners are routinely placed in the position of setting fee rates they know to be unsustainable, not because they are indifferent to the consequences for providers or for the people receiving care, but because the alternative is to commission services they cannot afford. This is not a failure of commissioning practice, though inconsistent, and sometimes poor practice across 153 authorities does compound the problem. It is a failure of central Government funding, and the distinction matters because it determines where the solution lies. Improved commissioning guidance and national standards, valuable as they are in the longer-term, cannot close a gap that is fundamentally a product of insufficient resources.

The pressure on local authority budgets also has consequences that extend beyond the direct commissioning of care. Preventative services, designed to support people to remain independent for longer and central to the government's Neighbourhood Health ambitions and the NHS 10-Year Plan's commitment to earlier intervention, are among the first to be reduced when councils face in-year budget pressures. The short-term saving is visible and immediate; the long-term cost, in higher acuity need entering the formal care system earlier than it otherwise would, is diffuse and deferred. The pattern of cutting prevention to fund crisis response is well established in local government finance and is directly encouraged by a funding model in which the cost of inadequate prevention falls on health and social care budgets in future years rather than on the local authority that reduced the preventative spend.

The consequences for NHS capacity and system flow

The relationship between adult social care and NHS performance is among the most extensively documented in health policy, and the evidence that inadequate social care capacity constrains hospital discharge, prolongs length of stay, and increases pressure on acute beds is well established. What is less often examined is the specific mechanism through which the funding gap in residential and nursing care contributes to that dynamic, and what the scale of the gap documented in this report implies for the NHS's ability to deliver against its own strategic commitments.

Nursing care in particular sits at the intersection of social care and NHS flow in a way that makes the funding conditions of that part of the market directly relevant to hospital performance. Nursing homes provide the step-down capacity that enables discharge from acute settings for people who require ongoing clinical input but no longer need an inpatient bed. The NHS's ability to discharge patients into nursing care in a timely way depends on that capacity being available and financially viable, and the data in this report documents a systematic process by which it is being made less so.

A related dynamic compounds this pressure in ways that are not yet fully visible in the national data. As the fee rates attached to nursing care have become increasingly unviable, commissioners have responded by placing people with nursing-level needs into residential settings, not on clinical grounds, but because residential care is what the available budget will support. The consequence is that residential providers are expected to deliver a standard of care that exceeds their funding, their staffing ratios, and in some cases their regulatory framework. This displacement of clinical need into underfunded residential settings understates the true cost of care being delivered across the sector and transfers risk onto providers who are neither resourced nor regulated to carry it.

The consequences extend beyond delayed discharge, significant as that problem is. The NHS 10-Year Plan and the government's broader ambition to shift care from acute hospital settings into community and neighbourhood-based services both depend on a social care sector that is stable enough, adequately funded enough, and sufficiently capacitated to absorb the increase in complexity and volume that this shift implies. A sector operating on a structural deficit of £2.36 billion, with provider viability under pressure and market capacity thinning in some regions, is not positioned to play that role. The ambition to rebalance the health system is well founded and clinically correct, but it cannot be delivered against a social care infrastructure that is being progressively defunded at the moment it is most needed.

The human cost

The cost of inadequate social care funding does not disappear when it is not paid by the state. It is redistributed, onto families, onto the labour market, and onto the health system, where it eventually presents at a higher cost than the investment that would have prevented it.

Behind the aggregate figures, the funding gap has consequences that are immediate, personal, and in many cases irreversible for the individuals and families affected. When a care home becomes financially unviable and closes, the residents it supports face a disruption to their lives and to the relationships and routines on which their wellbeing depends, at a point in their lives when they are least able to absorb it. When a provider withdraws from publicly funded care in a particular area, the choice available to families with limited means narrows, sometimes to the point where no suitable local option remains. When a service deteriorates because the funding attached to it does not support adequate staffing, the people living in that service bear the human consequences of decisions made at a level of the system entirely removed from their experience of care.

And where no formal care is available, the gap is frequently filled by unpaid family carers who reduce their working hours or leave employment altogether to provide the support that the formal system cannot. The scale of this substitution holds economic consequences through reduced household incomes, reduced labour market participation, reduced tax revenues; and when informal care reaches its limit, the human cost becomes acute. Needs that could have been met earlier go unaddressed, people deteriorate and arrive at hospital in crisis, and the unpaid carers who have held the system together are left carrying a burden that takes a serious toll on their own health and wellbeing. The cost of inadequate social care funding does not disappear when it is not paid by the state. It is redistributed, onto families, onto the labour market, and onto the health system, where it eventually presents at a higher cost than the investment that would have prevented it.

These consequences are the present reality for a significant and growing number of people and families in England, and the evidence in this report suggests that the conditions producing them are worsening rather than improving. The funding gap is the financial expression of a set of choices about what the state is prepared to pay for the care of its oldest and most vulnerable citizens, and the consequences of those choices are lived, in full, by the people receiving care and the families supporting them.

CHAPTER 05

Bridging the gap

The analysis in this report points to seven specific, achievable recommendations that could begin to close the gap between what care costs and what the system currently pays for it. These recommendations do not require the system to be rebuilt from scratch. They require government to fund care adequately, commission it fairly, and hold the system accountable when it falls short. Goodwill, local innovation, and provider resilience have carried the sector a long way, but they cannot substitute for a funding model that reflects the real cost of delivery, and the preceding chapters make clear that the distance between those two things is growing.

RECOMMENDATION 1

Provide an immediate funding injection to bridge the gap

A structural shortfall of £2.36 billion cannot be managed away through commissioning reform or operational efficiency. Without immediate intervention, providers will continue to absorb losses on every publicly funded placement, capacity will contract, and pressure on NHS discharge pathways will intensify. An immediate central government funding injection to commissioners is the necessary first step to stabilise the system while the longer-term structural reforms set out below are put in place. Each year of delay increases the cost of the correction that will ultimately be required.

RECOMMENDATION 2

Commit to multi-year, ringfenced funding linked to actual care costs

The current three-year settlement is welcome but insufficient as a foundation for sustainable planning. It is not a rolling settlement, and it will create the same cliff-edge uncertainty for future investment as annual settlements have done in the past. Its dependence on council tax precepts compounds this problem in ways that go beyond simple unpredictability. Areas with lower tax bases and higher levels of need raise the least through precept income, despite facing similar or greater care costs than wealthier areas. This hard-wires inequity into the funding model at source. At the same time, while government spending plans assume councils will maximise precept increases, local political decisions mean actual funding consistently diverges from national intentions. The result is a system in which government cannot guarantee that its intended quantum of support reaches the frontline, commissioners cannot plan with confidence, and HM Treasury lacks clear lines of sight on what is actually being spent and where.

What the sector requires is multi-year, ringfenced funding for adult social care set outside council tax generation and distributed through a nationally determined central grant, ensuring that the resource government intends to commit to care actually reaches providers in full and is distributed according to need rather than local tax base. This approach keeps overall spending within the agreed envelope while improving predictability for commissioners and providers, stabilising care markets, and giving government clear and comparable oversight of inputs and outcomes across all areas. Funding should be linked explicitly to both sector-specific inflation and workforce cost growth as a minimum floor and accompanied by accountability mechanisms to ensure uplifts are passed through to providers in full. Government should

regard five years or more as the appropriate planning horizon, as certainty of that duration is what gives providers and councils the confidence to recruit, invest in infrastructure, and expand capacity in the places where it is most needed.

RECOMMENDATION 3

Develop a reduced VAT rate for social care

Care providers are currently unable to recover input VAT on many of the goods and services essential to delivering care, diverting millions of pounds each year away from the workforce and frontline provision. Local authority and NHS-run services, which account for under 15% of residential care placements, do not face this burden. The result is a structural tax disadvantage for the independent sector providers who deliver the overwhelming majority of publicly funded care.

Care England has undertaken extensive analytical work demonstrating both the scale of this problem and the practical options available for reform. Government should now design and implement a reduced VAT rate for social care welfare services, enabling providers to recover input VAT on the goods and services essential to delivering care on the same basis as public sector providers. This reform would place no additional pressure on local authority budgets and would return meaningful resource directly to the workforce and services that need it.

RECOMMENDATION 4

Embed national commissioning standards ahead of the National Care Service

The variation in commissioning practice across 153 local authorities creates real and measurable inequity in access to care, entrenches underfunding in areas where local budgets are under greatest pressure, and produces the postcode lottery in provider sustainability documented in this report. National underfunding is the primary driver of the gap, but the absence of consistent standards means that limited resources are not always deployed in ways that prioritise market stability or reflect the genuine cost of provision. [The CQC's national report on its local authority assessment programme](#), published in July 2026, reached the same conclusion, identifying stark variation in commissioning practice and a gap in national standards around what people, providers and partners can expect.

The evidence in this report makes clear that the starting point is not uniform. Regional variation in the scale of the funding gap means some areas are considerably further from a sustainable baseline than others. Government should therefore first pursue a targeted programme of support to bring all areas to a common foundation, identifying where commissioning practice diverges most significantly from what sustainable, needs-led provision requires and directing improvement resource accordingly. Only once that baseline is established can a consistent national framework operate with equal effect across the country.

That national framework should then set clear and binding standards for how care is commissioned, including consistent rules on third and first-party top-ups that ensure equal treatment for equal need, protect families from unexpected charges, and end the variation in documentation, affordability assessment, and review processes that currently increases administrative burden for councils and providers and exposes the system to reputational risk.

RECOMMENDATION 5

Agree a standard national model for calculating the cost of care and a minimum uplift floor

In the absence of a consistent national framework, the cost of care is too often determined by what a local authority can afford rather than what it genuinely costs to meet assessed needs safely and to a high standard. Two reforms are needed to address this.

Government should publish a single national model for calculating the cost of care, developed with the sector, that ends the divergent local methodologies which currently prevent meaningful comparison between areas and hinder HM Treasury's ability to forecast pressures accurately. A common model would give Treasury a consistent and reliable basis for multi-year planning, reduce unplanned in-year top-ups, and improve fiscal control. Existing tools such as the IESE CareCubed system provide a foundation on which such a model could be built, and any national approach should incorporate a fair margin sufficient to sustain provider viability and enable future investment, ensuring it functions as the basis for informed negotiation rather than a ceiling on what commissioners are prepared to consider.

Government should also establish a nationally mandated minimum annual uplift for publicly funded placements, indexed to the National Living Wage, CPI, and sector-specific cost pressures. The structural lag between real cost growth and local authority fee uplifts is a primary cause of provider exits, cross-subsidisation by self-funders, and market instability. A minimum uplift floor would remove that volatility, stabilise the market, and give Treasury predictable expenditure profiles that reduce the need for emergency interventions and the higher costs that provider failure, unplanned spot placements, and delayed discharges inevitably generate.

RECOMMENDATION 6

Implement Section 72 of the Care Act 2014

A persistent and serious gap in the current framework is the absence of any effective, affordable mechanism for individuals or families to challenge commissioning decisions that fall below what is required to meet assessed needs. Judicial review remains the only formal route available, but it is costly, complex, and inaccessible to the great majority of people affected. [The final LeDeR Annual Report](#), presented to Parliament in July 2026, found that one in five people reviewed who died between January 2021 and December 2024 did not have a care package that met their needs. That figure is, in part, a consequence of the absence of meaningful accountability, and with the LeDeR programme's annual reporting now concluded, the case for an enduring statutory route of redress is stronger still.

Parliament addressed this when it passed the Care Act 2014, including in Section 72 a detailed appeals mechanism designed to give individuals and families a clearer and more proportionate route to challenge commissioning decisions that fail to meet statutory duties. Successive governments have chosen not to bring those provisions into force. Doing so would strengthen accountability within the commissioning system, provide individuals with a right of redress proportionate to the statutory duties owed to them, and help ensure that funding decisions are aligned with local authorities' legal obligations. While providers do not have standing under Section 72 themselves, they have an important role in supporting individuals and families to understand their entitlements and to seek redress where those entitlements are not met because of funding issues.

RECOMMENDATION 7

Commission a system-level review of the relationship between funding and quality

We recommend that the CQC conduct a comprehensive, system-level review of the relationship between funding conditions and quality outcomes in care homes. The current inspection dataset cannot give government a reliable national picture of how financial conditions are shaping care quality. That gap matters because decisions with real consequences for people's lives are being made without the evidence needed to understand what those consequences are.

The review should draw on both quantitative ratings data and qualitative inspection evidence, distinguish between the effects of methodological change and underlying financial and operational pressure, and examine regional and service-type variation to identify where financial conditions are having the greatest impact. It should be designed to work within the current inspection environment. The findings should give government clear, evidence-based insight into the extent to which funding decisions taken nationally shape the quality outcomes experienced by people in care homes across England.

Central to that insight should be a rigorous examination of the relationship between local authority commissioning practice and care quality. The CQC has now completed all of their local authority assessments, and [its national report on the programme](#), published in July 2026, found that inconsistent fee-setting and a failure to account for workforce pressures are directly constraining the quality and sustainability of services. That body of evidence makes it possible, in a way that has not previously been achievable at scale, to link commissioning approaches and funding settlements to quality outcomes in individual areas. Whether variation in quality between regions reflects differences in funding levels, differences in commissioning practice, or both, has direct implications for where policy intervention is most needed, and that question cannot be answered without drawing on the commissioning data now available.

The review should also examine a dynamic that is poorly understood but materially significant, which is the role that self-funded residents play in masking the true impact of low council fee rates. Where services operate with a mixed funding model, the income from self-funded placements can cross-subsidise the shortfall on publicly funded ones, obscuring the extent to which council fees fall below the cost of delivery. This cross-subsidy is neither transparent nor sustainable, and its effect is to consistently understate the financial pressure that inadequate public funding places on providers as a result of underfunding by the Government. Understanding how the mix of funding sources within individual services relates to quality outcomes would add an important and currently missing dimension to the national evidence base and help government understand the degree to which the stability of the publicly funded market depends on a mechanism that cannot be relied upon indefinitely.

A coordinated package of reform

These recommendations should be understood as a package. An immediate funding injection addresses the present crisis. Multi-year ringfenced settlements and a national cost model create the conditions for a sustainable funding framework over time. National commissioning standards and the reduced VAT rate ensure that available resources are deployed effectively and equitably. And the implementation of Section 72 provides the accountability that gives the whole framework meaning. Taken together, they would give adult social care the financial foundation it needs to fulfil its role, for the people it supports, for the NHS, and for the communities that depend on it.

CHAPTER 06

A crossroads for adult social care

The evidence in this report is not easily set aside. A structural funding gap of £2.36 billion, widening in every year but one since the government's own Fair Cost of Care benchmark was established, is not a sign of a system under temporary pressure. It is a sign of a funding model that has consistently failed to keep pace with the real cost of delivering care, and whose failure is now large enough to threaten the stability of provision that individuals, families, the NHS, and local authorities all depend upon.

That the sector continues to function at all is a testament to the people working within it, providers absorbing losses they cannot sustain indefinitely, care workers delivering exceptional support under conditions that should not exist, and local authority commissioners attempting to fulfil statutory duties with resources that do not match the obligations those duties impose. Resilience of that kind is real and it matters, but it is not a funding strategy, and the Health and Social Care Committee, in *its Cost of Inaction report*, is right to identify delay as carrying its own escalating cost. Every year in which the gap is not addressed, the investment required to close it grows, the providers capable of delivering it become fewer, and the families who need it find the system less able to respond.

Baroness Casey's Commission arrives at a moment when the case for reform has never been better evidenced or more broadly understood. Andy Burnham became Prime Minister in July 2026 inheriting *a social care record Care England has rated as requiring improvement*, and he has since made the case for reform his own, *bringing the Commission's final recommendations forward by a year to summer 2027 and setting out his ambition for a national care service integrated with the NHS*. The national conversation the Commission launched that same month has since *moved into a formal Public Panel*, and the public debate that reform requires is now underway. The opportunity this represents is genuine, and it will fall to the Commission to answer the difficult structural question of how adult social care is funded for the long term when it reports in summer 2027. But the work of building toward that point cannot wait for the report itself; it has to begin now. The gap between what care costs and what it is funded to deliver is widening, and the recommendations in this report are designed to begin closing it now, not as a substitute for the structural reform the Commission is working toward, but as the precondition for that reform to succeed.

Government faces a straightforward choice, though not an easy one. It can continue to treat social care as a residual call on public finances, managing the consequences of underfunding as they arise and accepting that those consequences, for the NHS, for families, for communities that lose provision they cannot replace, and for the people who need care and find the system unable to provide it, are simply the price of inaction. Or it can recognise that the distance between what adult social care costs and what it is funded to deliver has now reached a point where those consequences are no longer containable, and that a system absorbing a structural deficit of £2.36 billion cannot simultaneously be the foundation on which NHS reform, workforce development, climate commitments, and economic growth are built.

The evidence assembled in this report did not produce that conclusion. It confirmed one that the sector, its workforce, and the families who depend on it have lived with for years. What this report adds is the

quantification, the trajectory, and the proof that the direction of travel is not accidental. It is the predictable result of deliberate choices about what the state is prepared to pay for the care of its most vulnerable citizens, made year after year in the knowledge of what those choices cost.

The recommendations in this report are designed to begin closing the gap now, not as a substitute for the longer-term structural reform the Commission is working toward, but as the precondition for that reform to mean anything in practice. The analysis is clear, the evidence is substantial, and the moment is well chosen. The question government must now answer is not whether it understands what is at stake. It is whether, this time, it will act before the cost of not doing so becomes impossible to meet.

ANNEX

Methodology

This section sets out the analytical approach underpinning the findings in this report. The methodology produces a conservative, reproducible framework built on publicly available data, using minimum inflationary uplifts to forecast the Fair Cost of Care for years in which no national dataset provides those figures directly.

The benchmark

The analysis uses the government's own Fair Cost of Care exercise, conducted in 2021/22, as its baseline. That exercise established an evidence-based benchmark for the real cost of delivering care, drawn directly from provider-reported data and verified through local authority Market Sustainability Plans. Care England has maintained that benchmark by applying minimum inflationary uplifts to the original figures on a year-by-year basis, producing a rolling forecast which is then compared against the average fee rates reported by local authorities through the Market Sustainability and Improvement Fund, generating a consistent and reproducible measure of the shortfall between what authorities pay and what care genuinely costs to deliver.

The per-resident analysis

To assess how the gap has changed at the level of individual placements, the analysis draws on [client-level data published by the Department of Health and Social Care](#), covering adult social care activity across all local authorities in England. Data was available from this source up to and including 2024/25, with 2025/26 figures modelled on the basis of observed trends in preceding years and treated as indicative. Client-level data of this kind is published by the Department of Health and Social Care on a rolling quarterly basis. The position described here reflects what had been published at the time of writing (June 2026). This strand of the analysis allows the report to hold demand constant and assess whether the funding gap is widening because more people are entering the system, or because the funding attached to each placement is becoming less sufficient over time.

Scope and coverage

The analysis covers older people's residential and nursing care commissioned by local authorities, representing 57% of all placements in these settings. Homecare and working-age adult services are not in scope, though both face their own funding pressures. [The Homecare Association's Homecare Deficit 2025 report](#) identifies a gap of over £2.6 billion in homecare services in England alone, and there is an understood but unquantified shortfall in working-age adult provision. The figures in this report therefore capture only part of the adult social care market, and the true scale of underfunding across the sector as a whole is likely to be substantially higher than the headline figures suggest.

Data quality

The MSIF dataset carries a number of unresolved limitations. Local authorities were required to report blended averages without distinguishing between standard and enhanced service types, and in some cases included elements such as Funded Nursing Care in their reported averages despite guidance to the contrary, which may have inflated reported fee rates. Furthermore, legacy placements, held at rates well below current MSIF averages and receiving little or no annual uplift, are not reflected in headline figures, meaning the averages used in this analysis are likely to overstate the fees actually received by many providers. The funding gap identified in this report should be understood as a conservative estimate for this reason as much as any other.

The CQC inspection ratings used in Chapter 3 carry a comparable limitation. The 2025/26 row in that chapter's table reflects data to September 2025 only, a partial year, rather than the full financial year used elsewhere in this report. It is shown alongside the full-year 2025/26 funding shortfall figure from Chapter 2 for consistency with the other rows in that table, but the two figures cover different reporting windows and should not be read as directly comparable in scale. This is a limitation of data availability at the time of writing, not of the underlying analysis.

Calculations behind the minimum uplift

Each cost component is uplifted annually using the most directly relevant publicly available inflation measure for that category of expenditure. Workforce costs, which account for between 55% and 70% of total provider expenditure, are uplifted by reference to the National Living Wage increase, with the Funded Nursing Care rate applied separately to the nurse cost line in nursing settings. From 2025/26, the uplift to non-nurse staff costs incorporates the impact of changes to Employer National Insurance Contributions alongside the National Living Wage increase. Non-pay costs, covering premises, supplies and services, and head office overhead, are uplifted using the September CPI figure for the relevant year, reflecting the measure most commonly referenced in public sector contract indexation. Every one of these choices errs on the side of caution: the inflation measures used reflect public sector norms rather than the actual input cost experience of providers, no allowance is made for rising recruitment costs or training expenditure, and no adjustment is made for the growing complexity of need among people entering care.

What the figures represent

The figures in this report represent the minimum cost of running compliant, regulated services in their current form. They do not account for the investment required to modernise provision, develop the workforce, advance digitisation, or meet the growing complexity of need as people enter care later in life. The £2.36 billion shortfall recorded in 2025/26 is a baseline deficit, the gap in covering today's essential running costs, not the funding required to build a sustainable, future-facing care system. The true scale of underfunding across the sector as a whole, including homecare, working-age adult provision, and the investment required to meet future demand, is likely to be substantially higher.



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