

CARE. 
CREATES

A FRAMEWORK FOR THE REFORM OF SOCIAL CARE IN SCOTLAND

Introduction

This paper provides a framework and discussion piece to inform consideration of social care reform in Scotland. It starts from a simple premise: social care is essential to Scotland's wellbeing, economy and future.

Social care enables independence, choice and participation. It sustains families, relationships and communities, while supporting employment, skills, innovation and economic activity. It has a distinct purpose and an equal place alongside healthcare. Reform should align power, funding and responsibility so that these benefits are realised consistently across Scotland.

The paper:

- defines the purpose of social care;
- sets out the strengths reform should preserve and the changes it should deliver;
- establishes shared principles for reform; and
- offers common tests for assessing different proposals.

Scottish Care recognises that reform could take several forms. We are not recommending a preferred model or seeking to decide which option should be adopted. The collection instead presents three possible institutional models to support informed debate, together with a framework for assessing these, and any other proposals considered by the Scottish Government consistently and transparently.



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Three possible models for Scotland:



A fourth paper uses learning from Ireland to test the assumptions behind all three options. The models are presented for discussion and assessment, not as endorsed plans or recommendations.

Two connected tasks

The collection separates two related questions:

1

What must improve under any model?

This includes funding transparency, workforce planning, commissioning, evidence of unmet need and people's influence over decisions.

2

Where should responsibility sit?

This concerns the institutional arrangements most likely to sustain those improvements.

Work on both questions can proceed in parallel while continuity of support is protected.



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1. The purpose of social care

Social care enables people to live as equal citizens: exercising rights, making choices, sustaining relationships, participating in community and pursuing what matters to them. It connects practical support and safety with personal aspirations. Its purpose is to help people, families and communities flourish.

Institutional design determines who sets priorities, controls budgets, acts on unmet need and answers when support fails. Reform must connect that authority to sufficient care, a valued workforce and sustainable services. Its contribution should be visible in stronger rights and relationships, sustained prevention and fewer disruptions to support, with safeguards that address unmet need and continued crisis spending.



Care Creates in Practice: What Care Creates

Margaret is 84 and lives alone in a small town where she has spent most of her life. Following a series of falls, her daughter worried that residential care was becoming inevitable. Margaret's own concern was different: she feared losing the independence, friendships and routines that gave meaning to her days.

Through a combination of home care, reablement support, community transport, appropriate digital monitoring and local voluntary activity, Margaret remained in her own home. The support was not simply about personal care. It enabled her to continue attending church, meeting friends, shopping locally and caring for her garden. A volunteer befriending service reduced isolation and helped rebuild her confidence.

The outcome was not merely the avoidance of admission to a care home or hospital. Margaret retained relationships, identity and control over her life. Her daughter was able to remain a daughter rather than becoming a full-time carer. This is what social care creates at its best: possibility, participation, connection and citizenship.

Reform question: Which model is most likely to make this level of personalised, preventative support available consistently, regardless of where someone lives?

2. What Scotland should retain

Scotland has valuable foundations on which to build. Reform should preserve and strengthen these assets and address the barriers to making them part of everyone's experience.

- A rights-based ambition that understands support as enabling dignity, autonomy, participation and equal citizenship.
- Self-directed support and the principle that people should exercise choice and control over how their support is arranged.
- A distinct social model of care, centred on ordinary life, relationships, community and independent living, alongside appropriate diagnosis and treatment.
- A diverse ecology of public, independent, charitable, voluntary, co-operative and community provision that sustains choice, specialist expertise and local capacity.
- Local knowledge, trusted relationships and community connection.
- Examples of effective partnership across social care, health, housing, local government and communities.
- Regulatory, professional and improvement infrastructure that can support quality, learning and public confidence.
- Co-production, personal-outcomes practice and the expertise of people who access support, unpaid carers, the workforce and providers.
- A skilled and adaptable workforce whose contribution extends far beyond the completion of care tasks.

Reform should make these strengths reliable and accessible across Scotland. Rights need timely support; choice needs a viable range of services; and joined-up decisions need local knowledge. Unequal access, inconsistent integration and financial and organisational pressures remain significant barriers. Funding, structures and clear responsibilities should work together to put Scotland's values into practice.



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3. What must change

- Make responsibility clear across institutions so people know who should act and how to challenge decisions. Dispersed accountability currently makes this difficult.
- Secure fair access, clear eligibility and meaningful choice across Scotland, addressing significant differences in service availability and local capacity.
- Plan and fund support around relationships, personal outcomes, continuity and long-term capacity, addressing the current emphasis on short-term price and individual purchasing transactions.
- Fund the true cost of meeting rights, statutory duties, Fair Work expectations and increasingly complex needs, making current funding gaps visible.
- Coordinate workforce planning and strengthen pay, status, security, development and career pathways, addressing fragmented planning and inadequate employment conditions.
- Identify provider fragility early and protect local capacity through timely action. Current warning signs are often recognised after services have reduced or face closure.
- Give people who access support, unpaid carers, communities, workers and providers influence from the start, addressing consultation that currently comes after key decisions.
- Provide sustained investment in prevention, early support and community capacity, rebalancing resources currently concentrated in crisis response.
- Design for rural, island and remote communities from the outset, reflecting their circumstances in mainstream planning and funding.
- Build environmental sustainability and climate resilience into the planning, funding and delivery of social care. Reform should support energy-efficient buildings, lower-emission transport and travel, sustainable procurement, climate adaptation and continuity planning, while recognising the additional costs and practical realities faced by rural, island and remote services.
- Make resources, unmet need and trade-offs visible throughout reform so structural decisions address the real extent of scarcity.



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4. Essential principles for reform

For social care as a system

- Social care must retain a distinct identity, purpose, leadership and outcomes.
- Rights and minimum entitlements must be clear and supported by accessible advocacy, review, appeal and redress. Each option must distinguish existing legal duties and remedies from any proposed extension of entitlement, identify who would hold each duty and explain the legislation, funding and capacity needed to make the proposed guarantee enforceable.
- National consistency must establish a common floor while enabling genuine local responsiveness.
- Accountability must be intelligible from the person's perspective: who must act, by when, against what entitlement and with what remedy.
- Funding must reflect the assessed cost of meeting rights and duties, with transparent reporting of available resources, assumptions and any shortfall. Appraisal must distinguish the cost of support from transition and administration costs, identify proposed movements of resources and explain their consequences for the services and people affected.
- Prevention, early intervention and community capacity must receive protected, sustained investment.
- Reform must clarify responsibility, streamline decisions and make support easier for people to access and experience.
- Decisions must be transparent, evidence informed and open to independent scrutiny.
- Social care reform must contribute to Scotland's environmental and climate ambitions without transferring unfunded costs or impractical requirements to people, workers or providers.
- Commissioning, capital investment and true-cost funding should support energy efficiency, sustainable travel, responsible procurement and resilience to extreme weather and other climate-related disruption.

For people who access care and support

- People must be able to exercise choice, control and self-directed support through practical access to the support they choose.
- Support must enable citizenship, relationships, participation, safety and an ordinary life on the person's own terms.
- People should experience continuity and have a named point of responsibility.
- Lived experience must influence priorities, budgets, design and governance.
- Independent advocacy and routes to review, appeal and redress must be accessible.

- Equity must be pursued across rural, island, remote and urban Scotland and across different communities and circumstances.

For the workforce

- Fair Work, fair pay, security and safe staffing must be foundational and fully funded.
- Long-term workforce planning must connect projected need, education, recruitment, retention and immigration.
- Skills, professionalism, emotional labour and responsibility must be recognised.
- Workers must have meaningful influence over reform, service design and improvement.
- Learning, development and career pathways must be available across roles, employers and settings.
- Reform must strengthen workforce capacity and wellbeing across organisations, with clear action on shared pressures.

For providers

- Providers must be strategic partners in planning, design and improvement, with responsibilities that recognise their contribution alongside their contractual role.
- Governance must also define how people who access support and unpaid carers hold influence, how conflicts of interest are declared and managed, and how decisions about individual contracts remain fair and transparent.
- Commissioning must be based on true cost, quality, outcomes, continuity, Fair Work and wider community value.
- Multi-year funding and proportionate assurance should support stability, investment and innovation.
- The mixed ecology of provision and meaningful personal choice must be protected.
- Market stewardship must identify fragility, unmet need and emerging gaps early and act before services fail.
- Accountability must be reciprocal: providers should demonstrate quality and outcomes, while commissioners demonstrate adequate funding, timely decisions and responsible stewardship.

For unpaid carers and communities

- Unpaid carers must be recognised as partners with rights, support and a voice independent of the person receiving care.
- Communities must hold defined influence and authority through sustained participation in decisions.
- Local knowledge, relationships, community organisations and informal assets must shape planning and delivery.
- Social care must be recognised as social and economic infrastructure and as a contributor to community wealth, resilience and connection.
- Prevention and locally designed support must have real budgets and decision-making power.

Data, digital and intelligence as reform infrastructure

Scotland cannot reform social care using incomplete, fragmented and retrospective information. Every option requires a dependable national and local picture of need, unmet need, access, waiting, workforce capacity, provider sustainability, expenditure, personal outcomes and inequalities. Information should be collected once where possible, shared safely and used to support timely decisions rather than repeated reporting.

Digital reform must begin with the rights, choices and relationships of people who access care and support. Technology should increase personal control, continuity, accessibility and time for human care. It should not become a substitute for relationships, restrict non-digital routes to support or place additional administrative burdens on people, workers and providers.

Each institutional option should therefore establish:

- interoperable data standards across social care, health, housing and relevant public services;
- a timely national and regional picture of need, unmet need, waiting, workforce capacity, provider sustainability and inequalities;
- a secure digital record that people can access and contribute to, with clear consent and information-governance arrangements;
- meaningful measures of rights, personal outcomes, continuity, choice and participation, rather than reliance only on activity and service-volume data;
- investment in provider systems, connectivity, equipment, digital skills and cyber resilience;
- continuing non-digital access and support for people who experience digital exclusion;
- transparent and accountable use of automation and artificial intelligence, including human oversight and accessible routes to question or challenge decisions; and
- proportionate reporting so the same information is not repeatedly requested in different formats by commissioners, regulators and national bodies.



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Care Creates in Practice: Technology Creating Time for Care

A care at home organisation found that staff were spending increasing amounts of time recording information in multiple systems and completing repetitive reporting requirements. Workers felt that administration was reducing the time available for direct human support.

Following investment in digital systems, connectivity and staff training, information entered once could be used for agreed purposes across the organisation. Staff could update plans securely while delivering support, families could access agreed information, and managers gained earlier visibility of emerging concerns. Scheduling became more responsive and duplicated recording was reduced.

Most importantly, workers recovered time that could be spent with people rather than on administration. Technology did not replace relationships; it strengthened the conditions in which those relationships could flourish. People who preferred non-digital routes continued to receive information and support in ways that worked for them.

Reform question: How can investment in data and digital infrastructure improve personal outcomes while protecting privacy, human oversight, accessibility and inclusion?



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5. Common tests for every reform option

Every model in this series should be assessed transparently against the same questions. For each, assessment should establish a baseline, identify the proposed mechanism and evidence of change, and distinguish measured results from expected benefits. Findings should show how experiences differ between people and communities. Access measures include waiting, repeated assessments, continuity and people's experience of choice and control; comparable evidence is needed for the other tests.

- Does it strengthen enforceable rights, choice and control?
- Does it improve timely access, continuity, relationships and personal outcomes, including what people want support to achieve?
- Does it value, reward, develop and sustain the workforce?
- Does it support a diverse, stable and innovative provider ecology?
- Does it give people, unpaid carers, workers, providers and communities genuine power?
- Does it establish clear and accessible accountability, advocacy, review and redress?
- Does it secure sustainable investment, show the true cost of care and make funding gaps and their consequences clear?
- Does it move resources towards prevention, early intervention and community capacity?
- Does it work in rural, island, remote and urban Scotland?
- Does it strengthen equal partnership with health, housing and wider public services while sustaining social care's distinct identity and purpose?
- Does it reduce duplication and complexity for people and those delivering support?
- Does it create timely, trustworthy and shareable information about need, unmet need, access, workforce capacity, provider sustainability, expenditure and personal outcomes?
- Does digital innovation increase people's choice, control and continuity while protecting privacy, retaining human oversight and preventing digital exclusion?
- Does it support environmentally sustainable and climate-resilient care, with the investment needed to make change achievable across different services and geographies?
- Can it be implemented while protecting continuity of support, workforce stability and provider capacity?
- Above all, does it enable social care to create possibility, independence, connection and participation?

Adequate funding, a valued workforce, sustainable providers, enforceable rights, local power and investment in prevention are requirements shared by all three proposals. Each seeks clearer responsibility, national guarantees and stronger

planning while retaining social care’s purpose, local relationships and diverse provision. The comparison must therefore establish what each institutional design adds: which decisions it improves, who gains authority, how resources reach support and what new risks it creates. Shared ambitions alone cannot distinguish the options.

Framework for assessing any proposed model for social care reform in Scotland

This framework provides a consistent basis for assessing any proposed model for social care reform in Scotland. It should be applied to institutional proposals, changes to funding or commissioning, and reforms that could be delivered within existing structures. Assessment should begin with the outcomes reform is intended to achieve, establish a clear baseline and test whether the proposed mechanisms are credible, adequately resourced and likely to improve people’s lives.

How to use the framework

- Assess every model against the same domains and questions.
- Record the current baseline, the proposed change, the evidence supporting it and the expected effect.
- Distinguish evidenced benefits from assumptions, aspirations and benefits dependent on further investment or legislation.
- Identify distributional effects, including how impacts may differ across rural, island, remote and urban communities and among people with different support needs and circumstances.
- Assess the proposal both on its own terms and against realistic alternatives, including improvement within current arrangements.
- Publish evidence, uncertainties, trade-offs, dependencies and risks so that conclusions can be scrutinised.

Assessment domains

Domain	Questions for assessment	Evidence and indicators
1. Purpose and personal outcomes	Does the model preserve social care’s distinct purpose and enable people to exercise choice, control, rights, relationships, participation and ordinary life? What would improve for people, and through which mechanism?	People’s reported outcomes; continuity; choice and control; participation; avoidable disruption; access to support that reflects personal goals.

2. Rights, access and equity	Are entitlements, eligibility and duties clear and enforceable? Will access become more timely, fair and consistent without imposing uniform solutions? Are advocacy, review, appeal and redress accessible?	Waiting and unmet need; repeated assessments; variation in access; use and outcomes of advocacy, complaints, review and appeal; equality and human-rights assessment.
3. Power, voice and co-production	How will people who access support, unpaid carers, workers, providers and communities influence priorities, budgets, design, delivery and scrutiny? Is that influence formal, sustained and resourced?	Decision rights; voting or governance roles; delegated budgets; evidence of decisions changed through participation; accessible engagement and feedback.
4. Governance and accountability	Who holds authority, funding and statutory responsibility? Is accountability intelligible from the person's perspective? Are responsibilities between national, regional and local bodies clear, with independent scrutiny and remedies?	Published decision routes; named responsibilities; statutory duties; public reporting; audit and scrutiny findings; timeliness of decisions and dispute resolution.
5. Funding and fiscal sustainability	Does funding reflect the true cost of meeting rights, duties, Fair Work and changing need? Are support costs separated from administration and transition costs? Are funding gaps, trade-offs and movements of resource transparent?	Baseline and projected expenditure; assessed need; true-cost analysis; multi-year settlements; funding gaps; transition and administrative costs; distribution of spending across prevention, community support and crisis response.
6. Workforce	Will the model improve fair pay, security, status, safe staffing, wellbeing, recruitment, retention, learning and career pathways? Is workforce capacity sufficient for implementation and future demand?	Pay and terms; vacancies and turnover; absence; staffing sufficiency; training and progression; workforce projections; worker experience; implementation capacity.

7. Provider ecology and commissioning	Will the model sustain diverse public, independent, charitable, voluntary, co-operative and community provision? Do commissioning and procurement support quality, continuity, choice, innovation, Fair Work and true cost?	Provider viability; closures and withdrawals; market gaps; contract duration; fee adequacy; payment performance; choice of provider; capacity for specialist and local support.
8. Prevention and community capacity	Does the model shift power and sustained resource towards prevention, early intervention, unpaid carers and community capacity? Are preventative gains protected from short-term crisis pressures?	Protected investment; access to early support; carer outcomes; community capacity; crisis use; avoidable admissions and disruption considered alongside wider personal outcomes.
9. Place and local responsiveness	Can the model respond to rural, island, remote and urban circumstances, including workforce supply, travel, transport, housing, small-provider resilience and community infrastructure?	Place-based impact assessment; travel and delivery costs; service availability; workforce and provider capacity by area; locally delegated authority and resources.
10. Relationships with health and wider services	Does the model strengthen equal partnership with health, housing and wider public services while protecting social care's purpose, resources and leadership? Does it reduce cost-shifting and repeated processes?	Shared plans and responsibilities; coordinated transitions; duplicated assessment and reporting; movement of resources; measures of social care outcomes as well as health-system performance.
11. Data, digital and intelligence	Will the model create timely, trustworthy and shareable information on need, unmet need, access, workforce, provider sustainability, spending and outcomes? Does technology increase control and continuity while protecting privacy, human oversight and non-digital access?	Data completeness and timeliness; interoperability; reporting burden; access to records; cyber resilience; digital inclusion; governance of automation and artificial intelligence.

12. Environmental sustainability and resilience	Does the model support climate-resilient, environmentally sustainable care without transferring unfunded costs to people, workers or providers?	Funded plans for buildings, energy, transport, procurement and extreme-weather continuity; emissions and resilience measures; differential impact by geography and service type.
13. Deliverability and transition	What legislation, workforce, leadership, systems, data, contracts and resources are required? Can change be phased while protecting continuity, rights, workforce stability and provider capacity? What could be improved without structural transfer?	Implementation plan; critical path; readiness criteria; dependencies; transition costs; risk register; continuity arrangements; pilot and evaluation design; corrective review points.
14. Added value, risks and unintended consequences	What does this model achieve that credible alternatives do not? What new bureaucracy, remoteness, concentration of power, fragmentation or inequalities could it create? Are safeguards credible and enforceable?	Options appraisal; counterfactual; benefits and disbenefits; sensitivity analysis; independent challenge; safeguards, owners and triggers for corrective action.

Recording the assessment

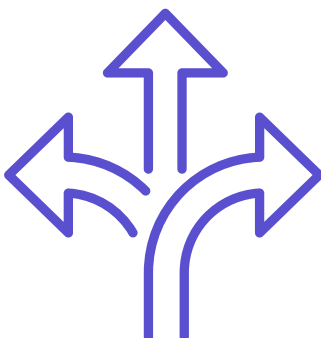
For each domain, the appraisal should record: the baseline; the intended outcome; the mechanism by which the proposal is expected to produce change; available evidence and its quality; likely benefits and disbenefits; impacts on different people, places and organisations; costs and resource dependencies; implementation risks; proposed safeguards; and the indicators and timescales for review.



Assessment	Meaning
Strong	Credible evidence and a clear, adequately resourced mechanism indicate material improvement, with manageable risks and enforceable safeguards.
Promising but conditional	Potential benefit is credible, but depends on specified funding, legislation, capacity, safeguards or further evidence.
Uncertain	Evidence is limited, the mechanism is unclear, or important impacts and dependencies have not been established.
Weak or adverse	The proposal is unlikely to improve the domain, creates significant unmanaged risks or performs less well than credible alternatives.
Not yet assessable	Essential information is missing. The appraisal should specify what evidence or design work is required before a conclusion can be reached.

Overall judgement and decision record

The final appraisal should not rely on a single aggregate score that conceals trade-offs. It should state which outcomes the model is likely to improve, where it is weaker than alternatives, the conditions required for success, who bears its costs and risks, and what remains uncertain. It should identify any minimum conditions that must be met before implementation and any reasons the proposal should not proceed.



6. The choices explored in this series

The three Scottish proposals place lead responsibility in different institutions. **A Scottish Local Care Compact** retains democratic local-government leadership, combining regional planning and funding with community accountability. **One System, Shared Responsibility** brings health and social care planning and funding into reformed NHS-led regions, with protections for social care's equal status and person-led purpose. **A National Care Trust for Scotland** gives an independent national institution responsibility for social care, with regional commissioning and local participation. The central choice is where authority and budgets should sit, how that authority should be held accountable and how people and communities would exercise power.

Learning Across the Irish Sea examines the assumption that clearer institutional responsibility improves support. Its account identifies potential benefits from national oversight alongside bureaucracy, uneven access, workforce shortages, provider fragility and hospital-led priorities. These features do not, on their own, establish which outcomes national coordination caused. For Scotland, the comparison identifies questions for all three proposals: how decisions would improve, and how staff, sustainable services and funding would turn those decisions into timely support.

The proposed numbers, areas and institutional arrangements are illustrations for discussion. They help explore the scale at which care could be planned and funded, democratic accountability exercised and communities given influence. Developing any option into a settled proposal would require detailed analysis of population, rurality, workforce availability, travel patterns, existing public bodies, law, finance, equality, implementation costs and transition risks.

7. Purpose and boundaries of the series

These papers identify choices for appraisal, principally concerning adult social care: where authority and accountability sit; how national consistency works with local power; how social care's purpose is protected; and how people, workers, carers, providers and communities shape decisions. They identify the legal, financial, workforce and practical conditions that each route would require. Full costing, implementation plans and a final institutional recommendation remain later-stage

work. The boundaries between commissioning, social work functions, service delivery and existing health and local-government responsibilities also require definition before any option becomes a settled proposal.

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Taking any option forward would require detailed legal, financial, workforce, equality and transition analysis against a clear baseline. Appraisal should identify the current arrangements each proposal would retain, replace or consolidate; compare costs, benefits and effects on different people and communities; and assess institutional capacity, implementation requirements and unintended consequences. It should distinguish improvements achievable through changes to current practice from those dependent on transferring statutory responsibilities, and explain how each proposed mechanism would improve access, personal outcomes and accountability.

8. How the papers fit together

Read the collection through three questions: what should reform preserve and change; where should authority, funding and accountability sit; and what evidence would show that each arrangement improves support? This opening supplies the shared principles and tests. The Scottish papers explore institutional mechanisms, and the Ireland paper examines the limits of structural solutions. Together they support comparison of decisions and consequences, rather than repeated statements of aspiration.

Every institutional option must demonstrate how authority will translate into greater personal control, reliable support and sustainable services. Comparison should identify the strengths each retains, the trade-offs it creates, the safeguards it requires and the evidence needed to substantiate its claims. The contribution of this collection is a common standard for that appraisal: reform should enable more of what care creates for people, communities and Scotland.



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A Scottish Local Care Compact

One possible model for democratic, community-based social care reform



Perspectives on the Future of Social Care in Scotland

A discussion paper for wider policy and political debate

Executive summary

This paper explores how reformed local-government leadership could strengthen person-led social care. The Scottish Local Care Compact would combine regional planning, community accountability, national rights and local decisions. Scottish Care offers it for discussion and testing alongside the other options in this series.

The central proposition

- Establish 6 to 10 Regional Care Authorities responsible for strategic commissioning, workforce planning and market stewardship.
- Create 120 to 160 Community Care Partnerships responsible for local planning, prevention, community support and democratic accountability.
- Set national standards and entitlements while retaining local decision-making and delivery.
- Give providers, communities, unpaid carers and people who access support formal roles in governance.
- Establish an equal partnership with the NHS, with social care led through reformed local government.

1. The challenge

The Compact aims to connect strategic planning with community influence. Workforce planning, service development and commissioning vary considerably between areas, and communities often have limited influence. Responsibilities shared across councils, Health and Social Care Partnerships, Integration Joint Boards, NHS boards and national government can make accountability difficult to follow. The Compact would need to define who acts and give people practical influence over decisions.

Integration experience shows why local planning needs clear authority and influence. A reformed democratic model could connect regional planning and funding with locally shaped support and nationally assured rights. The series tests this route alongside NHS-led commissioning and an independent National Care Trust.

2. Regional Care Authorities

The illustrative range of six to ten Regional Care Authorities would support planning and funding across wider areas. The proposal envisages committees or boards of democratically elected regional authorities, accountable through local government. Further design must establish how those authorities would be constituted, how elected representation and voting would work, which current responsibilities they would assume and how budgets would be authorised. Their scale would be assessed for workforce planning, sustainable provision and specialist support.

- Strategic commissioning and regional resource allocation.
- Workforce planning and development.
- Market oversight, provider sustainability and contingency planning.
- Specialist and complex care services.
- Regional commissioning frameworks and accredited provider arrangements.
- Housing, care and community wellbeing planning.
- Investment in prevention and early intervention.
- Regional data, digital and climate-resilience planning, including shared intelligence on unmet need, workforce, provider capacity, personal outcomes, transport, energy efficiency and continuity during extreme weather.

3. Community Care Partnerships

Between 120 and 160 Community Care Partnerships would serve recognisable local communities. Defined responsibilities and delegated budgets would keep decisions close to people. Clear boundaries between local and regional functions would keep the arrangements straightforward.

- Local needs assessment and care sufficiency planning.
- Community capacity building and support for local initiatives.
- Prevention and early intervention.
- Local community support services and delegated commissioning.
- Support for unpaid carers.
- Community engagement, participation and co-production.
- Local scrutiny of care quality, access and unmet need.

Care Creates in Practice: When Communities Shape Solutions

A remote rural community had experienced increasing difficulty recruiting care staff and maintaining reliable services. Long travel distances, limited public transport and a shrinking workforce meant that conventional service models were becoming increasingly fragile.

Local providers, unpaid carers, community organisations, housing partners and elected representatives worked together to develop a different approach. Community transport was aligned with care visits, accessible housing was included in local planning, residents were supported to undertake care training, and a community hub coordinated practical support and volunteering.

Care workers spent less time travelling and more time supporting people. Older residents were better able to remain within their own communities, unpaid carers gained practical assistance and the area developed greater resilience. The example shows how local knowledge, delegated resources and trusted relationships can turn community participation into practical change.

Reform question: Which governance arrangements give communities sufficient authority, resource and flexibility to respond to local challenges and opportunities?

4. A national framework

National government would establish shared rights and safeguards, with regions and communities shaping delivery to local circumstances. Common entitlements and flexible local delivery would aim to make access fair and reliable wherever a person lives.

- Eligibility principles and minimum national entitlements.
- Human rights standards and duties.
- Fair Work requirements.
- A national true-cost-of-care methodology.
- Core ethical commissioning principles.
- National outcomes, information and data standards.
- Independent routes of review, appeal and redress.

5. A new model of accountability

Democratic accountability

Regional elected members would approve budgets, commissioning plans and regional priorities. Community elected members would scrutinise local performance and require formal responses to local concerns. Meetings, decisions and performance information should be public and accessible.

Community accountability

Each Community Care Partnership would publish an annual local care report on access, waiting times, workforce capacity, unmet need, service sustainability and community outcomes. People who access support, unpaid carers and community organisations would hold formal membership and help shape decisions throughout the year.

Personal accountability

Every person accessing publicly funded support would have a named accountable professional, clear information on rights and entitlements, and access to independent review and appeal. People would know who should act, when to expect action and how to seek a remedy if their support is delayed or their rights are unmet.

Provider accountability and partnership

Providers would hold formal roles in planning and system design, alongside their contractual responsibilities. Accountability would be shared: providers would demonstrate quality and personal outcomes, and commissioners would demonstrate adequate funding, timely decisions, proportionate monitoring and responsible planning for service capacity.



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6. A different approach to commissioning

Open accredited provider frameworks would aim to support stable relationships and personal choice. Organisations meeting agreed standards could join a regional framework, giving people, with support from families and professionals where appropriate, a choice of approved providers. Design would need to explain how the framework supports self-directed support and individual preferences. Its contribution to continuity and reduced retendering would be tested against those aims.

Planning and funding would prioritise quality, personal outcomes, human rights, continuity, workforce investment and community benefit. Multi-year agreements would sustain services that need stable long-term capacity. Independently validated care costs would inform prices. This approach aims to build a mature partnership that plans for future need and supports people's lives.

7. Equal partnership with the NHS

The Compact would ground social care leadership in relationships, citizenship, housing, community, human rights and independent living, with democratic oversight and community influence. Its partnership with the NHS would need to demonstrate equal influence in decisions and effective coordination of support. Assessment should test whether the Compact's own arrangements deliver that balance and keep decisions connected to people.

The NHS would be an essential statutory partner in regional and local planning. Aligned budgets, shared information and coordinated support would strengthen people's experience. Clear responsibilities for transitions, prevention and clinical support would underpin a partnership of equals, with social care's own leadership, outcomes and identity.



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8. Potential advantages of the Compact

- Regional planning capacity with distinct democratic leadership for social care.
- Genuine local influence through recognisable community partnerships.
- Clearer democratic, community and personal accountability.
- Stronger market stewardship and more sustainable provider relationships.
- Common national rights combined with local flexibility.
- Better integration with health, housing and community planning.
- A stronger foundation for prevention and early support



9. Risks and safeguards

- Keep administration clear and proportionate by consolidating overlapping bodies and allocating functions explicitly. Additional bureaucracy remains a risk to test.
- Keep regional decisions connected to communities through delegated local budgets and formal scrutiny powers. Regional remoteness remains a risk.
- Support fair access through national entitlements, funding principles and transparent data, with continuing variation assessed openly.
- Provide sufficient, transparent social care funding linked to statutory duties, with safeguards addressing local-government financial pressure.
- Include providers through formal regional and community governance and planning roles, with clear checks on the risk of exclusion.
- Keep transition focused on people through phased implementation assessed against access, outcomes, workforce stability and continuity. Appraisal would need to identify legal responsibilities, staffing and workforce arrangements, information governance, contract continuity, transition costs and the capacity to maintain existing services while responsibilities change. These safeguards would address the risk that structural change distracts from support.

10. Tests by which the model should be judged

- Are decisions closer to people and communities?
- Can regions plan the workforce and provider capacity needed for the future?
- Are rights, access and routes of redress clearer?
- Do commissioning arrangements support Fair Work, continuity and provider sustainability?
- Has resource moved towards prevention and early intervention?
- Does partnership with the NHS improve while strengthening social care's distinct identity?
- Are rural, island and remote communities better able to shape workable local solutions?
- Do shared data, digital investment and climate-resilience planning strengthen local services without weakening personal choice or community control?

Conclusion

A Scottish Local Care Compact offers one route for exploring regional planning and funding, strong community accountability and democratic local-government leadership. It asks how care could be planned regionally, shaped locally and assured nationally through partnerships with people, communities, providers and unpaid carers.

The Compact should be judged by whether it makes decisions more democratic, clarifies accountability, strengthens prevention and puts human rights into everyday practice. Success would require sufficient funding, workforce capacity and sustainable services alongside the proposed structure. The shared framework supports open comparison with the alternatives

Selected references and policy context

- Public Bodies (Joint Working) (Scotland) Act 2014.
- Scottish Government (2021), Independent Review of Adult Social Care in Scotland.
- Care Reform (Scotland) Act 2025.
- Scottish Care, ethical commissioning work and evidence on social care reform.
- Audit Scotland reports on integration and Integration Joint Board finances.

One System, Shared Responsibility



*Exploring NHS-led
regional commissioning
with a distinct, equal role
for social care*

Perspectives on the Future of Social Care in Scotland

A discussion paper for wider policy and
political debate

Executive summary

This paper explores placing adult social care planning, funding and accountability within reformed regional NHS structures. A regional health system would hold one population budget and commission health and social care together, with clear responsibility for access, capacity and personal outcomes. Social care would retain its own purpose. Public, independent, charitable, voluntary and community organisations would continue to provide support. Scottish Care offers this option for discussion alongside the other models.

The model's central claim is that one regional authority could connect planning, budgets and responsibility for hospital, community and social care. At present these responsibilities are shared across government, councils, NHS boards, Integration Joint Boards and Health and Social Care Partnerships; delayed decisions and disputed budgets can leave people uncertain about who will secure support. The test is whether one strategic authority and population plan would resolve those delays while protecting social care's resources and priorities.

The model would need strong protections in law, governance, funding and practice. These should sustain social care as a distinct public good that supports citizenship, autonomy, relationships, housing, participation and ordinary life. Medicalisation, hospital-led priorities, narrower choice and weaker democratic and community influence remain significant risks. Explicit safeguards and independent scrutiny would be essential.

The central proposition

- Create a small number of Regional Health and Care Authorities based on reformed NHS regions.
- Pool health and adult social care commissioning budgets at regional level.
- Retain a plural provider landscape across public, independent, charitable, voluntary and community organisations.
- Give social care equal status through ring-fenced budgets, statutory leadership and balanced governance.
- Make national rights and entitlements enforceable locally, with transparent appeal and redress.

1. Why this option deserves serious consideration

The starting point is the person's experience. Someone leaving hospital, seeking support at home or considering residential care should receive timely, coordinated help and have a clear voice in decisions. Fragmentation can cause delays, repeated assessments and uncertainty about who will act. Shared regional responsibility could support planning around the person, account for the full public cost of support and address incentives to move costs between separate budgets. The Public Bodies (Joint Working) (Scotland) Act 2014 established shared planning and delegated functions to support integration. Councils and NHS boards retain separate employers, budgets, institutional incentives and statutory duties. Partnership has often improved relationships, while these distinctions continue to shape decisions. This option tests whether unified regional responsibility for population outcomes could build on that experience and clarify accountability.

Care Creates in Practice: One Person, One Conversation

Following a stroke, John spent three weeks in hospital. Previous experiences had involved repeated assessments, several professionals asking similar questions and uncertainty about who was responsible for securing support.

Under a more coordinated approach, planning for his return home began early. Health professionals, social care staff, housing specialists and John's family worked from an agreed plan. Information was recorded once and shared appropriately. A named coordinator maintained responsibility across organisational boundaries.

By the time John returned home, adaptations had been completed, home care was in place and community rehabilitation was arranged. Follow-up support focused not only on physical recovery but on rebuilding confidence, relationships and ordinary routines. The organisations remained distinct, but their boundaries became less visible from John's perspective.

Reform question: Which arrangements are most likely to reduce fragmentation while protecting social care's distinct purpose, values and voice?

2. The proposed architecture

Regional Health and Care Authorities

Under this option, a small number of regional authorities would bring territorial NHS planning and strategic adult social care commissioning together. Each would plan for a defined population and hold responsibility for commissioning acute, primary, community and adult social care. Population need, travel patterns, workforce availability and rurality would guide the geography, with existing boundaries considered as part of that assessment.

- A single regional outcomes plan covering prevention, community support, primary care, hospital care and social care.
- A pooled population budget with a protected social care allocation and transparent transfers between sectors.
- Regional workforce planning across health and care, while recognising different professions and employment models.
- Market and capacity stewardship, including provider sustainability, rural resilience and contingency planning.
- Commissioning of specialist and complex services where local purchasing is too fragmented.
- One public account of waiting, unmet need, availability, quality and outcomes across the region.

National guarantees

National government would set common rights, minimum entitlements, eligibility principles, Fair Work expectations, a true-cost funding method, data standards and routes of appeal. These guarantees would establish fair expectations wherever people live. Regions would organise the capacity and support needed to put them into practice.

Local care partnerships

Regional planning would work alongside strong local relationships and decision-making. Each region would establish local care partnerships with defined powers over prevention, community support, support for unpaid carers and neighbourhood priorities. Membership would include people who access support, unpaid carers, community organisations, providers, housing and local elected representatives. A defined share of the budget and formal scrutiny powers would give these partnerships practical influence.

3. Potential advantages to examine

- Clearer accountability. Ministers, Parliament and the public would know which regional authority is responsible for access, capacity and the movement of resource across the whole system.
- Shared financial responsibility. One body would account for the consequences of investment decisions across community and hospital care, including delays and crises linked to insufficient community capacity.
- Stronger population planning. Regional authorities could align hospitals, primary care, housing interfaces, home care, care homes and prevention around projected need.
- Greater strategic purchasing power. Regional commissioning could support multi-year contracts, common data, workforce investment and specialist provision that individual areas struggle to sustain.
- Investment in community support. A shared budget could make it easier to move resources from acute activity into community and social care capacity, with clear protection for social care funding.
- Reduced structural duplication. Fewer strategic bodies could simplify governance and release leadership effort from repeated negotiation across organisational boundaries.

4. Protecting social care's distinct purpose and equal status

A credible regional model would recognise health and social care's complementary purposes. Healthcare contributes expertise in diagnosis, treatment, clinical risk and intervention. Social care enables people to live, belong, choose, sustain relationships and participate in community. Clinical expertise supports this wider role in everyday life. Regional decisions would need to reflect both purposes.

Protected funding and balanced measures of success would be essential. The NHS's political and operational weight creates a risk that acute pressures could absorb pooled resources. Assessment should measure autonomy, continuity, inclusion, relationships and quality of life alongside social care's contribution to hospital outcomes. The effectiveness of these protections would be a central test of the model.

5. Essential safeguards

- A statutory Social Care Director for every region, equal in status to the senior medical, nursing and finance leadership.
- A legally protected social care allocation, published separately, with transparent public approval for any transfer to acute care. Detailed design must specify who approves transfers, the criteria applied and how the protection works within a pooled population budget, including how investment can move towards community support while sustaining essential services during transition.
- Balanced regional governance with equal social care, lived-experience, provider, workforce, local government and clinical representation.
- A social care outcomes framework centred on rights, relationships, participation, choice, continuity and community connection.
- Independent assessment, advocacy, review and appeal, with clear separation between commissioning decisions and independent judgements on entitlement.
- Formal provider partnership from the start of planning, budget development and service design.
- Commissioning rules centred on true cost, Fair Work, multi-year stability and personal outcomes, supported by stable provider relationships.
- A rural and island duty requiring explicit assessment of workforce, travel, housing, transport and small-provider resilience.
- A shared data and digital framework that gives equal weight to social care outcomes, including autonomy, relationships, participation, continuity and choice. Social care information should not be reduced to measures of hospital discharge, admission avoidance or acute-sector performance.
- A regional sustainability and climate-resilience duty covering buildings, procurement, transport, travel, extreme-weather continuity and the funded transition required of commissioned providers.

6. What this would mean for independent and third-sector providers

NHS-led commissioning would work with Scotland's diverse public, charitable, voluntary, community and private providers. They sustain choice, local knowledge, service capacity and investment. Responsible planning, funding and partnership should strengthen this diversity. Provider losses would put choice and local capacity at risk.

Regional authorities would use open accredited provider frameworks, with proportionate checks and opportunities for suitable organisations to join over time.

7. Democratic legitimacy and public voice

Public accountability would combine ministerial responsibility with regional openness and local influence. Regional authorities would meet in public, publish budget decisions and maintain standing citizens' and carers' panels. Local elected members would have defined scrutiny rights. A national Social Care Commissioner or equivalent independent office could report to Parliament on access, equality, unmet need, rights and the adequacy of regional action.

8. Transition and implementation

- Legislate first for purpose, rights and safeguards, before transferring functions.
- Establish shadow regional authorities and publish baseline budgets, workforce data, contracts, unmet need and provider capacity.
- Pilot pooled commissioning in selected pathways, with independent evaluation of personal outcomes and provider impact.
- Transfer strategic functions in phases, protecting continuity of support and existing rights under self-directed support.
- Publish annual transition accounts showing whether resource has moved into community and social care capacity.
- Use a formal review point after three years, with power to correct regional boundaries, governance and funding protections.



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9. Tests by which the model should be judged

- Do people obtain support earlier and with fewer repeated assessments?
- Has unmet need become visible and reduced?
- Has the share of resource reaching community and social care increased?
- Can providers plan, invest and sustain a skilled workforce?
- Are choice, self-directed support and continuity stronger in practice?
- Do rural and island communities have more reliable capacity?
- Is social care valued for its contribution to rights, relationships and everyday life, alongside its role in the wider health and care system?

Conclusion: an option for open consideration

- NHS-led regional commissioning offers a possible route to clearer shared responsibility for hospital, community and social care outcomes. Its potential lies in coordinated population planning, aligned investment and accountability for the effects of decisions across the system. These possibilities deserve careful comparison with the other options.
- The central test is whether unified regional responsibility would deliver a person-led experience. Protected funding, equal governance, enforceable rights, provider partnership and local power would be essential. Assessment should examine hospital-led priorities and unequal influence openly. Taking the model forward should depend on evidence that social care would have equal power, a distinct purpose and effective safeguards.

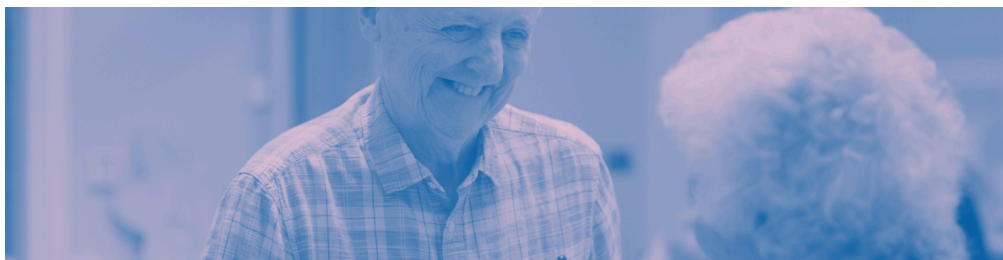


Image sourced via Unsplash by Age Cymru

Selected references and policy context

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A National Care Trust for Scotland



*An independent stewardship
model between central
government, the NHS and
local government*

Perspectives on the Future of Social Care in Scotland

A discussion paper for wider policy and
political debate

Executive summary

This paper explores an independent National Care Trust for Scotland. Established by statute and accountable to Parliament, it would take national responsibility for social care funding and oversight, working through regional commissioning partnerships. Social care would gain a visible institutional home alongside the NHS and local government. A national framework would support consistency across Scotland's thirty-two local-authority areas. Scottish Care offers this option for discussion and comparison.

The Trust would connect social care's preventative, rights-based purpose with clear institutional responsibility. Dispersed accountability, uneven oversight of provider capacity and variable local resources remain challenges. An independent Trust could bring together national funding and rights, regional commissioning, local participation and diverse provision. Its success would depend on translating those arrangements into reliable support.

The model would allocate functions at three levels. The national body would hold the shared framework, funding and assurance responsibilities. Regional partnerships would plan, fund and sustain service capacity. Local forums would shape prevention, community support and implementation. Public, independent, charitable, voluntary, co-operative and community providers would continue to deliver care through a diverse system.

The central proposition

- Establish a statutory National Care Trust accountable to the Scottish Parliament.
- Transfer strategic adult social care funding and stewardship to the Trust, while retaining delivery through a plural provider system.
- Create regional commissioning partnerships with delegated budgets and strong local participation.
- Define a national rights, entitlement, workforce and true-cost settlement.
- Separate commissioning from independent regulation, inspection and redress.

1. Why an independent institution?

The case for an independent Trust begins with a distinct national focus on social care's purpose. Local government contributes democratic legitimacy and connections to housing, community development and place. The NHS contributes scale, national recognition and a commitment to universal care. Both also manage competing priorities: councils balance many local functions under financial pressure, while NHS leaders respond to acute demand, clinical risk and waiting times. A dedicated institution could give social care its own starting point within those partnerships

Social care enables lives of choice, dignity, relationships, contribution and belonging. Institutional design should reflect what matters to people and protect the resources and responsibilities needed to support them. A National Care Trust would be built around citizenship, human rights, independent living, prevention and support for unpaid carers, in statutory partnership with health and local government.

2. What the National Care Trust would do

- Receive a consolidated national adult social care allocation voted by Parliament.
- Publish a national statement of rights, entitlements, eligibility principles and service expectations.
- Set an independently validated true-cost-of-care methodology and national funding rules.
- Lead long-term workforce planning, Fair Work implementation, learning and career development with sector partners.
- Maintain national intelligence on need, waiting, capacity, quality, provider sustainability and workforce risk.
- Commission selected national or highly specialist services where regional purchasing would be inefficient.
- Allocate multi-year budgets to regional commissioning partnerships using a transparent needs-based formula.

- Report annually to Parliament on access, unmet need, equality, expenditure and personal outcomes.
- Set national interoperability and ethical-digital standards, invest in provider digital capacity and cyber resilience, and ensure that people can access and contribute to information about their own support.
- Lead a funded social care sustainability and climate-resilience programme covering buildings, energy efficiency, transport, procurement and continuity planning.

Care Creates in Practice: Seeing Risk Before Crisis

A medium-sized care home serving a rural area began experiencing growing pressure. Rising energy costs, recruitment difficulties and increasing complexity of residents' needs created significant strain. None of these issues appeared catastrophic on its own, but together they threatened the long-term sustainability of a locally essential service.

In a system with stronger national and regional intelligence, early-warning indicators brought workforce vacancies, occupancy patterns, financial pressures and local demand projections into a single picture. Regional and national partners engaged with the provider before the situation became a crisis.

Commissioning arrangements were reviewed, recruitment and training support was coordinated, and targeted capital investment improved energy efficiency. The home remained open, residents retained continuity and families avoided the distress associated with an emergency closure. The value of stewardship lay in seeing the combined risk early enough to act.

Reform question: Which model is best able to identify provider fragility, unmet need and workforce risk early enough to take preventative action?



3. Regional commissioning partnerships

A limited number of regional commissioning partnerships would put the Trust's national framework into practice, with delegated leadership and operational commissioning responsibilities. Regions would have the scale to plan workforce, specialist provision and provider capacity, and remain close enough to respond to geography and community differences. Their leadership would include the Trust, local government, NHS bodies, people who access support, unpaid carers, providers and workers.

- Prepare a regional care sufficiency and prevention plan.
- Commission care homes, care at home, housing support and specialist provision through stable, outcomes-based arrangements.
- Operate open accredited provider frameworks to support choice and continuity.
- Hold a regional resilience fund for service failure, rural fragility and unplanned demand.
- Coordinate with NHS population plans, housing strategies, transport and community infrastructure.
- Publish accessible data on waiting, unmet need, provider capacity, workforce and expenditure.

4. Locality power and community wealth

The Trust would need strong connections to people and places. Locality care assemblies or partnerships would identify community priorities, shape preventative investment, scrutinise access and support micro-enterprises, co-operatives and community organisations. A defined share of regional funding should support locally designed prevention and community capacity. Protecting this investment would address the risk that crisis purchasing absorbs the available budget.

Commissioning could also strengthen community wealth. Social care is a major local employer and purchaser. Properly funded, proportionate contracts could reward Fair Work, local training, environmental responsibility, continuity,

investment and community resilience. Decisions should recognise the wider public value of sustainable providers rooted in place and assess each organisation on its contribution, with fair treatment across legal forms.

5. How accountability would work

Parliamentary accountability

The proposed Trust would report publicly to Parliament through its corporate plan and annual report, with its chair and chief executive answerable for national performance, public funds and the implementation of rights. Ministers would set broad policy and the funding settlement. Legislation would need to define appointments, financial accountability, ministerial direction, parliamentary scrutiny and operational independence. It would also need to distinguish the Trust's role in publishing and implementing the rights framework from decisions to create or change legal entitlements, so that responsibility remains clear when decisions are contested or support falls short.

Citizen and personal accountability

Every person seeking or receiving support should have clear information about entitlement, a named point of responsibility and access to independent advocacy, review and appeal. Published complaints data should reveal systemic barriers and protect privacy. A legal duty should require the Trust to demonstrate how lived experience changed policy and budgets, supported by evidence of its engagement.

Regulatory independence

Independent bodies should inspect services and regulate professional practice separately from the Trust's commissioning role. The Care Inspectorate and Scottish Social Services Council, or successor arrangements, would use the Trust's intelligence and retain independent judgement. An independent Social Care Commissioner could oversee rights, equality and redress across the system.

6. Funding and provider sustainability

The Trust's success would require funding and governance to improve together. It should publish the assessed cost of statutory duties, the funding available and the consequences of any gap. This would make funding a visible national choice for parliamentary debate. An inadequate national budget would still leave unmet need and service shortages, so scrutiny must address the resources as well as who controls them.

- A national true-cost methodology, independently validated and updated annually.
- Multi-year regional allocations and provider agreements wherever service continuity depends on long-term capacity.
- Full recognition of workforce, travel, training, regulation, digital, environmental and property costs.
- Prompt-payment standards with automatic transparency where public bodies fail to meet them.
- Capital and innovation routes for digital transformation, housing, energy efficiency and service redesign.
- Early-warning intervention where provider withdrawal or closure threatens community capacity.

7. Potential advantages to examine

- A distinct institutional voice. Social care would have its own national institution to express its purpose alongside health and local government.
- National consistency with regional and local authority. Common rights, funding rules and data would support delivery shaped by regional and local bodies.
- Stronger stewardship. A single organisation could see provider fragility, workforce gaps and unmet need across Scotland and intervene earlier.
- Clearer political accountability. Parliament could scrutinise one national body for whether the social care settlement is being delivered.
- Protection from acute-sector dominance. The Trust would collaborate with the NHS from a position of institutional parity rather than incorporation.

A more stable relationship with providers. National rules and regional partnership commissioning could replace repeated, fragmented procurement.

8. Risks and safeguards

- Keep national responsibilities clear and proportionate. Focus the Trust on funding, standards, intelligence and stewardship, delegate commissioning regionally and remove duplicate structures. Test whether these safeguards control the risk of added bureaucracy.
- Protect local democracy through statutory local-government representation, locality budgets, public meetings and formal scrutiny powers for elected members. Assess the continuing risk of reduced local democratic control.
- Keep decisions connected to people through enforceable co-production duties, locality assemblies, advocacy and clear feedback on changes. Test whether these measures address institutional remoteness.
- Combine national minimum entitlements with regional flexibility and explicit rural and island duties. Assess whether delivery remains responsive to different communities and address the risk of imposed uniformity.
- Make funding adequacy visible by publishing the cost of meeting rights and duties. Parliament and the public should be able to scrutinise any underfunding and its consequences; commissioning authority alone cannot resolve a resource gap.
- Protect continuity during transition. Phase functions and transfer data, staff and contracts after regions meet readiness tests. Appraisal should identify legal responsibilities, workforce arrangements, information governance, contract continuity, transition costs and the management capacity needed to run existing services while change proceeds. Monitor disruption and respond promptly to risks to people's support.

9. Relationship with the NHS and local government

The Trust would work in equal partnership with the NHS and local government. Health boards would contribute community health, clinical support, prevention and coordinated transitions. Councils would contribute housing, social work, community planning, transport, local democracy and knowledge of place. The Trust would plan and fund social care with the authority to negotiate as an equal partner with both.

Statutory reciprocal duties should require NHS bodies, councils and the Trust to share the plans, data and resources needed for agreed outcomes. Transparent arbitration should resolve disputes and protect people and providers from delays between institutions. Success means public bodies taking shared responsibility for one system and acting on that responsibility

10. A staged route to implementation

- Create the Trust in shadow form and appoint a balanced board with lived experience, provider, workforce, local government and health expertise.
- Map current expenditure, contracts, staff, waiting, unmet need, assets and provider capacity before any transfer.
- Agree the national rights, funding and workforce settlement through public and parliamentary scrutiny.
- Establish regional partnerships and test their readiness against governance, data, financial and community-participation standards.
- Transfer funding and commissioning in phases, beginning with national frameworks and selected regional functions.
- Review the model independently after three years against personal outcomes, access, sustainability, equality and administrative cost.

11. Common tests across every reform option

The Trust is one route to better social care. It should meet the same tests as NHS leadership and reformed local government: timely support; rights and meaningful choice; a valued workforce; sustainable providers; community influence; reduced inequalities; and sustained investment in prevention and everyday life. Assessment should show how resources shift from crisis response towards these aims.

Conclusion: an option for open consideration

An independent National Care Trust would give social care a national institution, a visible budget and direct accountability to Parliament, addressing the institutional status left open by Scotland's partnership reforms. Regional commissioning and locally shaped support would seek to combine national consistency, diverse provision and community influence. These are the model's proposed mechanisms; their value depends on whether they improve access, capacity and people's influence in practice.

Assessment must address genuine risks: remoteness, bureaucracy and inadequate funding. It should also examine the risks of pursuing national rights through dispersed authority and unequal partnerships. Giving social care an institution with clear purpose, legitimacy and responsibility could strengthen its place alongside the NHS as essential social infrastructure. The question is whether the Trust would deliver that promise in practice.

Selected references and policy context

- Scottish Government (2021), Independent Review of Adult Social Care in Scotland.
- Care Reform (Scotland) Act 2025.
- Scottish Government, National Care Service policy and co-design collection.
- Public Bodies (Joint Working) (Scotland) Act 2014.
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- Audit Scotland reports on social care, integration and Integration Joint Board finances.

Learning Across the Irish Sea

*What Scotland can learn
from Ireland and what
Ireland can learn from
Scotland*



Perspectives on the Future of Social Care in Scotland

A discussion paper for wider policy and
political debate

Executive summary

Ireland offers comparative learning for all three Scottish proposals, including NHS-led commissioning. Its arrangements illustrate the potential of national oversight, clear institutional responsibilities and coordinated commissioning. Assessment must connect these features to people's experience and examine the limits of structural reform, including differences between national arrangements and how services operate locally.

Scotland and Ireland share demographic pressures, increasingly complex needs, workforce shortages, provider sustainability challenges and rising expectations of quality, choice and control. They have taken different routes. Scotland has pursued integration, human rights, self-directed support and local partnership governance. Ireland has developed stronger national coordination through the Health Service Executive, central oversight of commissioning and institutional separation between commissioning and regulation.

Both countries still need to build sustainable, person-led and financially resilient systems. National coordination can strengthen consistency and clarity, while bureaucracy, waiting lists, workforce shortages, uneven access and provider fragility persist. Locally rooted, rights-based approaches offer strong foundations. Their success also requires clear accountability, consistent commissioning and effective national oversight.

The central proposition

- Governance reform must be judged by what changes for people, communities, workers and providers.
- National coherence must be combined with local responsiveness.
- Consistent commissioning must be accompanied by sustainable investment.
- Social care must retain its distinct identity, purpose and voice.
- Structural reform must be matched by investment in workforce and service capacity.

1. Introduction

The social care systems of Scotland and Ireland have evolved in response to similar social, economic and demographic trends. Both nations face growing demand arising from increased longevity, higher levels of multiple long-term conditions, frailty and dementia, alongside changing family structures, persistent workforce pressures and concern about long-term financial sustainability.

Their reform strategies have been different. Scotland's approach has largely focused on integration. The Public Bodies (Joint Working) (Scotland) Act 2014 established Integration Authorities and Health and Social Care Partnerships intended to align health and social care planning around shared outcomes and strategic commissioning. Ireland, while also pursuing integrated care ambitions, has retained stronger national control through the HSE and relies substantially on statutory, voluntary, community and independent providers operating through nationally shaped funding and accountability arrangements.

Useful comparison tests institutional design against people's experience. National coordination may coexist with difficult local access. Strong commitments to rights, personal outcomes and local partnership may coexist with inconsistent delivery. Assessing both design and implementation makes the lessons more reliable.

2. Understanding the Irish model

National commissioning and strategic stewardship

A defining characteristic of Irish social care is the central role played by the HSE. Through funding mechanisms arising from Sections 38 and 39 of the Health Act 2004, the HSE funds a substantial range of voluntary, community and other providers. Section 38 agencies provide services on behalf of the HSE under formal service arrangements, while Section 39 organisations receive grant support to deliver services that complement statutory provision.

National oversight is a potential strength of Ireland's model. Shared expectations guide funding, reporting, delivery and accountability across providers. Compared

with Scotland's numerous local commissioning bodies, this approach can provide a stronger basis for consistency, national intelligence and oversight of service capacity.

Assessment should distinguish consistent policies and contracts from consistent access and experience. National direction can lengthen decision-making chains, impose processes that fit local circumstances poorly and distance resource decisions from communities. Local influence and responsive implementation remain essential.

Regulation and quality assurance

The Health Information and Quality Authority develops standards, regulates designated social care settings, undertakes inspections and independently monitors quality and safety across significant areas of health and social care. Its organisational separation from the HSE helps distinguish the responsibilities of commissioner, provider and regulator.

Clear regulatory responsibilities support confidence and improvement. Inspection and standards identify shortcomings and guide action. Effective delivery also needs skilled workers, adequate funding and timely access. Regulation has an important role, with workforce and service shortages requiring wider system action.

3. The reality of the Irish model

Keep national decisions responsive and accessible

National consistency can reduce local variation. It can also slow decisions and limit providers' and local leaders' ability to adapt support. Clear accountability for the person seeking help requires accessible decisions and defined responsibilities at every level. Moving authority upwards can introduce new fragmentation, so that risk needs explicit attention.

Match clear responsibilities with timely access

Waiting and unmet need in community therapies, disability support, home support and other services show the gap between coordinated structures and available capacity. Clear responsibilities must sit alongside sufficient services, sustainable funding and an available workforce.

Invest in recruitment, retention and careers

Recruitment and retention remain difficult, particularly in rural areas. Reform needs to improve employment conditions, career pathways, workforce planning and the status of care. These investments build capacity; national structures alone leave workforce shortages unresolved

Assess fair access in every region

Regional access and service availability still vary with local capacity, workforce supply, provider presence and demand. Assessment should distinguish the entitlements people hold from the support they can obtain in practice, and identify the delivery mechanisms needed to secure fair access across different communities.

Give social care an equal voice alongside hospital priorities

Social care supports citizenship, relationships, autonomy, ordinary life and belonging. It also helps relieve hospital pressure. Health-led arrangements need to protect this wider purpose, expertise and voice, with safeguards against acute and clinical priorities dominating community and social care decisions. This is a question for the Irish comparison and for Scotland's NHS-led proposal.

Fund sustainable provision

Providers continue to face pressure from fees, inflation, workforce costs and short-term funding under nationally coordinated commissioning. Effective oversight requires realistic cost information and long-term planning. Funding adequacy needs explicit scrutiny because common national arrangements can also spread underfunding across services.

Design support around the person

People may still face complex eligibility rules, organisational boundaries and pathways shaped by available services. Success means receiving the right support at the right time, with meaningful choice and control. Assessment should test that experience directly.

4. Understanding the Scottish model

Integration as system reform

Scotland has sought to integrate health and social care in planning and delivery. The ambition recognises that people's lives cross institutional boundaries and that support should follow personal outcomes. Implementation has exposed continuing difficulties in governance, financial accountability, decisions and strategic commissioning. Resolving these remains central to realising integration's purpose.

Human rights and personal outcomes

Scotland's rights-based approach understands social care as a means of supporting citizenship, autonomy and belonging. Self-directed support, person-led planning, co-production and outcomes-focused commissioning give that purpose practical expression. Uneven implementation still leaves a gap between rights and experience. Meaningful choice requires available services and support to access them.

5. What Scotland can learn from Ireland, with cautions

Combine national consistency with local authority to act

National frameworks for funding, quality, Fair Work, service agreements and data could strengthen stability. They should define common entitlements and safeguards while giving local bodies authority over delivery. The aim is coordinated responsibility with decisions taken at the level best equipped to respond.

Make accountability clear from the person's perspective

Future reform should clarify responsibility and make routes for challenge and redress intelligible. Accountability should be tested from the citizen's perspective: who must act, by when, against what entitlement, and what remedy exists when support is delayed or denied?

Market stewardship requires national capability and honest funding

Scotland needs stronger national intelligence on unmet need, provider sustainability, workforce fragility, capacity and future demand. Oversight must be linked to true-cost methodologies, multi-year arrangements, contingency planning and meaningful provider partnership.

Align regulation and keep requirements proportionate

Regulators should assess how commissioning, funding and workforce supply affect services, alongside each provider's responsibilities. Clear, proportionate requirements should support improvement and keep compliance demands manageable.

Structural reform must be accompanied by capacity

Commissioning reform needs expanded community capacity, stable providers and workforce investment. Together, these can increase the care people receive. Changing responsibilities alone leaves existing service shortages unresolved.



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6. What Ireland can learn from Scotland

- Plan integration around people's lives and use institutional arrangements to support those priorities.
- Human rights can provide practical tests through dignity, autonomy, participation and equal citizenship.
- Co-production strengthens legitimacy when citizens, carers and providers have sustained influence over design and oversight.
- Judge support by personal outcomes and meaningful lives in connected communities, giving these priority over the volume of transactions.

7. Shared challenges

Both countries face challenges in funding, workforce supply, provider viability, choice and control, ethical technology use, digital infrastructure, environmental sustainability, climate resilience, rural provision and investment in prevention. Progress requires political priority, public investment, workforce capacity and a clear purpose for social care. National coordination and integration should help deliver those conditions, with assessment showing what changes in practice.

8. Principles for balanced Scottish reform

- National consistency should define rights, standards, fair funding principles and essential data while leaving room for genuine local design.
- Give social care a distinct identity and purpose, with equal influence alongside acute healthcare priorities.
- Use simpler structures to make support easier for people to access and experience.
- Commissioning reform should be inseparable from true-cost funding, workforce investment, Fair Work and provider sustainability.

- Accountability should include participation, transparency, accessible redress and independent scrutiny.
- Success should be measured through timely access, personal outcomes, equality and community connection as well as operational metrics.

Conclusion: learning from each other

The comparison identifies potential strengths and continuing limitations in both countries. Ireland's national oversight, regulatory separation and commissioning arrangements provide lessons alongside bureaucracy, waiting, uneven access, workforce shortages, provider insecurity and hospital-led priorities. Scotland's rights-based approach, community support, co-production and personal-outcomes focus provide a different set of lessons, alongside inconsistent implementation, dispersed accountability and insufficient capacity. The relevant test is which mechanisms improve support in practice and under what conditions

The opportunity is to learn from both countries: combine national consistency with local responsiveness, sustainable funding with human relationships, and strategic planning with community knowledge. People flourish in their homes, relationships and communities. That purpose should guide the institutional choices. The question for everyone involved in care and support is: what combination of rights, resources, relationships and responsibilities will best enable every person to live the life they choose?

Selected references and policy context

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**If you have any questions relating to this paper, please contact
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