

‘No man’s land’: the experience of patients at the interface between health and social care

Key points

- The health and social care interface often functions as a ‘no man’s land’, where people experience delays, confusion and gaps in support, particularly at moments of transition such as hospital discharge or when care needs change.
- Many of the most persistent problems at the interface stem from deeper structural issues, rather than miscoordination. Differences in funding, eligibility and accountability between the NHS and adult social care shape variation in access and fragmented experiences of care.
- Rising demand, particularly among older people with complex needs, is increasing pressure across the interface, contributing to avoidable hospital admissions, delayed discharge and greater reliance on families and unpaid carers.
- Expanding access to publicly funded social care would help ease these pressures, improving continuity of care and providing a more sustainable response to growing demand, alongside ongoing efforts to strengthen co-ordination between services.

Why is there a divide between health and social care?

Across England, health and social care are sometimes spoken about as though they form a single, seamless system. Yet anyone who has ever tried to navigate both knows that this is far from true. Within both the NHS and adult social care, people encounter variation, fragmentation and overlapping boundaries. Taken together, this creates a patchwork of distinct organisations with different statutory duties, funding models, incentives and cultures. The divide is most visible at the point where the two systems meet. This structure shapes how people experience care, especially those who rely on both the NHS and the adult social care sector simultaneously.

Baroness Casey, Chair of the Independent Commission on Adult Social Care, [described in her first public speech](#) the ‘deep and fundamental divide’ between health and social care, with the latter ‘the poor relation, forgotten and undervalued’. The roots of this divide are longstanding. Since its inception, the NHS has been universal and free at the point of use, predominantly funded nationally and designed around clinical treatment. Adult social care, by contrast, is means tested, funded by local authorities, and delivered under a different legal framework. This mismatch between access and accountability, and between medical and social models of care, [creates friction at precisely the moments when people most need seamless support](#).

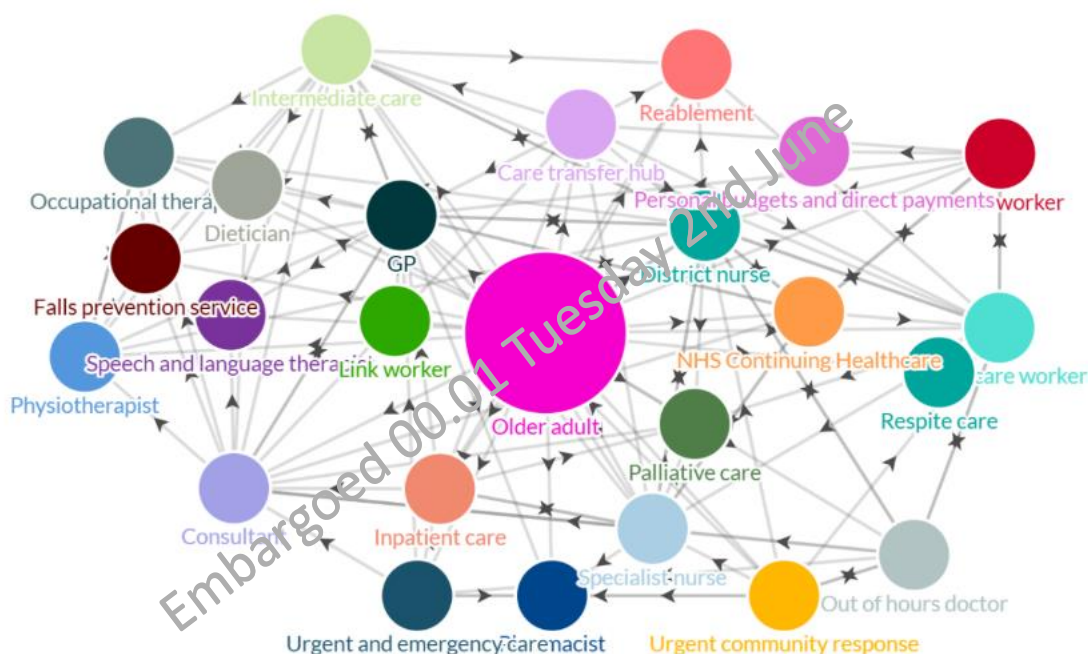
The pressures at the interface are intensifying. An ageing population means that more people are living with complex comorbidities, disability and frailty, which increases demand for both health and social care. This demographic shift, alongside workforce shortages and [low public satisfaction with the NHS and the adult social care sector](#), is stretching the system. Successive governments have recognised these challenges and attempted to respond through reform and reorganisation, from changes to NHS commissioning via legislation to the recent establishment of the [Casey Commission](#) to shape the future of adult social care. Yet daily dysfunction at the interface continues to harm people’s experiences and outcomes, drain scarce workforce capacity, and constrain NHS productivity.

In this piece we explore what the health and social care interface looks like in practice, highlighting the experiences of people stuck in the ‘no man’s land’ of where the two sectors meet. Drawing on common examples, such as Continuing Healthcare and discharge from hospital, this long read demonstrates how underlying structural tensions about health and social care funding, eligibility and responsibilities surface in the experiences of people who need care – and why incremental fixes alone struggle to resolve them.

What does the interface of health and social care look like?

The interface between the NHS and adult social care in England is not a single point. It is a dense web of interactions spanning prevention, urgent and emergency care, hospital treatment, rehabilitation, long-term support, and end-of-life care. These touchpoints or transitions represent some of the most vulnerable moments for individuals and their families, as well as being some of the most operationally challenging points for services. For many people receiving care, and indeed many delivering care, they [may not necessarily distinguish between ‘health care’ and ‘social care’](#).

Older adults may interact with many services across the NHS and social care



A non-exhaustive list of some of the many services, professionals and touchpoints across the NHS and social care that an older adult may interact with.



Across health and social care, many hundreds of thousands of staff work tirelessly to support patients and deliver high-quality, person-centred care. Yet the complexity, pressure and fragmentation of the system they work in often limit their ability to do so consistently. Different funding streams, commissioning arrangements and digital systems mean that [co-ordination can rely on relationships](#)

[and individual behaviours and attitudes](#). Under sustained pressure, these arrangements are fragile and difficult to sustain at scale.

This long read focuses on the experiences of older adults (aged 65 and over), who make up the largest group of users of the NHS and adult social care. However, many of the dynamics described also apply to other groups with complex or ongoing needs.

What is the experience of people requiring care across the interface?

When the interface between health and social care does not function as intended, people experience the consequences directly and often acutely. They may face longer hospital stays and delayed discharge resulting in preventable deterioration, unsafe transitions of care, poor communication and confusion over eligibility for care, as well as financial hardship and strain on family members acting as unpaid carers.

These failures are most sharply felt at moments of care transitions, such as from hospital to the community or from people's homes to care homes, when both sectors fail to take collective responsibility for ensuring that care needs are met. It is at these points that the interface becomes a 'no man's land' for people requiring care. Below, we have explored two common examples to illustrate this experience of being stuck in between the NHS and adult social care.

NHS Continuing Healthcare (CHC)

[CHC is a package of health and social care](#) provided outside hospital, often at home or in a care home, which is arranged and funded solely by the NHS. People who are eligible have long-term and complex physical or mental health needs. To qualify, their needs must primarily be for *health* care rather than for *social* care. CHC sits at the heart of the health and social care interface and has become a flashpoint for disputes about inequity, statutory responsibilities, and cost.

It's so blindingly obvious, but we need to start with people and their families and what they need, not who are the people providing it. CHC seems to be the worst-case example of fighting over whether something is a social care need or a health need, and who then pays for it.

[Sharon Allen OBE, Chief Executive of the Arthur Rank Hospice Charity, in conversation with Nuffield Trust](#)

CHC is a critical issue for local authorities and people who need social care because it funds not only an individual's health care – which would be free under the NHS anyway – but also their social care, which otherwise would be means tested. Since social care costs can be very expensive, it can make a huge financial difference to an individual (if they have to pay these costs themselves) or to the local authority (which would otherwise pick up the bill).

[Access to CHC is widely considered complex, opaque and inconsistent](#). It involves a referral, a multidisciplinary assessment using the [Decision Support Tool](#), and an eligibility decision – a process that can be [burdensome and difficult for families to navigate](#), with criteria that are hard to understand. Eligibility decisions and reviews can feel arbitrary or unfair, and leave people in need and their families in limbo. [Families often describe the process as 'a battle'](#), with long waits and delays for referrals and

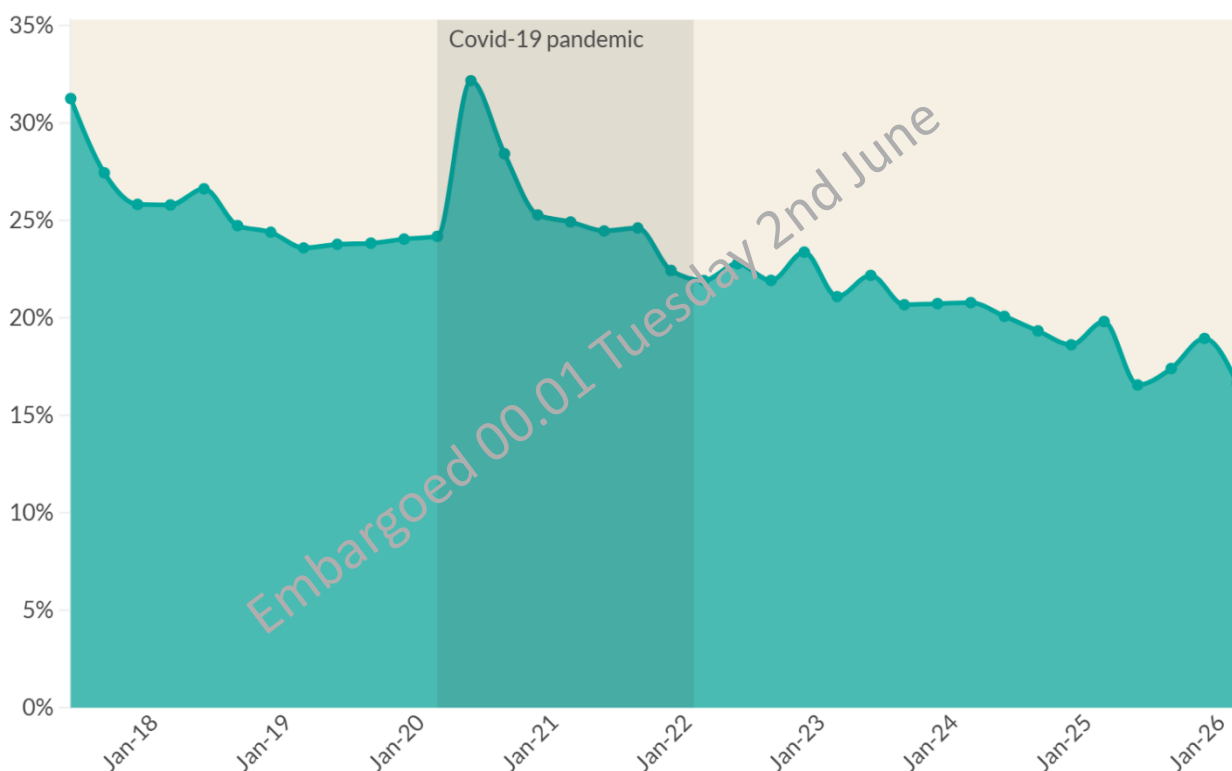
eligibility decisions, and in some cases people have [died before the assessment or appeals process is concluded](#).

Access to CHC has become more restrictive over time. Across England, [the proportion of people assessed for standard CHC who are found eligible has fallen](#) from around one in three (31%) in 2017 to fewer than one in five (17%) today. Alongside this, [variation in access between integrated care boards \(ICBs\) is a longstanding issue](#), with eligibility rates for standard CHC ranging from as low as 2% to as high as 35%. This is unlikely to be due to difference in need, suggesting that there are inconsistencies in how the national framework is interpreted and applied at a local level, which raises questions about fairness and creates significant uncertainty for families.

[Local authorities have reported that ICBs have shifted costs onto councils](#) via tighter eligibility thresholds, contributing to financial pressure in the social care sector. Meanwhile, [many people who should be eligible do not receive CHC at all, leaving them exposed to potentially catastrophic care costs](#). For those who do secure CHC, changes in eligibility can lead to moves between care homes,

The proportion of people assessed as eligible for Standard CHC has fallen from around 1 in 3 to fewer than 1 in 5

The percentage of people found eligible for Standard NHS Continuing Healthcare out of the total number assessed each quarter, 2017–26



Source: NHS England (2026)



destabilising the lives of individuals and their families.

A fast-track pathway for CHC exists to prevent delays for those who are at the end of life, but [some people still lose fast-track support on review, even when their needs have not improved](#). The uncertainty compounds emotional distress for these individuals and their families at what is already a very difficult time. [Variation in the balance between standard and fast-track routes between areas is a well-documented issue](#), leading to disputes between claimants, ICBs and local authorities, requiring resolution.

[In several areas, efforts have been made](#) to interpret and apply the framework more consistently at the local level, including providing training for CHC teams, providers, social care staff and NHS staff. [Joint teams between the NHS and local authorities can reduce duplication and speed up decision-making](#). Some areas use multidisciplinary panels to ensure that decisions reflect the full complexity of people's needs. More broadly, the most effective CHC approaches are those with strong relationships between commissioners and care providers, and where there is proactive work to align CHC with wider intermediate care, discharge and continuing care pathways.

What CHC exposes about the interface of health and social care

The fundamental problems of CHC are not solely due to poor co-ordination or inconsistent local practice. The requirement to determine whether a person has a 'primary health need' can force services and health care professionals into making distinctions that bear little relation to lived experience. Care needs associated with frailty, dementia or neurological conditions are rarely solely medical or personal, yet CHC requires them to be treated as such. In doing so, it transforms questions about how to best support each of the many tens of thousands of people with complex care needs into disputes about funding responsibility. Until this artificial divide between health and care is addressed, CHC will continue to generate instability, uncertainty and significant financial anxiety for those caught at this interface.

Delayed discharge

Delayed discharge occurs when someone is clinically ready to leave hospital, but the right package of support is not yet in place. Sometimes that support is social care, sometimes it is NHS community health services, and often it is a combination of the two. Delayed transfers of care remain one of the most visible symptoms of a failing interface between health and social care, with headlines warning about 'bed-blocking' every winter (and, increasingly, all year round).

Every day, on average, around [10,000 hospital beds](#) are occupied by patients fit for discharge. [Despite years of policy attention](#), people continue to spend unnecessary time in hospital after they are medically fit for discharge. The issue is particularly acute for older people with high levels of frailty, dementia and multiple long-term conditions, who are more likely to be admitted, to deteriorate in hospital environments, and to then require co-ordinated packages of care to return home safely.

The reasons for delay are often portrayed as social care-driven, such as waits for care packages or appropriate accommodation, or delays in arranging home support. These issues are real and all too common due to [shortages in the social care workforce, limited availability of intermediate care services and delays in transfer plans to residential care](#). However, [many delays in local systems actually originate within the NHS](#), including waits for other NHS services, access to medicines or therapies, completion of assessments, or bottlenecks in internal processes. When pathways rely on multiple organisations and teams acting in tandem, small delays or miscoordination can quickly compound.

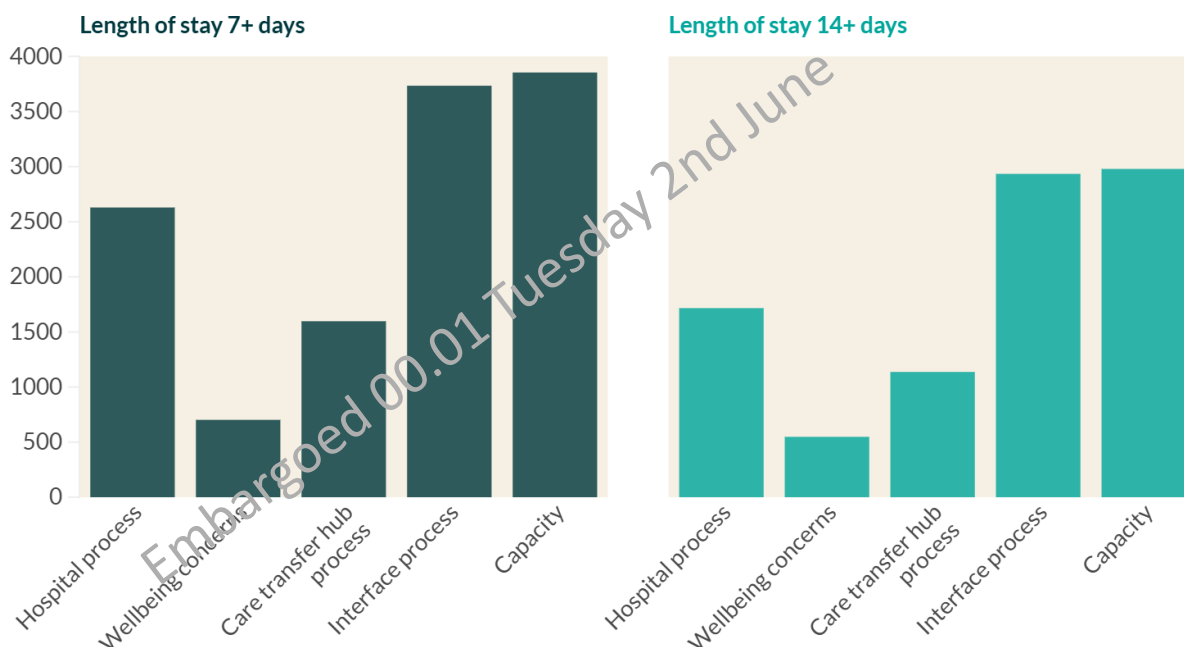
These delays have significant consequences. For individuals, unnecessary hospital stays contribute to [deconditioning, loss of independence, increased risk of infection, and poorer outcomes](#). People typically lose mobility and confidence the longer their hospital stay, sometimes to the point where they cannot return home safely. [Many patients and their families feel uninvolved in discharge decisions and unprepared for leaving hospital](#), causing undue stress, frustration and anxiety. [Healthwatch research has found that almost half of respondents were not given clear contact information after discharge](#), and many did not feel the care plan put in place was sufficient. Some were readmitted within days because essential support was missing.

Poor discharge flow also leads to [long waits for patients in emergency departments, corridor care, ambulance handover delays, and reduced hospital productivity](#) – with effects felt across the urgent and emergency care pathway. For staff, discharge can become a point of friction between sectors, exacerbated by cultural differences, relentless pressure to free hospital beds, and overlapping responsibilities.

In an effort to improve discharge, [care transfer hubs](#) are being rolled out nationally. These co-locate NHS, social care and community workers to co-ordinate transfers of care, manage real-time capacity, and streamline communication. They [carry out early discharge planning to reduce the risk of last-minute delays, act as a single point of contact, and often follow the discharge to assess pathway and/or](#)

Capacity and interface process delays are the most common reasons for delayed discharge

Average number of people per day with a length of stay of 7 and 14 days or over who no longer meet the criteria to reside in hospital but were not discharged, broken down by reason, in March 2026



Source: NHS England: Acute discharge situation report (2026)

'Interface process' covers delays where referrals have been made but discharge arrangements are still being worked through across organisations, including NHS community services, local authorities, social care, housing teams and families. 'Capacity' covers delays where the discharge plan is agreed but cannot proceed because services, placements, housing, equipment or workforce are not yet available. These delays span NHS services such as Continuing Healthcare or reablement, housing, equipment supply and social care.



[the home first approach](#). The [Better Care Fund](#) has helped in some areas by creating a pooled budget and shared priorities, although its [effectiveness varies and is sometimes undermined by short-term pressures](#).

What delayed discharge exposes about the interface

Despite examples of good practice, sustained improvement in delayed discharge is difficult without clearer and shared accountability for people leaving hospital and needing ongoing support. Systems are incentivised to manage risk and costs within organisational boundaries rather than considering the whole care pathway. Where areas perform better, they tend to treat discharge not as the end of health care or the start of social care, but as a joint responsibility requiring aligned decision-making, shared information, and collective ownership of outcomes. Fundamentally, improving delayed discharge will require a consensus between the NHS and the adult social care sector around responsibility for delivery of onward care.

What causes challenges at the interface – and what can be done?

The truth is those who need help feel this division every step of the way. They navigate their own way through a myriad of processes that we in ‘the system’ have cobbled together with drawn-out discussions on who pays for what. It is simply anxiety-laden and confusing.

[Baroness Casey, calling for a ‘moment of reckoning’ on adult social care](#)

The experience of people caught in the ‘no man’s land’ between the NHS and social care, as described in the previous section, is compounded by [significant unmet need in adult social care](#). Workforce shortages, fragile provider markets, and constrained local authority finances mean that many people are either receiving less support than they require or none at all. As a result, the interface often becomes a place where pressures within social care are felt most acutely.

The challenges that arise at the interface are often described as operational failings, and it is right to expect the NHS and adult social care to work together as effectively as possible. But even with improved operational performance, this alone would not overcome the scale and complexity of demand facing the system. Many of the persistent problems at the interface are better understood as the product of deeper structural misalignment between the NHS and adult social care. Here, we set out the main sources of this friction and consider what can – and cannot – be addressed within the current system.

Inherent structural misalignment

The NHS and adult social care were designed on two entirely different statutory bases and financial footings, and each with its own ethos. The NHS is a national, universal service, funded from general taxation and free at the point of use. It is directly accountable to NHS England and the Department of Health and Social Care. Adult social care is locally commissioned, means tested, and delivered under a separate legal framework – the 2014 Care Act – which places duties on local authorities rather than national government. These fundamental differences in eligibility and accountability mean that there are different decision-making bodies and funding flows, which create [different incentives, expectations and agendas](#).

These structural tensions shape cultures and behaviours throughout the system and can lead to disagreements, delays, and a transactional mindset. This can be seen in [cost-shunting](#) (moving patients – and therefore costs – between services), with NHS trusts pressured to meet operational performance targets while local authorities face ever-constrained budgets.

In addition, there are broader cultural differences between [a historically clinically focused NHS and a social care sector oriented towards individuals' wider wellbeing](#), with greater emphasis on independence and person-centred support. Although the NHS's increasing emphasis on population health offers an opportunity to narrow this divide, without conscious effort, these cultures can still clash rather than complement each other.

What can be done?

Stronger joint accountability at the system level can mitigate some of these effects, but existing arrangements have not yet delivered this consistently. Mechanisms such as the Better Care Fund and health and wellbeing boards have improved joint planning and pooled some resources, but they do not always translate to genuine joint activity. The government's push towards integrated neighbourhood teams similarly creates opportunities for more co-ordinated delivery, but without explicit shared accountability across organisations and a strong foundation of data-sharing and interoperability, these models risk layering new structures onto existing divides.

The government should refresh and strengthen the role of the Better Care Fund and set clearer national expectations that local leaders are collectively responsible for outcomes, with aligned incentives, shared performance measures, and stronger mechanisms for holding systems to account. System-wide data should inform commissioning decisions across NHS and local authority partners.

Fluctuating and fragmented commissioning

Local authorities and ICBs have different statutory duties and oversight mechanisms. Although there are tools under Section 75 agreements like the [Better Care Fund](#) to encourage collaboration and pool budgets, these arrangements can be [administratively complex, time-consuming and limited in scope](#). Some parts of the NHS, such as primary care, do not always sit neatly within joint arrangements and may fall out of pooled budgets entirely.

Repeated reorganisation of NHS commissioning has added further instability. The [statutory introduction of integrated care systems in 2022](#) brought together providers and commissioners of NHS services with local authorities, and [further changes in 2025 narrowed the role of ICBs and drastically cut their budgets by 50%](#). These structural changes [disrupt established ways of working](#) and make it harder for teams operating at the interface of health and care to build and maintain steady and effective working relationships. They also [draw leadership focus and time away](#) from improving day-to-day service delivery.

The government's ambition to [deliver more care through integrated neighbourhood teams](#), bringing together general practice, community services, social care and the voluntary sector, has the potential to improve co-ordination and shift care closer to home. However, delivering this model will depend on stable commissioning arrangements, clear accountability, and sufficient capacity at system level.

What can be done?

Pooled budgets allow organisations to plan and commission jointly, leading to shared accountability and fewer funding disputes. Some areas have pooled all intermediate care funding, enabling them to respond rapidly and flexibly to the needs of their local population. However, many places limit pooling to minimum Better Care Fund requirements. Simplifying Section 75 agreements and widening their scope to include more NHS functions would help spread this model of working and shift system behaviours. This is particularly important for addressing delays and gaps during transitions of care.

Stretched local authority budgets

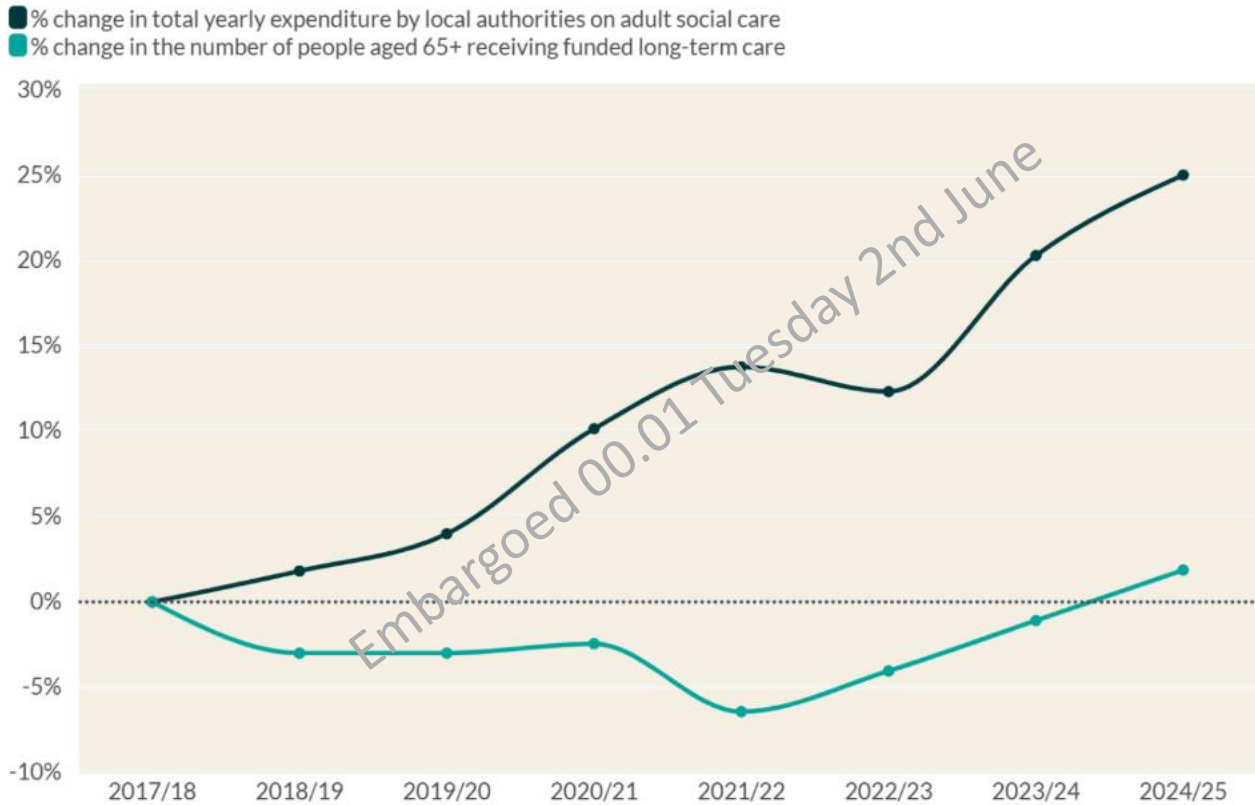
The fragility of the adult social care provider market and the precarious financial position of local authorities responsible for commissioning adult social care is a major source of strain at the interface. Although the NHS also operates under financial pressure, constraints in social care both drive additional demand into the NHS and slow the flow of people out of it.

Many adult social care [providers are struggling to meet rising costs, while local authorities are being forced to make savings even as the complexity and volume of need grows](#). The result is [increasing levels of unmet need, especially for people in more deprived areas](#). Older people and families are increasingly making up the shortfall through top-up fees, privately purchased care, or by going without support altogether. The number of older adults aged over 65 receiving funded long-term care fell between 2017/18 and 2021/22, and has not yet recovered to 2017/18 levels.

Embargoed 00.01 Tuesday 23rd June

Access to long-term care among older people has remained broadly unchanged since 2017/18, despite a 25% rise in local authority spending

Percentage change in the total number of people aged 65+ receiving long-term care during each year, and the yearly expenditure by local authorities on adult social care in real terms, compared to a 2017/18 baseline



Sources: DHSC adult social care finance, DHSC adult social care activity, NHS England Adult Social Care Activity and Finance Report
Inflation calculated using September 2025 GDP deflators from HM Treasury. The GDP deflator has been affected by the impact of Covid-19 on the economy. Long-term support is care is provided or arranged by local authorities and includes support delivered in the community, residential care, nursing care and in prisons.



What can be done?

Addressing stretched local authority budgets will ultimately depend on providing local government with greater certainty and sustainability of funding, so that access to care, fees paid to providers, and levels of support are driven by people's needs rather than by short-term financial constraint. This would reduce the extent to which unmet need spills over into hospitals and other parts of the NHS.

The gap between demand and provision

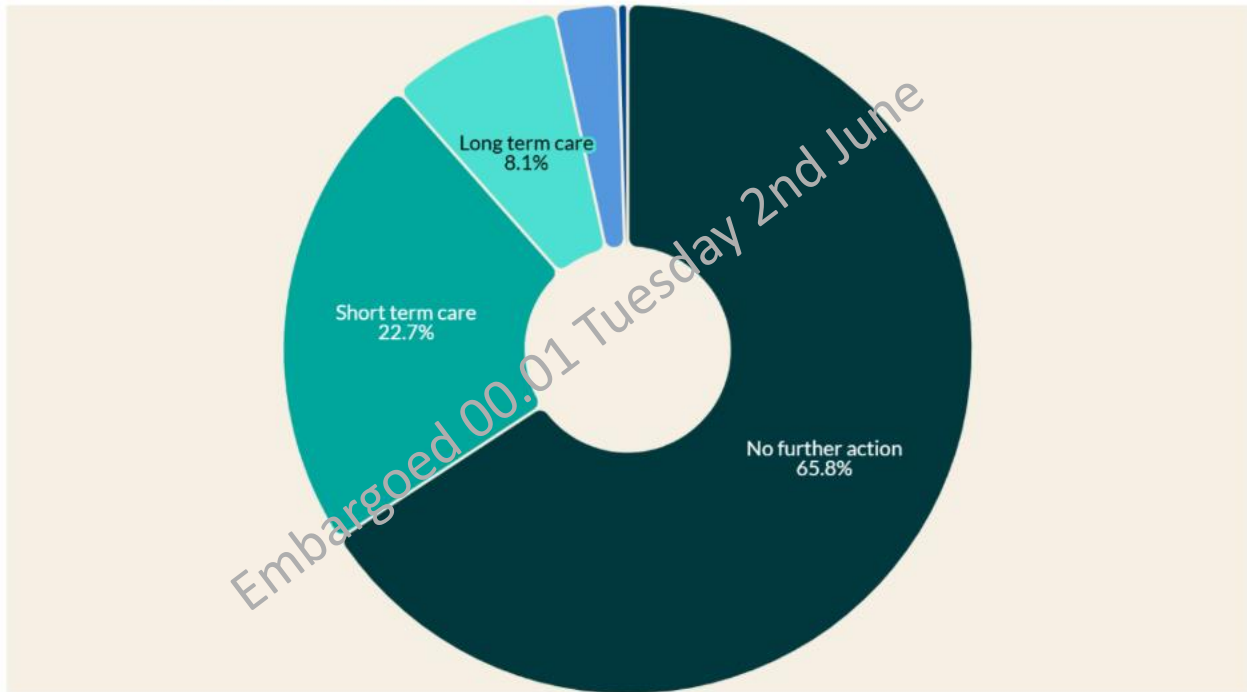
Community health services and [step-down intermediate care](#) are [consistently associated with better outcomes for patients](#). However, both [often lack sufficient capacity](#) to support timely discharge or prevent admissions. This reflects the reality that the NHS is not a single, uniformly resourced sector; [funding and workforce capacity are squeezed in community services](#), where investment has historically lagged behind acute care. The [latest national audit of intermediate care](#) found that delays in accessing both home-based and bed-based rehabilitation were common, undermining system flow. Services are

shaped by local needs and resources, meaning that [the type and quality of intermediate care people receive and the level of joint working and co-ordination can differ significantly from place to place.](#)

Less than a third of requests for support for people aged 65 and over resulted in funded long term or short term care

Care outcomes following requests for support received by local authorities from new clients aged 65 and over in 2024/25

■ No further action ■ Short term care ■ Long term care ■ Unknown ■ Admitted to hospital



Source: Department of Health and Social Care

A total of 1,301,885 requests for support were received by local authorities from new clients in 2024/25. Some outcomes have been grouped for the purposes of this chart: 'Long term care' includes long term care in community, nursing, prison, and residential care settings. 'Short term care' includes ongoing low level support, ST-Max, and other short term care. 'No further action' includes information and advice or signposting, deceased, moved to another LA, outcome stated and not found, referral to NHS services or NHS funded social care or end of life care, self-funded client, service ended as planned, and services not provided.



What can be done?

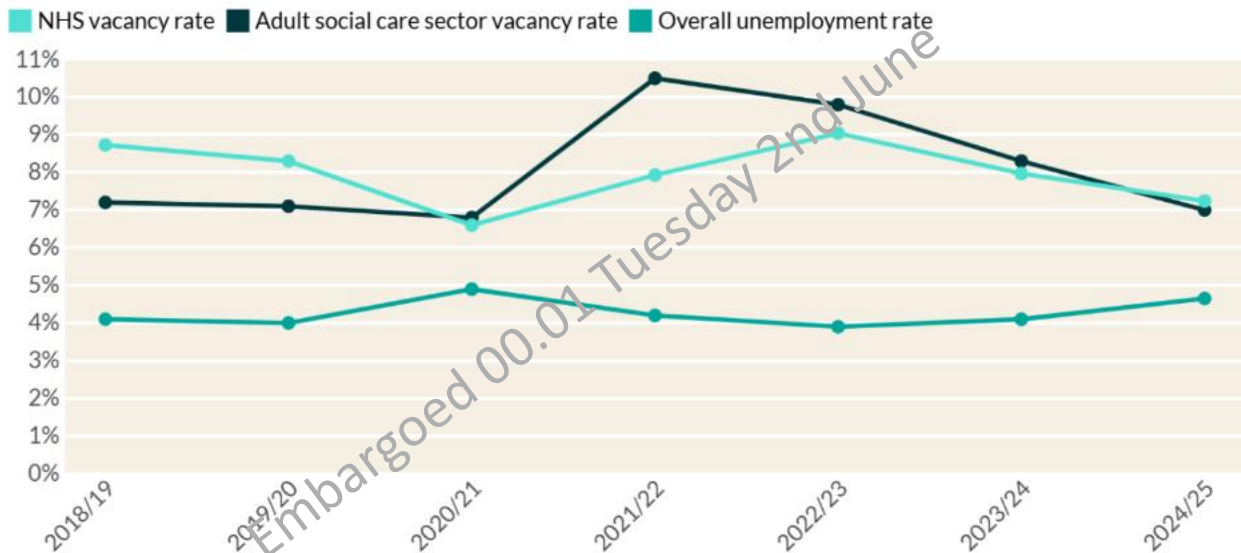
Targeted expansion of intermediate care and community-based support is an effective way to improve patient outcomes and experience, preventing hospital admissions and stabilising people in their own homes. However, investment must be matched with adequate workforce planning if improvements are to be sustained.

Workforce pressures

Although both the NHS and adult social care sectors face staff shortages, high turnover and burnout, the pressures are particularly acute in the social care workforce. [Pay, terms and conditions, and career progression lag significantly behind the NHS](#), affecting [retention and recruitment](#). Providers struggle to compete with other local employers, leading to persistent care worker vacancies and high churn: in March 2025, there were an [estimated 90,000 social care vacancies](#).

The adult social care and NHS vacancy rates are higher than the overall unemployment rate

Percentage of the population that are unemployed, and respective percentages of social care and NHS posts that are unfilled, England



Source: Skills for Care 2024/25, NHS Vacancy Statistics
Partly reproduced from Skills for Care analysis. Social care vacancy data are for the independent and local authority sectors only.



Unequal pay, terms and conditions contribute to social care professionals moving from social care into NHS roles, reducing capacity in one part of the system without increasing overall system capability. At the same time, [workforce gaps in the NHS in community nursing, therapy services and primary care](#) constrain capacity at the points where collaboration with social care is most important, such as discharge and reablement. When the workforce in both sectors is stretched, neither has enough headroom for effective collaboration or time to embed shared approaches.

What can be done?

The effectiveness of the interface depends on strengthening both the social care and NHS workforces to ensure sufficient capacity across the system. The [government's fair pay agreement](#) in adult social care is an important step towards addressing longstanding issues of pay and conditions, which are central to improving recruitment and retention. More fundamentally, [the Casey Commission should consider wider reforms to conditions, training pathways and career development, and better recognition of the role of the social care workforce](#). Addressing existing disparities is critical to reduce churn between sectors and ensure that workforce supply is aligned with the areas of greatest need across the care pathway.

[Delegating health care activities](#) to trained care workers, supported by NHS clinical governance, has proven to be effective in some areas by reducing delays, building skills and strengthening continuity of care. However, this relies on a stable and skilled social care workforce and sufficient NHS capacity in community and primary care to support them.

Complex routes to accessing support

The NHS and social care operate under different structures, which means that eligibility tests, funding pathways, assessment tools and legal duties overlap and diverge in ways that even commissioners find challenging. For individuals and their families, these differences are [bewildering, unfair, and difficult to navigate](#). People often describe feeling ‘passed around’ or forced to repeat their stories to multiple teams. CHC assessments (as noted earlier) have [long been criticised for inconsistency and opacity](#), and [variation in access is well-documented](#). This complexity drives variation, disputes and administrative burden.

What can be done?

Reforming poorly functioning access routes for care would help reduce the harm, distress and instability experienced by many people and families at the interface. NHS Continuing Healthcare, in particular, plays an important and often overlooked role in social care, yet access has been falling. A government review is needed to address unwarranted variation, apply stronger national oversight to bring about more consistent application across ICBs of the national CHC framework, and standardised training for assessors. Backlogs could be reduced by simplifying triage, limiting ineligible referrals, and making community-based assessment the default. Clearer, more timely communication throughout the process would also help reduce anxiety and improve transparency in decision-making.

More fundamentally, the Casey Commission’s initial recommendation for the DHSC to look at a fast-track process that speeds up assessments and access to care for people diagnosed with motor neurone disease (MND) will, in practice, inevitably require scrutiny of CHC’s current role in meeting this need, not just for individuals with MND, but for all people with life-limiting conditions in urgent need of access to care. It should also prompt further thought from the Commission about the role that CHC plays within the overall social care system.

Weak data-sharing and digital infrastructure

Too often, [incompatible systems, limited shared care records, and confusion about information governance hamper seamless care](#). This contributes to duplication, poor discharge co-ordination, and avoidable risk at points of transition of care. Although progress has been made through the digitising social care programme, with [80% of providers now using digital social care records](#), more work is needed to reach complete digitisation of social care records, and to ensure that digital systems are embedded, interoperable, and used to support joined-up care. Without this join-up, letters and emails remain the only way to share data. Delays to the implementation of electronic patient records (EPRs) are also hampering progress, limiting the ability to share information reliably across settings.

What can be done?

Progress requires a more coherent and system-wide approach to digital and data. Completing the rollout of EPRs across the NHS and achieving full digital adoption in social care are essential first steps, alongside clearer and more consistent data standards to support interoperability. Digital infrastructure should support multidisciplinary teams working across settings, including through emerging models such as neighbourhood health services, virtual wards and remote monitoring. The [NHS intermediate](#)

[care framework](#) sets out good practice for harnessing high-quality data to support co-ordinated planning and performance improvement.

Equally importantly, leadership across health and care is crucial to support cross-working, strengthen information governance and build trust between the NHS and social care in data-sharing, increase staff confidence and skills in using digital tools, and ensure co-ordinated procurement of digital systems.

Claiming the ‘no man’s land’ between health and social care: The King’s Fund’s view

We are living with a broken social care system. It is not providing adequate care to the people who need it, it is creating ever-increasing costs for local authorities and the NHS, and it is putting unsustainable pressure on unpaid carers, many of whom have to leave work to care for loved ones.

[House of Commons Health and Social Care Select Committee](#)

There is clearly scope to improve people’s experience within the current system. Clearer access routes, fairer and more transparent CHC processes, better discharge planning, and stronger information-sharing can all make a difference in the short term. Equally important is ensuring that people and carers are better informed, supported and involved in decisions about their care, particularly at moments of transition.

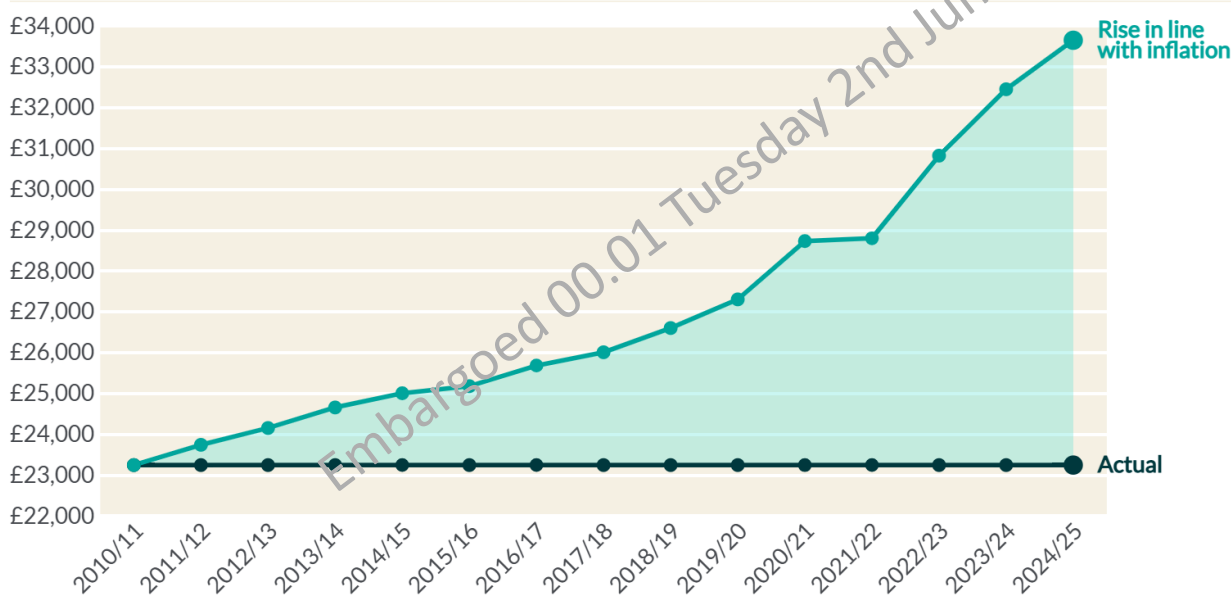
The public are right to expect that the NHS and adult social care sector work together as effectively as possible for the people they serve. But these improvements will still be taking place in a system in which eligibility, accountability and funding are fundamentally misaligned.

The experiences and challenges described throughout this long read point to a consistent issue: a system that restricts access to publicly funded social care too narrowly. For people whose needs fall just below formal thresholds, or fluctuate over time, the interface becomes a ‘no man’s land’ where responsibility is contested, support is delayed, and need is unmet.

The King’s Fund’s view is that improving the interface between health and care depends on widening eligibility for publicly funded social care. [There are different ways this could be achieved – and all come at a cost.](#) Making the current means tested system more generous would represent a minimum step forward by providing protection for more families against catastrophic care costs. Other options, such as free personal care or social insurance models, would go further in narrowing the gap between health and care by increasing collective risk-sharing and providing clearer entitlement.

If the social care financial assessment (means test) had kept pace with inflation it would be £10,404 higher today

Actual threshold compared to inflation-adjusted threshold, 2024/25



Source: Local authority circulars 2024/25

Inflation calculated using September 2025 GDP deflators from HM Treasury. The GDP deflator in 2020/21 was heavily affected by the impact of Covid-19 on the economy. Axis compressed to allow greater visibility.



Wider eligibility for publicly funded social care would not, on its own, solve every problem at the interface, but it would significantly reduce the need to draw artificial boundaries between 'health' and 'care' for people in need. This matters not only for fairness, but for how the whole system functions. Wider eligibility could ease pressure at the interface by reducing cost-shunting and disputes over who pays, enabling faster and more efficient transitions of care, and tackling variation in provision of support. It could also give more people greater clarity about what they can expect from the system and greater security as their needs change over time.

The Casey Commission offers a critical opportunity to confront this head-on. Its focus on the future design of adult social care should explicitly consider how eligibility can be widened and made more consistent, including [whether a national approach to assessing need could reduce variation and rationing driven by local financial constraint](#). Any such reform would need to be carefully managed, but avoiding the question risks entrenching the very problems the Commission seeks to address.

Ultimately, policy-makers face a choice: they can continue with a system in which access to publicly funded social care is tightly rationed, leaving people, families and other parts of the system to absorb the consequences, or they can widen eligibility and rebalance responsibility between the state and the individual. The latter is undoubtedly more politically and fiscally challenging, demanding national leadership, sustained investment, and buy-in from the public. But it is also the most credible and sustainable response to an ageing population and rising care needs. Widening access would mean a

clearer, fairer offer of support over the course of people's lives, reclaiming the land between health and social care as a space where people can expect continuity and quality of care when they need it.

Further reading:

[Social care 360 \(2026\)](#)

[Fixing social care: the six key problems and how to tackle them \(2025\)](#)

[Integrated care systems and social care: the opportunities and challenges \(2021\)](#)

[Making our health and care systems fit for an ageing population \(2014\)](#)

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