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REGULATION VS FLEXIBILITY: A COMPARATIVE STUDY OF MICRO-CARE MODELS IN DECENTRALIZED SOCIAL CARE SYSTEMS

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Abstract

The English adult social care landscape has progressively decentralized through the Care Act 2014, expanding personal budgets and direct payments and creating space for very small, community-based "micro" providers alongside conventional larger providers (Department of Health, 2014). This study compares regulation-led and flexibility-led micro-care models within this decentralized system to assess how their different balances of compliance and adaptability shape access, personalisation, workforce stability, and value for money. Drawing on a structured secondary analysis of 2024–2025 administrative datasets from the Care Quality Commission, Skills for Care, the Department of Health and Social Care, and the Association of Directors of Adult Social Services, the study triangulates provider counts, ratings, vacancy and turnover rates, expenditure, and client-level data across England (Care Quality Commission, 2025; Skills for Care, 2025). The hypothesis was that flexibility-oriented micro-providers achieve stronger personalisation outcomes while regulation-oriented providers show stronger compliance signals. Findings show that micro-providers deliver more tailored support and lower hourly costs, while regulated medium and large providers dominate capacity and inspection coverage. The paper concludes that hybrid commissioning that protects flexibility within proportionate regulation is the most viable pathway for sustainable decentralized care.

Keywords: *decentralized social care[1], micro-enterprises[2], personalisation[3], regulation[4], Care Act 2014[5].*

1. Introduction

Adult social care in the United Kingdom has shifted decisively over the past decade from a centralized, council-delivered model toward a decentralized, mixed-economy system in which 153 upper-tier local authorities commission and oversee a diverse set of independent providers (Foster, 2025). The Care Act 2014 codified this shift by giving every eligible adult a legal entitlement to a personal budget and the right to request a direct payment, thereby allowing individuals to commission their own care from a wider market that includes small community-based "micro-providers" (Department of Health, 2014; Samsi & Manthorpe, 2017). By 2024–2025, gross current expenditure on adult social care in England had reached £29.4 billion, with total expenditure of £34.5 billion, of which roughly 80% was directed to long-term support (Department of Health and Social Care, 2025a; Foster, 2025). Within this decentralized architecture, two ideal-typical approaches to care delivery have

emerged. The first is a regulation-led model, dominated by medium and large CQC-registered care homes and domiciliary agencies that operate within a prescriptive Single Assessment Framework introduced in 2024 (Care Quality Commission, 2025). The second is a flexibility-led micro-care model, exemplified by community micro-enterprises with five or fewer employees, frequently supported by intermediary networks such as Community Catalysts, which prioritise tailored relationships, local responsiveness and individual choice over standardised processes (Community Catalysts, 2024; Needham, Allen, & Hall, 2016).

The trade-off between regulatory assurance and operational flexibility has become a central policy question. Regulation-heavy oversight is intended to safeguard quality and protect people from harm, but it can also impose disproportionate compliance costs on small providers and discourage innovation (Glasby et al., 2018). Conversely, flexibility-led micro-models have been associated with better personalisation, stronger user voice, and lower hourly costs, yet they often operate "below the radar" of formal commissioning, raising concerns about safety, sustainability, and equitable access (Needham & Carr, 2015; Bristol University Press, 2016). The UK provides a strategic context for studying these dynamics because the Care Act 2014 framework, the financial pressures revealed in successive ADASS surveys, and a vacancy rate of 7% in 2024/25 (around three times that of the wider economy) make the regulation–flexibility tension empirically observable (Skills for Care, 2025; Association of Directors of Adult Social Services, 2025). This paper therefore asks: how do regulation-led and flexibility-led micro-care models compare across personalisation, workforce stability, capacity, and value within England's decentralized social care system, and what configuration produces the best balance?

2. Literature Review

A coherent body of UK research has examined how decentralization, personalisation, and provider scale interact to shape care quality. Foundational work conceptualised personalisation as both a normative ideal and a marketisation device, with Needham (2011) arguing that the personalisation narrative was deliberately designed to support a more pluralistic provider market. Samsi and Manthorpe (2017) traced how the Care Act 2014 operationalised this through statutory wellbeing duties, eligibility frameworks and personal budgets, while emphasising that translation into practice depends heavily on local authority capacity. Recent Bourdieusian analysis by Hudson (2025) shows that austerity, a 12% real-terms fall in per-person social care spend by 2018/19 and persistent staffing shortages have constrained the realisation of these emancipatory ambitions. The dedicated micro-enterprise literature is anchored in the ESRC-funded "Does Smaller Mean Better?" programme. Needham, Allen, and Hall (2016) compared 27 organisations (including 17 micro-enterprises) and concluded that micro-providers achieved more personalised, innovative, and lower-cost care than larger counterparts. Glasby et al. (2018) refined this analysis through their "Goldilocks question," showing that size operates as an independent variable in care quality, with micro-enterprises strongest on personalisation but weaker on workforce development and resilience. Allen, Needham, Hall, and Tanner (2019) further examined the methodological tensions of evaluating these small providers using validated outcome measures, highlighting the challenge of capturing relational value within standardized regulatory metrics.

A parallel strand has examined micro-provision for marginalized groups. Needham and Carr (2015) reviewed how community-based micro-providers respond to needs that mainstream services often fail to meet, particularly for people with protected characteristics under the Equality Act 2010, while warning that mainstream providers should not abdicate inclusion responsibilities. Henderson, Hall, Mutongi, and Whittaker (2019) extended this through a realist evaluation of social enterprise delivery, demonstrating that flexibility and "boundary-spanning" community ties are mechanisms that improve outcomes. Wider system literature confirms similar patterns: Hanlon et al. (2024) describe integrated place-based services as dependent on micro-level relational coordination, while Noble et al. (2024) map innovation across English regions and show that smaller, locally rooted services often pioneer new responses to inequality. Workforce evidence completes the picture.

Skills for Care (2025) reports 1.60 million filled posts and 111,000 vacancies in 2024/25, with turnover rates substantially lower for international staff. Foster (2025) and the Institute for Government (Pope, Davies, Iacobov, & Tetlow, 2025) document how international recruitment temporarily eased pressures before 2025 visa restrictions narrowed this route. The Care Quality Commission (2025) shows homecare vacancy rates above 10%, more than double those of care homes, suggesting that decentralized community-based delivery faces the most acute workforce risk. Across this literature, a clear gap remains: few studies systematically compare regulation-led and flexibility-led models using the most recent 2024–2025 administrative data. This paper addresses that gap.

3. Objectives

1. To compare regulation-led and flexibility-led micro-care models on personalisation, workforce stability, capacity, and value for money in England's decentralized social care system.
2. To identify policy and commissioning configurations that balance proportionate regulation with the flexibility required for sustainable micro-care provision.

4. Methodology

The study adopts a comparative, mixed-methods secondary analysis design situated within England as the study area, since it offers the richest, most consistent administrative dataset on decentralized adult social care and a clearly defined statutory framework under the Care Act 2014. The unit of analysis is the provider model, operationalised along a regulation–flexibility continuum, with regulation-led providers identified as larger CQC-registered care homes and domiciliary agencies operating under the Single Assessment Framework, and flexibility-led providers identified as community micro-enterprises with five or fewer employees, including those supported through the Community Catalysts development programme (Care Quality Commission, 2025; Community Catalysts, 2024). The sample comprises the full national population of CQC-registered adult social care provider locations active during 2024–2025 ($n \approx 17{,}500$ locations), cross-referenced with Skills for Care workforce records covering 1.60 million filled posts and approximately 18,500 establishments (Skills for Care, 2025). For micro-providers, sample evidence is drawn from Community Catalysts' published 2023–24 impact report covering 599 supported micro-enterprises across England and Wales (Community Catalysts, 2024) and from the Needham, Allen, and Hall (2016) case-study cohort of 27 organisations.

Tools and data sources include: (a) CQC State of Care 2024/25 ratings and inspection data; (b) Skills for Care State of the Adult Social Care Sector and Workforce 2025 estimates; (c) DHSC monthly statistics for adult social care, including occupancy and Capacity Tracker domiciliary care figures (Department of Health and Social Care, 2025b); (d) DHSC Adult Social Care Finance Report 2024–25; (e) ADASS Spring Survey 2025; and (f) peer-reviewed studies cited in the literature review. Techniques include descriptive statistical analysis (proportions, mean comparisons, percentage change calculations), narrative synthesis aligned with the four comparison dimensions, and triangulation across independent sources. No primary data collection was undertaken; therefore, ethical approval was not required, and all data are publicly available official statistics or peer-reviewed evidence.

5. Results

Table 1. Capacity of Adult Social Care in England, 2024–2025

Indicator	Value	Period
People receiving CQC-regulated domiciliary care	505,886	Week ending 16 Feb 2026
Occupied care home beds	85.8%	Week ending 16 Feb 2026
People receiving an LA assessment (no prior support)	599,000	Jul 2024–Jun 2025
Care home visiting accommodated	99.5%	14 Oct 2025
Population rate of LA assessments	1,290 per 100,000 adults	Jul 2024–Jun 2025

Source: Department of Health and Social Care (2025b); Department of Health and Social Care (2026)

Table 1 indicates that the regulation-led component of the system carries the bulk of capacity, with over half a million people receiving regulated domiciliary care and care home occupancy stable at 85.8% in early 2026. Assessment volumes (599,000 people; 1,290 per 100,000 adults) confirm that the system is high-throughput and demand-led. The very high visiting rate (99.5%) suggests that, despite criticism of regulation, formal providers maintain core access standards consistently across regions.

Table 2. Adult Social Care Workforce, England, 2024/25

Indicator	Value
Filled posts	1.60 million
Vacant posts	111,000
Vacancy rate	7.0%
Turnover rate (independent sector)	24.7%
Homecare vacancy rate	>10%
Health and Care Worker visas issued	7,891

Source: Skills for Care (2025); Care Quality Commission (2025)

Table 2 shows that workforce capacity has stabilised, with the vacancy rate falling to 7.0% from 10.5% at its 2021/22 peak, and turnover dropping to 24.7%. However, homecare vacancy rates above 10% are more than double those for care homes, which signals that the decentralized, community-facing part of the regulation-led model remains the most fragile workforce segment. The collapse of new Health and Care Worker visas to 7,891 in 2024/25 suggests further pressure ahead.

Table 3. Adult Social Care Expenditure, England, 2024/25

Indicator	Value (£bn)
Total expenditure	34.5
Gross current expenditure	29.4
Long-term support spend	23.6
Real-terms increase vs 2023/24	4.1%
Long-term support: working-age adults	11.5
Long-term support: older people	12.0

Source: Department of Health and Social Care (2025a); The King's Fund (2025)

Table 3 confirms the financial scale of the decentralized system: total expenditure rose to £34.5 billion in 2024/25, an increase of 4.1% in real terms and 29% above 2015/16. Long-term support absorbs 80% of gross current spend, and expenditure is split almost evenly between working-age adults (£11.5bn) and older people (£12.0bn). This confirms the regulation-led infrastructure dominates fiscal flows, leaving micro-models comparatively under-resourced despite policy aspirations under the Care Act 2014.

Table 4. Micro-Enterprise Outcomes versus Larger Providers

Outcome	Micro-enterprises	Medium/Large providers
Mean hourly cost	Lower	Higher
Personalisation score	Higher	Lower
Innovation prevalence	More frequent	Less frequent
Workforce resilience	Lower	Higher
Number of case-study organisations	17	10

Source: Needham, Allen, and Hall (2016); Glasby et al. (2018)

Table 4 summarises comparative findings from the seminal "Does Smaller Mean Better?" study. Micro-enterprises outperform larger providers on personalisation, innovation, and hourly cost-efficiency, but are weaker on workforce resilience and operational scale. The relatively small comparison sample (17 micro vs 10 larger) limits generalisability, yet the consistent direction of effects across multiple outcome domains supports the flexibility hypothesis advanced in this paper.

Table 5. ADASS Indicators of System Strain, 2024/25

Indicator	Value
Net adult social care budget overspend	£774 million (3.46%)
Authorities exceeding budget	80%
Planned net budget 2025/26	£22.4 billion
Average homecare hourly fee 2025/26	£23.85
Homecare Association minimum sustainable rate	£32.14
Planned cut in prevention spend 2025/26	-11.6%

Source: Association of Directors of Adult Social Services (2025); Foster (2025)

Table 5 reveals deep system strain in the regulation-led architecture. A £774 million overspend, the highest in a decade, and 80% of authorities breaching budgets, are accompanied by an average commissioned homecare fee (£23.85) that is 25.7% below the Homecare Association's minimum sustainable rate. The 11.6% planned cut to prevention budgets in 2025/26 directly threatens the upstream community ecosystems on which flexibility-led micro-providers depend, indicating that fiscal stress is now compressing both ends of the regulation–flexibility continuum.

Table 6. Community Micro-Enterprise Reach, 2023/24

Indicator	Value
Micro-enterprises supported (Community Catalysts)	599
Local Area Coordination Network reach	>1 million people
Big Conversation participants (Nottinghamshire)	542
Worcestershire residents supported to start enterprises	165
Programmes delivered	59

Source: Community Catalysts (2024)

Table 6 quantifies the reach of one of the most established flexibility-led infrastructures in England. Community Catalysts supported 599 active micro-enterprises and reached more than one million people through the Local Area Coordination Network in 2023/24. The Nottinghamshire "Big Conversation" included 542 participants in co-producing strategy, illustrating how flexibility-led models also generate civic engagement. While the absolute scale is modest compared with regulated provision, the qualitative depth of reach supports the personalisation hypothesis.

6. Discussion

The findings, examined directly against the two stated objectives, support a nuanced rather than binary reading of the regulation–flexibility debate. With respect to Objective 1, the comparative evidence suggests that each model is dominant on a different dimension. Regulation-led providers, captured in Tables 1, 2, and 3, control the bulk of capacity, occupancy, regulated workforce volume, and expenditure. They process more than 505,000 people in regulated domiciliary care alone, account for the £34.5 billion fiscal footprint, and underpin nationally consistent access standards. Flexibility-led micro-care providers, captured in Tables 4 and 6, dominate on personalisation, innovation, and lower hourly cost, with an empirically grounded but smaller footprint of 599 active micro-enterprises and a Local Area Coordination reach above one million people. This pattern is consistent with the original "Does Smaller Mean Better?" findings of Needham, Allen, and Hall (2016) and the Goldilocks framing of Glasby et al. (2018), which found micro-enterprises strongest on personalisation but weaker on workforce sustainability.

The workforce evidence in Table 2 deepens this comparative reading. The headline reduction in vacancy rates to 7% disguises a homecare vacancy rate above 10%, indicating that the part of the regulated system that most resembles micro-care, namely community-based delivery, is also the most fragile. This converges with concerns raised by Hudson (2025) about the gap between Care Act ambitions and lived workforce conditions, and with the Institute for Government analysis (Pope et al., 2025) showing that international recruitment, not domestic supply, has been doing most of the stabilising work. For flexibility-led micro-providers, who often cannot offer competitive employment packages or international visas, this signals a structural workforce vulnerability that regulation alone cannot address. The fiscal evidence in Tables 3 and 5 also speaks to Objective 1. Despite a £34.5 billion budget and a 4.1% real-terms expenditure increase, 80% of local authorities overspent in 2024/25, and the gap between the average commissioned homecare rate (£23.85) and the Homecare Association's minimum sustainable rate (£32.14) is approximately 26%. This means that the regulation-led system is being purchased below cost, while the prevention budgets that nourish flexibility-led ecosystems are being cut by 11.6% (Association of Directors of Adult Social Services, 2025; Foster, 2025). Both ends of the continuum are therefore being squeezed, which undermines the stylised assumption that more regulation automatically protects quality.

With respect to Objective 2, the evidence points clearly toward a hybrid commissioning configuration rather than a binary choice. Drawing on Needham and Carr (2015), Henderson et al. (2019), and Hanlon et al. (2024), the most viable configuration appears to be one in which proportionate regulation, calibrated to organisational scale and risk, is combined with sustained investment in flexibility-led infrastructure such as Community Catalysts and Local Area Coordination. This allows the regulation-led system to anchor capacity, safety assurance, and continuity of care for highly dependent users, while the flexibility-led micro-care model contributes personalisation, innovation, and access for groups that are persistently underserved by mainstream provision. Direct payments under the Care Act 2014 already provide the legal mechanism for this hybrid, but uptake remains uneven. A second policy implication, supported by Tables 5 and 6, is that prevention spending is the structural hinge between the two models. When prevention is funded, micro-enterprises and community networks can flourish, taking pressure off the regulated system; when prevention is cut, both models become

more fragile and reactive. The ADASS Spring Survey 2025 finding that prevention spend will fall from 8.2% to 5.6% of net adult social care expenditure between 2023/24 and 2025/26 therefore represents a significant strategic risk for the entire decentralized architecture (Association of Directors of Adult Social Services, 2025). Sustaining prevention is, in effect, the commissioning lever that determines whether flexibility-led models can continue to complement the regulated system. Taken together, the discussion confirms the hypothesis: flexibility-oriented micro-providers do show stronger personalisation and cost-efficiency signals, while regulation-oriented providers show stronger compliance, capacity, and workforce signals. The optimal configuration is neither pure regulation nor pure flexibility, but a deliberate, well-resourced hybrid.

7. Conclusion

Decentralized adult social care in England in 2024–2025 is shaped by a productive but unstable tension between regulation-led assurance and flexibility-led personalisation. Regulation underpins capacity, expenditure, and consistency; flexibility-led micro-care models offer the personalisation, innovation, and community embeddedness that the Care Act 2014 promised but that large-scale provision struggles to deliver. The evidence presented across six tables, drawn from official 2024–2025 administrative data and peer-reviewed research, indicates that fiscal strain, workforce fragility, and prevention cuts now jeopardise both ends of the spectrum simultaneously. The most defensible policy direction is a hybrid commissioning model that applies proportionate regulation, sustains prevention funding, and invests in micro-enterprise infrastructure so that decentralization delivers on its statutory promise of choice, control, and wellbeing.

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