



A New Approach to Health and Social Care: Integrated, Personalised and Cost-effective

Using tried and tested existing policies, flexibilities and processes differently can make all the difference

Executive summary

Resources are to be shifted from hospital to community, from disease to prevention enabled by technology. This paper sets out the ways of maximising the health outcomes and productivity gains from these shifts.

It proposes a means of implementing Integrated Neighbourhood Teams in practice, including pooled place-based budgets across health and care, and removing charging for domiciliary social care. Place-based budgets are delegated to local neighbourhood teams to control as their operating budget, which is used to fund staff, personal health / integrated (i.e. holistic) personal budgets and community development.

The use of the Comprehensive Model of Personalised Care, savings in assessment and administration costs, and efficiencies from adopting modern technology, to offset additional spending on a broader range of community support options keeping people well at home, including through removing charging for domiciliary care. The pooled budgets set up to fund this, include a cap on Local Authority contributions, enabling more of their resources to be spent on prevention. This proposal would be an enabler for a National Care Service.

The Challenge

The NHS is overwhelmed with lengthy waits for treatment in hospital and at emergency departments, and primary and community care are struggling. The current model is fragmented, with repeated onward referrals and re-assessments, delayed care provision, and a reliance on hospital-based interventions rather than community-based, preventative support. All leading to growing health inequalities, workforce shortages and low productivity.

Local authorities are facing increasing pressures delivering social care, as demand for care is rising, yet funding remains constrained or cut in real terms. Means-tested contributions from individuals adds administrative burden, delays care, and discourages people from

seeking support early. Other services provided by Local Authorities, including those which support the population to be healthier, are being cut to fund the escalating social care bill. The workforce crisis in care—low pay, lack of career progression, and high turnover—further weakens the system.

A New Model for Integrated Neighbourhood delivery: Integrated, Personalised, Cost-effective, and Locally Led

This proposal outlines how to **transform community health care and support sustainably** and enable the shift from hospital to the community through:

- **A fully integrated health and social care budget**, enabling health and care support that is timely, free at the point of need, with services working together seamlessly.
- **A shift towards prevention and early intervention**, reducing crises and unnecessary hospital admissions.
- **Stronger local control and accountability**, giving place-based teams the responsibility and funding to meet the needs of their communities.
- **A fairer and more sustainable workforce model**, ensuring care staff, health staff and community support staff receive better pay, career progression, and flexible working opportunities.

By implementing **Integrated Neighbourhood Teams**, including local authority social care, NHS community services, primary care and voluntary sector partners, we can provide a single, joined-up service that responds to individual needs and prioritises those at highest risk.

Key Actions

1. Integrated Neighbourhood Team Delivery

- Enable multi-agency, multi-disciplinary **Integrated Neighbourhood Teams** (including NHS community, primary care, mental health, social care, and voluntary sector staff) to coordinate health care and support, proactively addressing health inequalities (including linking with other local services such as schools, policing, housing and job centres, welfare legal advice).
- Use **Population Health Management** data to identify and support individuals before they reach crisis point.
- Replace the current time-and-task model with a flexible, personalised approach using the **Comprehensive Model of Personalised Care** to jointly assess and produce strength based personalised care and support plans focused on what matters to the person and their loved ones, to help people live independently in their own homes wherever possible.
- Establish a **single brokerage and payments system** across health and social care for paying for all support provided to people in their own homes.

2. A Pooled Budget for Integrated Health and Social Care

- Create a jointly funded Place-based budget (via a Section 75 agreement) for funding **delegated neighbourhood operating budgets** for local multi-agency teams to manage directly, using existing budgets for community delivered services, including for long-term conditions management, social care funding, the Better Care Fund etc.
- Local authorities and NHS Integrated Care Boards (ICBs), and NHS Trusts to agree on a **sustainable funding model** for their area ensuring **local government contributions are fixed**, with ICBs having a phased plan over three years to leverage sustained shifts in resources to the community from acute sector (via consolidating specialty secondary care treatment on fewer sites, and reforming outpatients), to rebalance the total share of NHS spend spent on primary and community services verses acute spend back to 2010 levels (2010 acute = 49%, 2026 = 58%, 2010 Primary and Community 28%, 2026 = 18% (source Kings Fund)). This uses the principle that the NHS will make the financial gain from the shift from disease to prevention, so the NHS should carry the risk of transition budget pressure, not local authorities.
- Use **integrated personalised health and care budgets**, allowing **joined up personalised care and support plans** for people living at home to be delivered free at the point of need (micro-commissioning at scale, reducing waste by only funding elements of the strengths based personalised care and support plan that cannot be delivered from existing local provision).
- **Remove means-tested charges for non-residential social care**, reducing bureaucracy and financial barriers for joined up timely health care and support. Use existing intermediate care frameworks linked to The Care Act (2014) requirements to provide the flexibility to do this now, without the need for legislative changes.
- Capped contribution to the pooled budget from **local authorities** will allow them to **remain solvent** and start to **reinvest in community prevention**.
- **Strengthen the role of voluntary and community organisations** as part of local care delivery, through funded involvement of voluntary sector roles in multi-agency teams, use of integrated personal budgets to pay for a blended ranged of targeted support based on individual needs, including a broader range of community support options such as social prescribing, supported self-management and peer support typically delivered by the sector. This blend of options is often cheaper than delivery solely via traditional care options.
- **Merge health and social care commissioning and brokerage teams** to improve efficiency and consistency.

3. Integrated Neighbourhood, Multi-agency, Multi-disciplinary Teams

- Combine **social care teams, NHS community services, primary care, mental health, and voluntary sector partners** under a **single local neighbourhood team operational structure**.
- **Streamline assessments**, focused on what matters to people, with **one personalised care and support plan** per person, rather than multiple reassessments by different services. Use of trusted assessor status within multi-agency teams/multi-disciplinary team case management and no financial assessments, will reduce duplication and staffing capacity required for assessments.

- **Proactively target those most in need**, using Population Health Management data to **prevent crises and reduce long-term costs**.
- Ensure **care and support is built around the individual**, with flexible options such as personal assistants and micro-providers, as well as traditional domiciliary care agencies.
- **Support informal carers with training, advice, and financial support**, enabling them to play a sustainable role in care.
- **Redeploy appropriate existing ICB and social care management capacity to join Integrated Neighbourhood teams (INTs)**, enabling clinical time to be freed up from management tasks, and preventing system wide single condition-based commissioning inadvertently cutting across local decision-making, prioritisation and the micro-commissioning of support for people (especially those with multiple-long-term conditions) - Shift from system wide single condition based commissioning focus to operational management and micro-commissioning for individuals at place.
- **Develop clinical leadership roles** enabling progression into the management grades for clinical staff staying in frontline roles, where their key functions are training, mentoring and providing clinical oversight for people, carers and staff in INTs for delegated clinical tasks and supporting uptake of supported self-management, building on and expanding upon the Community Matron model.

4. Workforce Transformation: Supporting, Recognising, and Growing the Health and Care Workforce

- **Fair Pay and flexible hours for Care Workers:** Care staff should be able to earn at least as much as in retail and hospitality. Match carers with people, place and the hours they can work, wherever possible to improve job satisfaction, reduce travel time and carbon footprint, using digital tools. Together this will help make the sector competitive and sustainable.
- **Flexible Career Paths:** Create opportunities for **career progression**, allowing staff to move between social care, NHS roles, and voluntary sector positions.
- **'Passporting' of Staff:** Enable care workers to move between different settings, including **supporting individuals in hospital and at home**, ensuring continuity of care.
- **Training and Delegated Responsibilities:** Expand training for care workers so they can safely undertake delegated health-related tasks (where appropriate supported by digital technologies), reducing the need for multiple professionals in simple health and care interventions, thereby increasing capacity.

5. Shift from analogue to digital

- **Introduce a single personalised care and support plan**, which is sharable electronically with all who need to see it, including with the person. Eliminating multiple care plans from existing siloed services.

- **Expand the use of digital technology**, such as **remote monitoring, shared care records, and assistive technology**, to improve efficiency and independence.
- **Shift financial monitoring to person-centred outcomes.** All spend recorded on a per person basis using a single identifier (NHS number). Analytics support to be made available to local teams so they can make an analysis of value by including health and care outcomes and person level experience measures, alongside whole system cost spend on that individual.
- **Reduce administrative costs** by commissioning local authorities to handle all health and social care payments, using existing electronic payment processes.

Key Benefits

1. **Financial Stability:** Fixing the local authority contribution to the pooled budget, reducing their financial risk and enabling investment in prevention.
2. **Better Outcomes, Lower Costs:** Early intervention and prevention reduce expensive crisis care and hospital admissions, allowing funding to be spent more effectively.
3. **More Responsive Support and Care:** A locally managed integrated neighbourhood approach ensures faster access to support, avoiding delays from fragmented assessments and referrals.
4. **Empowered Communities:** Stronger partnerships with voluntary organisations tap into community resources, reducing reliance on formal care.
5. **Workforce Stability:** Improved pay, flexibility, training, and job satisfaction make health and care a more attractive long-term career, reducing turnover and staffing shortages.
6. **Reduced Bureaucracy:** Eliminating means-testing for home care and multiple assessments reduces administration, allowing focus on service delivery.
7. **Stronger Local Control:** Delegated budgets allow integrated neighbourhood teams to respond flexibly to local needs.

Addressing Risks and Challenges

- **Financial Loss from Social Care Charges:** Reduction in income from means-tested care charges (for care in people's own homes), will be partially offset by administrative savings, reduced bad debt collection, and better long-term cost management. Local pre-implementation analysis by local authorities of their current income via charging v. the cost of administering financial assessments for everyone before the pooled budget is negotiated can quantify the amount (past analysis in one local authority area with high levels of deprivation, showed that the financial assessment process cost more than the income from residents being charged for their care).
- **Implementation Barriers:** Properly resourced training, leadership, and co-design with frontline staff will be essential to ensure successful cultural change, time taken to do this can be off-set against reduction in time taken for current repeated assessment approaches by separate services.
- **Data Sharing and Digital Integration:** Local authorities and NHS partners must work closely together to prioritise seamless digital record-sharing and training for staff, not just in how to use the technology, also how to share risk appropriately in multi-

agency, multi-disciplinary working and providing proactive care using tools including AI.

- **Risk of Neighbourhood Based Operating Budget Overspending:** Local teams will be supported with business intelligence tools to track spending and adjust services efficiently. The NHS holding the risk will act as a lever for accelerating shift of resources from hospital to community (to cover the increased costs incurred within the community on health and social care and on prevention).
- **Social care demand increases significantly:** using the integrated strengths based Comprehensive Model of Personalised Care, including: health coaching; goal focused reablement; supported self-management; a broader range of community support options including social prescribing and peer support; access to support for informal carers; and using integrated personal health budgets for creative care planning will partially mitigate pressure from an increase in costs through not charging for local authority based personal care at home.
- **Workforce Hesitancy:** A clear communications strategy, co-design of local implementation, sharing and learning networks, case studies of success will help staff understand and embrace new ways of working.

Conclusion: An equal partnership Vision for Integrated Support

This proposal **places local authorities and social care at the heart of a joined up solution** with the NHS to the UK's health and care challenges. By **pooling budgets, integrating teams, and prioritising prevention**, we can create a system that is:

- **Fairer:** Care is free at the point of need, removing financial barriers to joined up timely health and care.
- **More Sustainable:** Local authorities have predictable funding, and care is delivered efficiently.
- **More Responsive:** People receive support before they reach crisis, reducing pressure on hospitals and emergency services.
- **Empowering for Staff and Communities:** A stable, well-supported workforce and strong voluntary sector partnerships ensure care is both high-quality and person-centred.

By **investing in integrating health and care services**, we can build a system that truly works for local people, delivering better outcomes while ensuring financial sustainability for local authorities, enabling them to invest in the shift from disease to prevention.