

Caring together

A joint vision for the future of cooperation between
adult social care and the NHS

In partnership with



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About us

The NHS Confederation

The NHS Confederation is the membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland. The members we represent employ 1.5 million staff, care for more than 1 million patients a day and control £150 billion of public expenditure. We promote collaboration and partnership working as the key to improving population health, delivering high-quality care and reducing health inequalities.

For more information, visit www.nhsconfed.org

ADASS

The Association of Directors of Adult Social Services (ADASS) is a membership organisation for those working in adult social care. As a charity we work with professionals, other organisations and people with lived experience to influence decision makers, policy and legislation – from the local to regional and national level. We raise awareness of the benefits social care can bring to individuals and communities, and aim to ensure all of us who need care and support can live the lives we want regardless of age, ability and background.

For more information, visit www.adass.org.uk

RLDatix

RLDatix helps organisations reduce harm, improve safety and strengthen patient outcomes and experiences through systemwide decision-making.

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Key points

- The NHS integrated care boards and local authorities commissioning adult social care in England face rising demand for services within tight budgets. Despite the best efforts of staff at all levels of both adult social care and the NHS, cooperation between the two sectors is not consistent.
- Deeper integration and use of new technology can help to better meet the needs of the population and put the social care sector on a more sustainable footing.
- To inform local commissioners and Phase 1 of the Casey Commission, which will review how to make the most of existing resources, this report by the NHS Confederation, ADASS and RLDatix examines existing collaboration and use of new technology, making seven recommendations:
 - 1. Explore joint social commissioning teams** across NHS integrated care boards and local government to deliver neighbourhood health, including shared appointments and budget pooling.
 - 2. Amend legislation to better enable joint commissioning** by reforming Section 75 legislation and/or replicating provisions of Section 65Z5 of the NHS Act 2006 to enable local government to delegate commissioning.
 - 3. Expand use of delegated health tasks** to frontline social care staff, with appropriate funding, to deliver improved person-centred care and support, to relieve pressure on community care providers and provide career and pay progression opportunities for social carers. This should be based on a **new national framework** of responsibilities.
 - 4. Revise the Continuing Healthcare referral checklist** so only those patients likely to be eligible are referred to speed up assessments and access to care.

5. Review the Continuing Healthcare assessment framework to ensure a consistent approach which meets care needs.

6. Develop a more flexible neighbourhood workforce across social care and health aligning:

- a. pay
- b. training
- c. career paths
- d. recruitment.

This could be done by **implementing the Skills for Care Workforce Plan and legislating for social care workforce planning.**

7. Embed social care providers and local authorities in neighbourhood teams to better response complex needs, realising their expertise and potential.

Introduction: meeting the challenge

Deeper integration between the NHS and local-government-commissioned social care can help to better meet the needs of the population and put the social care sector on a more sustainable footing. With NHS and social care alike facing rising demand, higher costs and tightening budgets, the future for both sectors lies in maximising cooperation.

Social care offers a valuable and essential service to many people, helping them to live a better quality and more independent life. However, as the Darzi Review acknowledged, demand for social care ‘has risen, largely as the result of an ageing population... a colossal gap has opened up between resources and need’. The Care Quality Commission (CQC) found that ‘demand for support funded by a local authority continued to rise [in 2024/25] – new requests for care were 4 per cent higher in 2023/24 than in the previous year, and 8 per cent higher than in 2019/20.’ As a result, NHS and local authority commissioners are being asked to do more with less. Cooperation can help achieve that.

However, despite the best efforts of staff in local authorities and integrated care boards (ICBs), cooperation between the two sectors is inconsistent across the country, as are the terms upon which each provides services. These foundational differences have led to a history of interaction between the two services that has been piecemeal and emergent rather than planned, and this has created a series of ‘frictional areas’ at key points of interface. Financial pressure on both local authorities and ICBs, given their funding struggles to meet statutory care requirements, can make relationships and cooperation difficult. This in turn impacts outcomes on the ground, from the quality of care to delayed discharge from hospitals.

Change is coming. The 10 Year Health Plan has set out how the NHS will evolve over the next decade and a vision for neighbourhood health; the Casey Commission will lay down how to make the most of existing resources and what long-term reform of social care needs to include. Yet with the final report

from the Commission not expected before 2028, how can local government and the NHS strategic commissioners work better to improve care in the meantime?

This report by the Association of Directors of Adults Social Care (ADASS) and the NHS Confederation – in partnership with RL Datix – sets out a shared vision of what can happen now. It recommends changes that local commissioners could make to improve care within existing resources and for part 1 of the Casey Commission to consider. Central to this is improving the interface between NHS health services and NHS- and local-government-commissioned social care, supporting the ‘consistency of care’ emphasised in the government’s [2024 manifesto](#).

Already, local government and NHS commissioners are joining up to improve care and are helping stretched budgets go further. This report outlines where leaders in England are making the most of the tools currently available to them. It considers where legislative changes may be needed to better enable joint working ahead of the upcoming health bill expected in early 2026. Based on engagement with NHS ICB strategic commissioners and local authority directors of adult social services, it looks at opportunities from collaborating and harnessing technology to:

- co-locate teams
- explore joint commissioning teams and pooling budgets
- improve NHS Continuing Healthcare
- delegate health tasks to social carers and empower carer recipients
- support the workforce and realise its potential
- join services to provide S117 mental health aftercare.

Neither the NHS nor local government commissioners can meet the challenges they face alone. Realising the mutual benefits of cooperation between the two sectors will require challenge and change. Given the scale of the pressures impacting health and care, doing nothing is not an option. Better outcomes – including more personalised, preventative care – will require health and social care to learn from each other, mutually supporting the reforms each sector is set to undergo.

Change is achievable. This shared vision of the interface between social care and the NHS sets out both what is possible today and what could become possible in future.

Making the most of existing resources: learning from successful collaboration

Local authorities and NHS ICBs share responsibility for commissioning public-funded social care services. The Care Act sets out a legal duty for an adult's 'eligible needs' to be met by the local authority, subject to their financial circumstances. Their eligible needs are those that are determined after a Care Act assessment. ICBs have a legal duty to fund [NHS Continuing Healthcare \(CHC\)](#) for people with complex care needs assessed above a defined threshold; [Funded Nursing Care \(FNC\)](#) for people assessed as needing nursing home care from a registered nurse; and [Section 117 mental health aftercare](#) (which can include social care) to individuals detained under the [Mental Health Act 1983](#). Additionally, ICBs and local authorities make mandatory contributions to the [Better Care Fund \(BCF\)](#), to which they can voluntarily choose to add and pool further funding, to integration of health, housing and social care in a way that supports person-centred care.

Despite systemic challenges, there is good practice in NHS and local government joint working across the country to deliver these services, which shows the way forward. By making the most of the tools at their disposal today, these initiatives can offer both a model for others in England seeking to emulate their successes, and also provide some key models to inform the Casey Commission's considerations.

Co-locating staff

NHS and local authority staff can co-locate to improve joint working, improving and accelerating decision-making. From locality hubs to utilising freed-up hospital wards, staff from local authorities, NHS ICBs, NHS providers and wider

partners are physically sharing space so they can talk more easily and reach decisions on social care provision, avoiding delays that are worse for people's health and waste money.

Gloucestershire's Integrated Flow Hub

Gloucestershire's Integrated Flow Hub co-locates staff from NHS Gloucestershire ICB, Gloucestershire County Council and Gloucestershire Hospitals NHS Foundation Trust to accelerate decision-making on social care packages between the NHS and local authority and speed up discharge from hospital. Patients no longer have to wait in hospital while staff from all three organisations liaise by email between different offices to agree and facilitate a discharge pathway. Staff physically located in the same space can meet much faster to agree a decision.

The hub is now based in a former ward in Gloucestershire Royal Hospital, which has been freed up as the services has enabled more healthy patients to be sent home faster. Over 60 per cent of discharge decisions are made on the same day as referrals, down from 19 per cent before the Integrated Flow Hub came into action. On average, patients spend 1.9 days less in hospital and currently 68 per cent of patients get a home-based pathway decision.

Walsall Together

Walsall Healthcare NHS Trust and Walsall Council have a well-established integrated partnership, supported by a comprehensive Section 75 agreement and early joint working through locality hubs. Adult social care and community health teams now operate through multidisciplinary teams and the co-design of emerging neighbourhood teams, working closely with voluntary and charitable organisations to prevent worsening ill health. The partnership benefits from strong leadership, with the council's chief executive serving as a senior responsible officer for neighbourhood health and Walsall's executive director for adult social care and health acting as the national Association of Directors of Adult Social Services co-lead for health and care.

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Building on this foundation, the Walsall Together collaboration delivered tangible improvements, including lower hospital admissions, faster A&E handovers and twice as many emergency calls receiving a rapid community response. The partnership also saw a marked improvement in delayed transfers of care, demonstrating how collective NHS and local authority resources can achieve more from the same funding, while embedding community health services to prevent unnecessary ambulance conveyances and avoidable hospital admissions.

This early integration work has underpinned Walsall's participation as one of 43 pilot sites in the National Neighbourhood Health Improvement Programme (NNHIP), helping the partnership move confidently into the next phase of neighbourhood-level working.

Joint commissioning teams and pooled budgets

Some areas have gone further than co-locating staff, establishing a single team commissioning both local authority and NHS funded social care across a shared geography. This is often supported by pooled budgets. Many of these partnerships are governed by [Section 75 of the National Health Service Act 2006](#). While this approach may not be immediately appropriate everywhere, it may offer a means to improve co-ordination and reduce cost and duplication.

However, limitations in the law hinder collaborative working from going further. Section 75 agreements are a tool to facilitate joint working but too often they can be complicated and time-consuming to agree. Some parts of the NHS – such as primary care and voluntary, community and social enterprise (VCSE) providers – still [struggle to fall within its scope](#). This impedes joint working with other organisations such as adult social care providers, alongside other challenges such as governance and data-sharing arrangements.

Legislative changes by the government could help. Widening the scope and easing the creation of Section 75 agreements could make them more effective. Alternatively, authorities could be given the same freedom as ICBs to delegate

some functions. Replicating powers in Section 65Z5 of the NHS Act 2006 for local authorities could enable them to delegate commissioning, providing a simpler and easier alternative to Section 75.

Joint commissioning team in Rochdale

Hailed as the ‘future of integrated care’ by the NHS Confederation’s chair, Lord Adebawale, Rochdale’s approach is part of the broader alignment of the two sectors across Greater Manchester. A single joint commissioning team between the local authority and the ICB across a coterminous footprint and with pooled funding enables them to gain best value from their collective resources, working to a united vision.

On the ground, this has allowed Rochdale to develop a mature neighbourhood working model. Teams made up of NHS, social care, and third-sector staff all contribute to an offer which provides a 24/7 single point of access, enabled in part by growing colocation, as seen in Heywood and Middleton. This collaboration has deepened since its inception over a decade ago, adopting a cradle-to-grave scope with a strong role for the voluntary and charitable sector in particular. Care users and patients receive a better service while pressure has been reduced on the local hospital.

Joint commissioning in Leeds between health and social care

Following the Covid pandemic in 2021, the social care market in Leeds was fragmented, with staffing a particular challenge. Meanwhile, public dissatisfaction from a lack of continuity of care and delayed hospital discharge was growing.

Leeds City Council and Leeds Community Healthcare Trust (LCH) began jointly commissioning a new model of home care, from two external home care providers as a pilot, organised on a neighbourhood basis in 2024 to try to improve outcomes, staff retention and care provision. This involved a

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stakeholder board, which included carers, care recipients, third sector, trade unions and providers from both health and social care to shape the future direction of the pilot service. A dedicated nurse within LCH delivers training on spotting signs of deterioration, skin care and specific delegated health activities.

Joint commissioning ensures all care workers receive the National Living Wage as a minimum, localises recruitment and uses shift-based contracts with adjusted unit costs. These all contribute to better staff retention, more holistic care, and improved outcomes for care recipients.

A comprehensive Section 75 agreement in Sunderland

Sunderland City Council and NHS North East and Cumbria ICB are sharing resources to make their money go further. Collaboration has created a deep partnership across both bodies that is not only enduring but thriving.

This allows Sunderland City Council to provide Continuing Healthcare, Personal Health Budget and Section 117 assessments and reviews on behalf of the ICB. Similarly, the local authority is the lead commissioner for community and residential services, responsible for all of the financial aspects including agreeing fees and payments to and from providers.

Initial feedback has shown an improvement in relationships between all the partners involved, as well as increased consistency and clarity for families. While both organisations still face financial challenges, pooled budgets through the Better Care Fund allow for these risks to be shared. Moreover, the links forged across health and social care are also providing a good basis on which to further develop integrated neighbourhood working, in line with the 10 Year Health Plan.

Delegated health tasks and empowering carers and care receivers

Delegated health tasks (DHTs) – healthcare, often clinical, activity carried out by social care staff – can improve the experience of those drawing on care and support with fewer professionals involved in delivering their care. DHTs can also relieve pressure on community and urgent and emergency healthcare. Training, development and pay progression opportunities for social care staff to deliver DHTs, using resultant savings from spend in community care, could help to incentivise staff retention. The delegation of specific healthcare tasks is already underway in some parts of the country. The Secretary of State for Health and Social Care has already announced his intention to upskill the adult social care workforce more widely, to take on additional tasks that would have been traditionally viewed as healthcare.

To be successful, a more systematic approach is needed across health and social care, setting clear responsibilities and ensuring fair funding for staff taking on additional roles and responsibilities. The evolution of DHTs could be more strategic and joined up to ensure the best use of existing funding between adult social care and the NHS. Local authority leaders have expressed their concern that professional development remains reliant on one-off, discontinuous funding pots rather than forming a reliable programme. As a result, a majority of directors of adult social care report that their workers are having to perform tasks for which they may not be sufficiently trained or equipped. This also impacts the financial viability of contracts, many of which are already unsustainable.

The Care Act 2014 defines the circumstances in which adult social care providers may offer healthcare services. The need to satisfy both the ‘quantity’ and ‘quality’ requirements precludes a wider uptake of DHTs by social care without a separate Section 75 agreement, even where the provider is adequately remunerated and staff are correctly equipped to carry out this role. Similarly, social care leaders stated that the Act’s terms can impede innovation, for example the direct employment of nurses.

Local partners can expand use of DHTs but should ensure social care providers receive remuneration for DHTs and use this to improve pay of those staff delivering DHTs, funded from consequent savings in community care. This should be supported by a national framework of responsibilities.

Additionally, new technology can empower care recipients themselves as well as their families and unpaid carers to better monitor their own health. They can use remote technology to monitor and self-report their health directly to the NHS, enabling clinicians to spot any deterioration in a person's health before they need an emergency response and intervene earlier. This helps keep people healthy and reduces pressure on urgent and emergency care services.

Delegated health tasks in Bradford

Bradford District Council, Bradford District Care NHS Foundation Trust, and Bluebird Chrysalis (a private social care provider) partnered to pilot training and upskilling social care staff to manage routine pressure ulcers, in order to relieve pressure on overstretched district nurses and provide career development opportunities in social care. Care staff received training in how to spot and prevent pressure ulcers from developing, as well as handling the recording of any incidences.

The pilot cut district nurses' pressure ulcer management caseload by 25 per cent. Care staff reported improved understanding and confidence dealing with pressure ulcers. However, incompatible IT systems between NHS and social care providers impeded reporting. High turnover rate of social care staff increased the frequency of training required and prevented accumulation of experience. Financial pressure has prevented a wider pilot of delegating health tasks to build sufficient evidence for a business case to permanently embed this model or expand the scope to other health tasks, such as insulin administration or phlebotomy.

Streamlining delegated health tasks in Kent and Medway

A suite of new processes and technologies are bringing care homes, local authority staff and NHS workers together in the Kent and Medway area. The aim of the partnership is to maximise the efficiency with which routine care and key health interventions can link up, ensuring continuity wherever possible.

The aim of the programme is to provide hospital-quality, multi-disciplinary and proactive care to people at home. The local authority funds health assessment kits, as well as a dedicated app to support care assistants identify health issues, and a virtual care portal for multi-disciplinary teams. The ICB and local authority have provided training for GPs and care homes alike via an online academy to ensure alignment across settings.

As a result, escalations from care homes to urgent and emergency medical response services have halved. By upskilling carers to assess residents' health needs with confidence, demand for urgent and emergency care has reduced dramatically.

Reducing unnecessary hospital conveyances and admissions is better for care recipients, who are at risk of worsening health from infection and muscle wastage through prolonged stay. Reduced demand for care has also saved money and could save over £14.2 million annually if scaled across the whole ICB.

Improving Continuing Healthcare

NHS Continuing Healthcare (CHC) comprises non-means tested social care, provided by the NHS free at the point of delivery, for those whose 'main aspects or majority part of the care they require is focused on addressing and/or preventing health needs'. However, assessment for CHC is a notable challenge to local authorities and ICBs alike, with both demand and complexity of need growing in tandem. Variation in CHC access and spending is well documented.

The combination of difficulties in assessing need – coupled with the financial challenges faced by the NHS and local authorities alike – can challenge the strong relationship that councils and ICBs require to reach the right decisions about CHC. Data sharing, mutual trusts, clear communication and aligned expectations are all necessary to achieve this, while the focus should always remain on the rights of the individual to access care when they are eligible to do so.

The NHS Confederation has previously proposed that amending the checklist used to refer patients for a full CHC assessment could speed up CHC decision-making by reducing the volume of assessments for cases that are unlikely to meet the criteria for eligibility. While this would not change eligibility, it would reduce the volume of cases turned down for eligibility and speed up access to care within available resources. Additionally, new technology can be used to accelerate decision-making on CHC assessments and access to care, including harnessing ambient voice technology

Many ICB strategic commissioners and local authority directors believe that the existing CHC assessment framework is no longer adequate given the difficulties the sector faces. A revised CHC framework could reduce disputes within the process that undermine relationships between those responsible for care and health locally, which in turn affects access to care for people who need it. Examining how the assessment framework should change needs closer review with the involvement of ICBs, local authorities and care users.

Improving CHC practice in Herefordshire and Worcestershire

Responding to growing demand for CHC, Herefordshire and Worcestershire ICB has been exploring how to streamline the CHC pathway and improve outcomes. The current criteria means that many individuals enter the CHC assessment process, including some who are less likely to be eligible, which can impact the timeliness of support and place additional pressure on resources. Currently, approximately 20 per cent of standard (non-fast track) assessments result in eligibility.

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In collaboration with West Midlands Health and Wellbeing Innovation Network, the ICB has invested in an innovative new system which features both a database and communication portal with patients, incorporating AI technology. This aims to increase the productivity in CHC, enable better information sharing between NHS and local authority colleagues and ultimately improve outcomes for patients.

The next steps are a research bid with the National Institute for Health and Care Research to see if people could get help sooner, and if assessments can be focused on the people most likely to need this support, so the system works better for everyone. This will require a joint evidence and best practice base, developed between NHS, social care and local authority partners.

Supporting the workforce and realising its potential across neighbourhoods

The shortage of staff in the adult social care – short by around 131,000 workers, even as demand on both sectors grows – makes it difficult to maintain and deliver services. Poorer pay, pensions and leave in the social care sector compared to healthcare drive social care staff to move into NHS roles, where there are 100,000 vacancies, exacerbating social care workforce shortages. While experience of both sectors is valuable, at a time of serious staff shortages across the board the loss of experienced staff risks undermining organisational capabilities and therefore the quality of care on offer.

The government has already recognised the workforce retention challenge through the developing Fair Pay Agreement (FPA) for the care sector. The first details set a positive direction, which is scheduled to begin from 2028. Properly designed and funded, the FPA can deliver fair pay and better terms for frontline care workers and improve recruitment and retention across the sector. People who draw on care and support will benefit from a sustainable and motivated workforce, delivering high-quality care, who feel valued, respected and fairly paid.

NHS and local authority strategic commissioners need a more flexible workforce across social care and health, able to work across both sectors where needed and respond flexibly to the changing needs of the population by aligning pay, training, career paths and recruitment. To do this, the Department of Health and Social Care (DHSC) should adopt and implement all the proposals in the [Skills for Care Workforce Strategy](#). Additionally, the DHSC should introduce a legislative requirement for a social care workforce strategy in the next health and care bill. This should be similar to requirement in the Health and Care Act to: ‘at least once every five years, publish a report describing the system in place for assessing and meeting the workforce needs of the health service in England.’

Additionally, the skills and knowledge of the social care provider, local authority commissioner workforce and VCSE sector could be better integrated to work alongside the NHS to improve neighbourhood health. The insights of social care providers and commissioners into daily support and continuity of care, the home environment and the social determinants of health is vital to respond to complex needs – especially for those living with frailty, disability or chronic conditions. Therefore, as part of their neighbourhood health strategy, DHSC and NHS England should encourage and support local systems to embed social care providers and local authority directors of adult social care into neighbourhood multidisciplinary teams and joint care planning processes as co-leaders in proactive, preventative care, not just as a recipient of hospital discharges or community referrals.

Community health and wellbeing workers (CHWW) provider health outreach and social care in Westminster

Westminster City Council and North Central London ICB proactively sent [community health and wellbeing workers](#) – trained and paid members of the local community – to provide proactive health checks and social care support to around 120 households each month. Crucially, the service connects residents to wider local services and nurtures relationships in neighbourhoods. Within the most deprived 20 per cent of communities in the borough, the CHWW team visits the 25 per cent micro-areas with the highest need, based on evaluation by Imperial College London. CHWWs work with eight GP practices, St Mary’s A&E and local community services.

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The evaluation of the pilot showed a lowering in unplanned GP appointments by 7 per cent, reduced hospital admissions by 10 per cent, increased the likelihood of vaccination by 47 per cent, and cancer screening and NHS health checks by 82 per cent, while also increasing prevention opportunities and scheduled GP reviews.

Section 117 aftercare

Section 117 (S117) aftercare provides services for people who have been discharged from an inpatient episode following a compulsory period of treatment for their mental disorder and who need aftercare services to reduce the risk of re-admission, keeping them as well as possible and out of hospital. Local leaders believe it has become a ‘flashpoint’ in relations between ICBs and local authorities.

The Department of Health and Social Care has provided national guidance on how budgets and responsibilities should be shared to pay for S117 aftercare in accordance with the Mental Health Act 1983. Regular review of people on S117 care is needed to check when people should be moved off S117 care, including onto Continuing Healthcare. Joint services can help to better manage S117 care more affordably.

Joint S117 care in Hertfordshire

Jointly developed by Hertfordshire County Council and Hertfordshire Partnership University NHS Foundation Trust (HPFT), Cherry Tree Cottage is an Ofsted-registered children’s home for those with complex mental health needs. Those aged 12-17 years are cared for in a holistic manner through an integrated health and social care staffing model. The local authority and ICB/ Hertfordshire Partnership NHS Foundation Trust fund this on a 60:40 basis.

Cherry Tree Cottage provides an alternative to difficult-to-source residential placements, which can cost up to £17,500 a week, enabling these young people to be discharged more quickly from acute mental health care and

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remain in the area. In all, the cost of Cherry Tree Cottage is much less than the cost of inpatient admission or residential placements.

The team includes an Ofsted-registered manager employed by Hertfordshire County Council, a Band 7 nurse who is the deputy manager, 4.4 Band 6 nurses with mental health experience, and a consultant psychiatrist offering three sessions per week, via Hertfordshire Partnership University NHS Foundation Trust.

While only operating on a small scale, the 12-week programme of intensive support has reduced A&E presentations and acute admissions among those young people in the home. More than this it has improved quality of life, with care home residents proceeding to university and gaining successful employment.

Conclusion and recommendations

Collaboration between the NHS and local authorities is essential to help meet the challenges in social care. However, organisational, financial, legal and human factors are all contributing to substantial friction at the interface between the NHS and social care. The knock-on effects are hindering performance for both sectors and leading to negative consequences for staff and people drawing upon health or social care and support alike.

Since 1997 there have been [25 social care commissions, select committee inquiries and white papers](#). None of these resulted in meaningful change but have thoroughly detailed the problems facing social care. Ultimately, Phase 2 of the Casey Commission must result in meaningful reform and multi-year settlements for the sector. But in the meantime, action is needed now, within the bounds of what local commissioners can practically do. There are pragmatic steps that can be taken now to improve efficiency and care outcomes.

Many NHS and local authority commissioners are finding innovative ways to make best use of their collaborative resources, despite workforce and funding shortages in the face of growing demand for care. The NHS Confederation and ADASS have shared examples of joint collaborative working to show how we can make the most of existing resources to support people to improve their lives over the medium term, to inform Phase 1 of the Casey Commission. They can also inform how NHS and local authority leaders work together now to make best use of limited resources.

Phase 1 of the Casey Commission should therefore consider the following opportunities from collaborating and harnessing technology:

- 1. Explore joint social commissioning teams across NHS integrated care boards and local government**, include **shared appointments** (where sufficient co-terminists makes this feasible) and an **expansion in budget pooling** to support joint services.
- 2. Amend legislation to provide more flexibility** for NHS organisations and local government to **jointly commission health and care services**, collaborating to deliver best outcomes for people. This could be achieved through **reforming Section 75 legislation** and **replicating provisions of Section 65Z5** of the NHS Act 2006 to enable local government to delegate commissioning in the upcoming health and care bill or other legislation.
- 3. Expand use of delegated health tasks (DHTs)** to social care workers, based on a new national framework of responsibilities, relieving pressure on community healthcare and providing carer and pay progression opportunities to social carers. This can improve staff retention and continuity of care. **Social care providers should receive remuneration for DHTs and use this to improve pay of those staff delivering DHTs**, funded from consequent savings in community care. Additionally, empower care recipients and their families to **use remote technology to monitor and report their own health**, enabling early intervention when needed.
- 4. Revise the Continuing Healthcare referral checklist**, which is currently too wide, so only those patients most likely to be eligible are referred for an assessment. This will speed up assessments and access to care, by reducing the assessment backlog, meaning fewer patients and families have false hopes raised and reducing abuse of staff that too often occurs as a result.
- 5. Review the Continuing Healthcare assessment framework** to ensure a consistent approach, supported by ICBs and local authorities, which meets care needs. A revised CHC framework could reduce disputes within the process that undermine relationships between those responsible for care and health locally, which in turn affects access to care for people who need it. In the meantime, **ambient voice technology and other digital tools can accelerate CHC assessments**.

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6. Develop a more flexible neighbourhood workforce across social care and health, able to work across both sectors where needed and respond flexibly to changing needs of the population **by aligning:**

- **pay**
- **training**
- **career paths**
- and **recruitment.**

This could be done by **implementing the Skills for Care Workforce Plan and legislating for social care workforce planning.**

7. Embed social care providers and local authority directors of adult social care in neighbourhood multidisciplinary teams and joint care planning processes, not solely as a recipient of hospital discharges or community referrals, but rather as a co-leader in proactive, preventative care. The insights of social care providers and commissioners into daily support and continuity of care, the home environment and the social determinants of health is vital to respond to complex needs – especially for those living with frailty, disability or chronic conditions.

While care users, staff and commissioners wait and hope for longer term reform of social care following the Casey Commission's final report in 2028, there are things that can be done now to make the most of what we already have. Spreading the best practice already in action across the country could help cash-strapped integrated care boards and local authorities to maintain and even improve services with their limited budgets.

This requires NHS and local authority commissioners to work together. A concerted effort to share resources could reap significant rewards for both sectors. For too long, budget pressures have encouraged cost shunting. This transactional mindset is unhelpful and can undermine the very relationships on which joint working relies. Challenges of commissioning, workforce, flow and scale are shared by the NHS and adult social care alike. Instead of conflict, we need cooperation.

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