

Agenda

Health and Wellbeing Board

Date: **Monday 13 July 2026**

Time: **2.00 pm**

Place: **Conference Room 1 - Herefordshire Council, Plough Lane Offices, Hereford, HR4 0LE**

Notes: Please note the time, date and venue of the meeting.

For any further information please contact:

Ben Baugh, Democratic Services

Tel: 01432 261882

Email: Ben.Baugh2@herefordshire.gov.uk

If you would like help to understand this document, or would like it in another format, please call Ben Baugh, Democratic Services on 01432 261882 or e-mail Ben.Baugh2@herefordshire.gov.uk in advance of the meeting.

Agenda for the meeting of the Health and Wellbeing Board

Membership

Chair	Councillor Carole Gandy	Cabinet Member Adults, Health and Wellbeing, Herefordshire Council
Vice-Chair	Sarah Shingler	Managing Director, Wye Valley NHS Trust
Members	Stephen Brewster	Voluntary and community sector representative
	Jon Butlin	Assistant Director (Prevention), Hereford & Worcester Fire and Rescue Service
	Zoe Clifford	Director of Public Health, Herefordshire Council
	Hilary Hall	Corporate Director for Community Wellbeing, Herefordshire Council
	Susan Harris	Director of Strategy, People and Culture, Herefordshire and Worcestershire Health and Care NHS Trust
	John Hobbs	Corporate Director for Economy and Environment, Herefordshire Council
	Councillor Jonathan Lester	Leader of the Council, Herefordshire Council
	David Mehaffey	Executive Director: Strategy, Health Inequalities and Integration - NHS Herefordshire and Worcestershire Integrated Care Board
	Superintendent Gareth Morgan	West Mercia Police
	Vicky Morris	Joint Non-Executive Member (Quality and Patient Involvement), NHS Herefordshire and Worcestershire Integrated Care Board
	Joanna Newton	Independent Chair, Herefordshire Safeguarding Adults Board
	Dr Lauren Parry	Director of Quality and Clinical Integration, Herefordshire General Practice
	Councillor Ivan Powell	Cabinet Member Children and Young People, Herefordshire Council
	Christine Price	Chief Officer, Healthwatch Herefordshire
Tina Russell	Corporate Director for Children and Young People	
Simon Trickett	Chief Executive, NHS Herefordshire and Worcestershire Integrated Care Board	

Agenda

		Pages
1.	<p>APOLOGIES FOR ABSENCE</p> <p>To receive apologies for absence.</p>	
2.	<p>NAMED SUBSTITUTES (IF ANY)</p> <p>To receive details of any member nominated to attend the meeting in place of a member of the board.</p>	
3.	<p>DECLARATIONS OF INTEREST</p> <p>To receive any declarations of interests from members of the board in respect of items on the agenda.</p>	
4.	<p>MINUTES</p> <p>To approve and sign the minutes of the meeting held on 18 May 2026.</p> <p>HOW TO SUBMIT QUESTIONS</p> <p>The deadline for the submission of questions for this meeting is 5.00 pm on Tuesday 7 July 2026.</p> <p>Questions can be submitted via the Public Questions Portal (link).</p> <p>Accepted questions and the responses are usually published as a supplement to the agenda papers prior to the meeting.</p> <p>Further information and guidance is available at Get involved - Ask a public question (link)</p>	9 - 16
5.	<p>QUESTIONS FROM MEMBERS OF THE PUBLIC</p> <p>To receive any accepted written questions from members of the public.</p>	
6.	<p>QUESTIONS FROM COUNCILLORS</p> <p>To receive any accepted written questions from councillors.</p>	
7.	<p>NEIGHBOURHOOD HEALTH UPDATE</p> <p>To provide a summary update on neighbourhood health progress in Herefordshire.</p>	To Follow
8.	<p>BEST START IN LIFE - GOOD LEVEL OF DEVELOPMENT (GLD) IN CHILDREN AGED 5 YEARS</p> <p>To provide an update on one of the key priorities in The Best Start in Life (BSiL) Strategic Plan, namely a Good Level of Development (GLD) in children aged 5 years.</p>	17 - 22
9.	<p>GAMBLING AND RELATED HARMS</p> <p>The purpose of this briefing is to provide an overview of the scale and impact of gambling-related harms, outline the aims, approach and key actions of the gambling harms prevention project, and its alignment with wider public health</p>	23 - 28

- and community safety priorities. It will also present current understanding of harm, identify key challenges, risks and opportunities for further development, and seek the Board's feedback, challenge and support to strengthen delivery and overall impact.
- | | |
|---|---------|
| 10. THE BETTER CARE FUND (BCF) YEAR-END REPORT 2025/26 | 29 - 46 |
| <p>To update the Health and Wellbeing Board (HWB) members on the Herefordshire's Better Care Fund (BCF) End of Year 2025/26 performance template and seek formal Health and Wellbeing Board approval.</p> | |
| 11. HEREFORDSHIRE'S BETTER CARE PLAN 2026/27 | 47 - 94 |
| <p>To update Health and Wellbeing Board members on Herefordshire's Better Care Fund (BCF) Plan 2026/27 and seek formal Health and Wellbeing Board approval.</p> | |
| 12. WORK PROGRAMME | 95 - 96 |
| <p>To consider any items for inclusion in the work programme for the board.</p> | |
| 13. DATE OF NEXT MEETING | |
| <p>There will be a workshop for board members on Monday 28 September 2026, 1.00 pm.</p> | |
| <p>The date of the next scheduled board meeting in public is Monday 26 October 2026, 2.00 pm.</p> | |

The seven principles of public life

(Nolan Principles)

1. Selflessness

Holders of public office should act solely in terms of the public interest.

2. Integrity

Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.

3. Objectivity

Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.

4. Accountability

Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.

5. Openness

Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.

6. Honesty

Holders of public office should be truthful.

7. Leadership

Holders of public office should exhibit these principles in their own behaviour and treat others with respect. They should actively promote and robustly support the principles and challenge poor behaviour wherever it occurs.

The public's rights to information and attendance at meetings

You have a right to:

- Attend all council, cabinet, committee and sub-committee meetings unless the business to be transacted would disclose 'confidential' or 'exempt' information.
- Inspect agenda and public reports at least five clear days before the date of the meeting. Agenda and reports (relating to items to be considered in public) are available at www.herefordshire.gov.uk/meetings
- Inspect minutes of the council and all committees and sub-committees and written statements of decisions taken by the cabinet or individual cabinet members for up to six years following a meeting.
- Inspect background papers used in the preparation of public reports for a period of up to four years from the date of the meeting (a list of the background papers to a report is given at the end of each report). A background paper is a document on which the officer has relied in writing the report and which otherwise is not available to the public.
- Access to a public register stating the names, addresses and wards of all councillors with details of the membership of cabinet and of all committees and sub-committees. Information about councillors is available at www.herefordshire.gov.uk/councillors
- Have access to a list specifying those powers on which the council have delegated decision making to their officers identifying the officers concerned by title. The council's constitution is available at www.herefordshire.gov.uk/constitution
- Access to this summary of your rights as members of the public to attend meetings of the council, cabinet, committees and sub-committees and to inspect documents.

Recording of meetings

Please note that filming, photography and recording of this meeting is permitted provided that it does not disrupt the business of the meeting.

Members of the public are advised that if you do not wish to be filmed or photographed you should let the governance support team know before the meeting starts so that anyone who intends filming or photographing the meeting can be made aware.

The reporting of meetings is subject to the law and it is the responsibility of those doing the reporting to ensure that they comply.

Public transport links

The Herefordshire Council office at Plough Lane is located off Whitecross Road in Hereford, approximately 1 kilometre from the City Bus Station.

Directions, parking, and public transport information is available at www.herefordshire.gov.uk/directories/council-offices/plough-lane/

Minutes of the meeting of Health and Wellbeing Board held in Conference Room 1 - Herefordshire Council, Plough Lane Offices, Hereford, HR4 0LE on Monday 18 May 2026 at 2.00 pm

Board members present in person, voting:

Stephen Brewster	Voluntary and community sector representative
Jon Butlin	Assistant Director (Prevention), Hereford & Worcester Fire and Rescue Service
Zoe Clifford	Director of Public Health, Herefordshire Council
Liz Farr	Service Director, Education Development, Herefordshire Council
Councillor Carole Gandy (Chairperson)	Cabinet Member Adults, Health and Wellbeing, Herefordshire Council
Hilary Hall	Corporate Director for Community Wellbeing, Herefordshire Council
Councillor Jonathan Lester	Leader of the Council, Herefordshire Council
David Mehaffey	Executive Director: Strategy, Digital, PHM and Partnerships, NHS Herefordshire and Worcestershire Integrated Care Board
Dr Lauren Parry	Medical Director, Herefordshire General Practice
Christine Price	Chief Officer, Healthwatch Herefordshire
Sarah Shingler (Vice-Chairperson)	Managing Director, Wye Valley NHS Trust

Board members in attendance remotely, non-voting:

Naomi Keeling	Director of HR and Deputy Director of Strategy, People and Culture, Herefordshire and Worcestershire Health and Care NHS Trust
Chief Inspector Gregory Tudge	West Mercia Police

Note: Board members in attendance remotely, e.g. through video conference facilities, may not vote on any decisions taken.

Others present in person:

Ben Baugh	Democratic Services Officer	Herefordshire Council
Councillor Pauline Crockett	Chairperson Health, Care and Wellbeing Scrutiny Committee	Herefordshire Council
Mohamed Essoussi	Public Health Programme Officer (Strategy and Partnerships)	Herefordshire Council
Clara Gibbs	Local Systems Influencing Officer	Alzheimer's Society
Judy Gibbs	Joint Programme Director: Health and Work	NHS Herefordshire and Worcestershire
Donna Thornton	Democratic Services Support Officer	Herefordshire Council

Others in attendance remotely:

Lindsay MacHardy	Public Health Principal	Herefordshire Council
Vicky Morris	Non-Executive Member with a Focus upon Quality and Delivery	NHS Herefordshire and Worcestershire Integrated Care Board
Dr Sarah Williams	Associate Medical Director	Taurus Healthcare / Herefordshire General Practice

44. APOLOGIES FOR ABSENCE

Apologies for absence had been received from board members: Sue Harris (Director of Strategy, People and Culture, Herefordshire and Worcestershire Health and Care NHS Trust); Superintendent Gareth Morgan (West Mercia Police); Joanna Newton (Independent Chair, Herefordshire Safeguarding Adults Board); Tina Russell (Corporate Director for Children and Young People, Herefordshire Council); and Simon Trickett (Chief Executive, NHS Herefordshire and Worcestershire Integrated Care Board).

45. NAMED SUBSTITUTES (IF ANY)

The following substitutes were noted: Naomi Keeling for Sue Harris; Liz Farr for Tina Russell; and Chief Inspector Gregory Tudge for Superintendent Gareth Morgan.

46. DECLARATIONS OF INTEREST

No declarations of interest were identified.

47. MINUTES

The minutes of the previous meeting were received.

Resolved:

That the minutes of the meeting held on 15 December 2025 be confirmed as a correct record and be signed by the Chairperson.

48. QUESTIONS FROM MEMBERS OF THE PUBLIC

No questions had been received from members of the public.

49. QUESTIONS FROM COUNCILLORS

No questions had been received from councillors.

50. HEALTH AND WELLBEING BOARD MEMBERSHIP

Further to the item 'Board membership and arrangements for the appointment of the vice-chairperson' considered at the 15 September 2025 meeting ([minute 23 of 2025/26 refers](#)), it was reported that NHS Herefordshire and Worcestershire Integrated Care Board (ICB) had requested that it be permitted to nominate a third representative to the Health and Wellbeing Board.

The Health and Wellbeing Board supported this request, and the Chairperson welcomed Vicky Morris, Non-Executive Member with a Focus upon Quality and Delivery, as the nominee of the ICB.

Resolved:

That the following change to Herefordshire Council's constitution be recommended to full Council:

- **Paragraph 2.8.9, bullet point 8 be amended to read 'Three nominated representatives from the Integrated Care Board'.**

51. NEIGHBOURHOOD HEALTH UPDATE

Zoe Clifford introduced the report and provided an overview of the [Neighbourhood Health Framework \(link\)](#), published by the Department of Health and Social Care on 17 March 2026, including the roles of the NHS and local authorities, alongside wider partners, in delivering the vision and the expected outcomes. It was noted that the national goals included: improve health outcomes, with specific focus on high-priority cohorts; improve access to general practice, so people can see their GP in a timely, high quality way; improve experience of planned care and cancer care, and support delivery of the referral to treatment standard; better urgent and emergency care performance; and improve patient and staff satisfaction.

Sarah Shingler explained that the Health and Wellbeing Board had a strategic role in neighbourhood health, by leading the development of the local plan and setting strategic priorities. With Herefordshire being one of the 43 National Neighbourhood Implementation Programme (NNHIP) sites, it was reported that the NNHIP delivery group included a wide range of stakeholders and met fortnightly to develop place-based plans; there were 18 different workstreams within the programme currently. Attention was drawn to *Fig. 1: Local Neighbourhood Health Delivery* which illustrated the system governance for designing and delivering neighbourhood health in Herefordshire.

Zoe Clifford highlighted progress in Herefordshire, as referenced in paragraph 5 of the report, under the headings: defining neighbourhoods; priority cohorts identified; data linkage; neighbourhood health profiles; VCSE (voluntary, community and social enterprise) involvement; developing a single point of access; developing the Neighbourhood Teams approach; and HWB Neighbourhood Health Strategy development session.

The board was advised that a bid for funding for investment in neighbourhood health centres had been submitted to NHS England. In response to a question from the Chairperson, Zoe Clifford advised that a 'hub-and-spoke' model had been identified as the optimal archetype for Herefordshire, and Dr Lauren Parry explained that this might involve extending or improving existing general practice, council, or other NHS buildings. The Chairperson commented on access issues for many rural communities and suggested that mobile facilities should be considered. Dr Parry said that input from councillors and other board members would be valuable in understanding the needs of local communities and in addressing challenges, including transport. The Chairperson said that consideration would also need to be given to Herefordshire residents who accessed health services in Wales.

Stephen Brewster welcomed the inclusion of voluntary and community sector representation at an early stage.

Resolved: That the board notes:

- a) the Neighbourhood Health Framework; and**
- b) local progress in developing neighbourhood health.**

52. HEALTH AND WELLBEING BOARD DEVELOPMENT WORK

Zoe Clifford explained that, in anticipation of the publication of the Neighbourhood Health Framework, the Local Government Association had supported a development session workshop with board members in February 2026. This had identified the following principles for ways of working for the Health and Wellbeing Board (HWB): strong connections from leadership to organisations; strategic deep dives; focus on where the HWB can have the most impact; ensuring a clear interface between HWB and One Herefordshire Health and Care Partnership Board; focus on truly system-wide,

population health and wellbeing issues; addressing health inequalities; a commitment to workshop development sessions; a commitment to in-person meetings; ensuring that lived experience is heard by the HWB to inform decisions; allowing time for meaningful HWB discussion; prevention focused; and sponsor to be identified for each priority. It was noted that a workshop for board members was planned for 28 September 2026 to explore lived experience in the context of the work on neighbourhood health.

The Chairperson commented that: a workshop for board members held in March 2026 had demonstrated that local context was key to board development going forward; and stakeholders in the Autism Partnership Meeting and the Learning Disability Partnership Board had suggested that groups and individuals with lived experience should be involved at an earlier stage in public sector decision-making generally. David Mehaffey reported that the Integrated Care Board was in the process of creating a bespoke role specifically around patient involvement and, at its [20 May 2026 meeting \(link\)](#), was due to consider corporate objectives including '1.3) Implementing a strengthened approach to co-production, patient voice, patient experience and patient feedback'. Noting the workshop to be held in September 2026, Hilary Hall commented on the need to explore and build upon existing mechanisms.

Resolved: That

- a) the findings of the LGA facilitated work with the board be noted; and**
- b) the next steps for the board development work be agreed.**

53. HEALTH AND WORK – WORKWELL

David Mehaffey introduced the report and, referencing the workshop for board members held in March 2026 which had explored wider determinants of health and health inequalities, noted that employment had a significant impact on long-term outcomes for individuals and families.

Judy Gibbs provided an overview of the Health and Work Strategy, Government direction, and the progress of WorkWell, the main points included:

- a. In 2024, NHS Herefordshire and Worcestershire Integrated Care Board (ICB) had been selected, as one of 15 areas in the country, to pilot the Government's WorkWell programme.
- b. The [Herefordshire and Worcestershire Health and Work Strategy 2025-2030 \(link\)](#) had been published in Autumn 2025 which sets out a system wide approach to improving employment outcomes by recognising the strong, two-way relationship between health and work.
- c. The Government's [Get Britain Working White Paper \(link\)](#) identified an ambition to achieve an 80% employment rate; currently 78.3% in Herefordshire. Attention was also drawn to the [Keep Britain Working report \(link\)](#) which identified that 'The UK has been sliding into an economic activity crisis driven in large part by ill-health and by barriers to work faced by disabled people'.
- d. The Health and Work Strategy was structured around four strategic ambitions: work with employers to create inclusive, healthy and productive work environments for all; provide the right support and pathways needed to help individuals to move into employment; provide early health and employment support to help individuals leaving work due to ill health; and encourage and foster collaboration between local stakeholders to help residents to get into and stay in work.

- e. An outline was provided of the activity of the Health and Work Operations Board in Herefordshire, a multi-agency group including representatives of Herefordshire Council, Public Health, NHS partners, Department for Work and Pensions (DWP), and the Growth Hub.
- f. Information was provided on: the 'Connect to Work' programme; the 'Fit Note' pilot; work with the Growth Hub; and collaboration around events, with a 'Keep Herefordshire and Worcestershire Working Conference' scheduled for 8 July 2026.
- g. WorkWell was being delivered countywide by Taurus Healthcare, providing personalised health and work coaching tailored to the specific needs and circumstances of individuals, typically involving six to twelve sessions.

Dr Sarah Williams provided further details about the WorkWell programme, explaining that: the programme was supported by three experienced health coaches; the team met individuals in appropriate locations; from 1 October 2024 to 31 March 2026, the programme had seen 220 participants; the number and range of referrals was increasing each month, with primary care being the main referral route; approximately 58% of participants were out of work at the point of referral; approximately 16% remained in or returned to work following support; approximately 13% secured new employment; around 5% had completed the plan but had been referred onwards for further employment or health support; and the programme had received very positive feedback from participants about their involvement in decision-making and the way that they were treated throughout their contact with the service.

In response to questions from the Chairperson:

- i. David Mehaffey advised that, as part of the national programme, the DWP would undertake the assessment of impacts and outcomes over time; metrics were monitored locally on participants entering the programme and levels of satisfaction with the programme.
- ii. Judy Gibbs noted that WorkWell was designed as an early intervention employment and health support programme but acknowledged the high percentage of participants that were out of work at their first appointment; the Connect to Work programme supported people with complex barriers to employment but there were capacity challenges given the levels of unemployed and economically inactive residents.
- iii. David Mehaffey said that WorkWell was considered a cost-effective method and, as a non-medical intervention, supported the strategy of driving the shift upstream to more prevention.

Dr Lauren Parry commented on the health benefits of work, whether paid or voluntary, for overall wellbeing, and suggested that the partner organisations should amplify messages about the importance of staying in work and the value of early intervention.

In response to a question from Stephen Brewster, Judy Gibbs noted that lessons learned from the UK Shared Prosperity Fund and the involvement of the VCSE (voluntary, community and social enterprise) sector had informed the concepts, particularly in terms of the Connect to Work programme.

Vicky Morris welcomed the positive feedback from participants in the WorkWell programme and the DWP's extension of the programme.

The Leader of the Council commented on the potential for employers to promote the health and wellbeing support available to individuals from the outset. David Mehaffey acknowledged the importance of working with employers to create healthy work

environments and to equip them to support their own workforces. Judy Gibbs provided further details about work with the Growth Hub and on engagement with employers through events. The Leader of the Council said that a healthy workplace could be presented as a positive reason for an individual to work with a particular employer. Judy Gibbs commented on the value of early and open conversations about health and work. Zoe Clifford noted that the anchor organisations represented on the board could give further consideration to related matters within their own workplaces.

In response to questions from Zoe Clifford, Judy Gibbs said that: there were no waiting lists across the programme currently but, if there was a significant increase in referrals, discussions regarding capacity may become necessary; and linkages between WorkWell and the Crisis and Resilience Fund could be explored.

The Chairperson highlighted the need for appropriate training (e.g. kinetic lifting) and health and safety assessments (e.g. Display Screen Equipment assessment) to ensure that employees had safe and comfortable working environments.

Resolved: That the contents of the report be noted.

54. INTEGRATED CARE STRATEGY DELIVERY UPDATES

David Mehaffey reported that the Herefordshire and Worcestershire Integrated Care Partnership Assembly (ICPA) had been created in 2022 to oversee the development and delivery of the Integrated Care Strategy across Herefordshire and Worcestershire. However, following changes in national policy in 2025, it had been agreed by the chairpersons of the respective health and wellbeing boards and the joint chairs of the ICPA that the annual reporting function would be undertaken through the two health and wellbeing boards.

Consequently, the report provided an update on the delivery of the shared commitments, priorities and outcomes described in the Integrated Care Strategy during 2025/26. It was noted that the three core priorities (providing the best start in life; living, ageing and dying well; and reducing ill health and premature deaths from avoidable causes) aligned with the main priorities of Herefordshire's Health and Wellbeing Plan (best start in life for children; and good mental wellbeing throughout life).

In response to a question from Stephen Brewster about the focus on frailty and older patients in the neighbourhood health high-priority cohorts, Zoe Clifford explained that the pilots would test ways of working and inform the model as it extends to other population cohorts, and noted the importance of the wider determinants of health. Dr Lauren Parry referred to the activity being undertaken in other workstreams.

Resolved: That the contents of the report be noted.

55. WYE VALLEY NHS TRUST FIVE TO TEN YEAR STRATEGY

Sarah Shingler introduced the report and provided an overview of the Wye Valley NHS Trust (WVT) Five to Ten Year Strategy, as adopted by the [WVT Trust Board on 2 April 2026](#).

The main points included:

- a. The purpose was 'To improve the wellbeing, independence and health of the people we serve'; the mission was 'We give everyone the quality of care we would want for ourselves, our families and friends'; and the vision was 'Together with our partners, we will shape the future of healthcare alongside our communities – ensuring everyone experiences outstanding, seamless care in our hospitals and closer to home'.

It was noted that the strategy aligned closely with council priorities around prevention, independence and community-based approaches.

- b. The interconnected priority areas were outlined, as follows: 'Being a supportive employer', promoting an inclusive and caring organisational culture; 'Innovating to improve care', accelerating digital and data-enabled change; 'Strengthening our services', particularly around urgent and emergency care, and reducing waiting times for surgery; 'Treating people in the right place', shifting focus from acute to community, reflecting the neighbourhood health model; and 'Delivering on our responsibilities', by being an effective partner, planning for the end of the Private Finance Initiative (PFI) contract in 2029, and supporting wider sustainability goals.
- c. The strategy reinforced the importance of: strong NHS-local authority and VCSE (voluntary, community and social enterprise) collaboration, particularly around prevention, community services and frailty; shared place-based planning through the One Herefordshire Health and Care Partnership Board; joint workforce, digital and sustainability approaches; and co-design with communities to ensure services meet local needs.

In response to questions from the Chairperson, Sarah Shingler explained: how an enhanced discharge team had reduced avoidable admissions in December 2025; work on end of life care pathways; and the preparation of a business case for investment in additional multi-disciplinary staff.

In response to questions from the Leader of the Council, Sarah Shinger advised that: the strategy was designed for a period of five years but there was a need for flexibility given changing circumstances; urgent and emergency care improvements were being made tangible by collaborating with health, care and other partners; discussions were ongoing with the Powys system to help decrease preventable admissions and the amount of time patients spent in hospital; consideration was being given to potential measurable improvements in outcomes arising from the strategy and an update on progress could be provided in six months; the neighbourhood health model was key to transforming the approach to reducing attendances, redesigning pathways, and moving activity safely out to communities.

David Mehaffey commented that the strategy reflected the key shifts in national strategy but questioned whether objectives around reducing health inequalities should be made more explicit. Sarah Shingler confirmed that these would be detailed under 'Delivering on responsibilities'.

Dr Lauren Parry said that Herefordshire General Practice welcomed the collaborative approach and involvement in neighbourhood health workstreams, with work being undertaken on pathways and inequalities.

In response to a question from the Chairperson, Sarah Shingler confirmed that WVT's Chief Strategy and Planning Officer was involved in conversations about the government requirement to plan for 27,260 new homes in Herefordshire.

Stephen Brewster commented on the benefits of physical activity for people at risk of developing frailty and there was a brief discussion about this in the context of upstream prevention.

Resolved: That the contents of the report be noted.

56. BETTER CARE FUND (BCF) QUARTER 3 REPORT 2025-26

Hilary Hall updated the board on the Better Care Fund (BCF) quarter 3 performance template 2025/26, the main points included:

- i. Performance against national metrics had been mixed, with: 'Emergency admissions to hospital for people aged over 65 per 100,000 population' being on track; 'Average length of discharge delay for all acute adult patients' not being on track; and 'Long-term admissions to residential care homes and nursing homes for people aged 65 and over per 100,000 population' being below target.
- ii. A huge amount of work had gone into the revised Discharge to Assess (D2A) Model; it was noted that high levels of spending, particularly on hospital discharge services, represented a significant risk to maintaining financial balance in the BCF by the end of the financial year.
- iii. Work was being undertaken on Herefordshire's Better Care Plan for 2026/2027.

Resolved: That

- a) **the Better Care Fund (BCF) 2025/26 quarter three report at Appendix 1 submitted to NHS England be approved retrospectively; and**
- b) **the ongoing work to support integrated health and care provision that is funded via the BCF be noted.**

57. WORK PROGRAMME

The work programme for the board was considered, with attention drawn to the following matters:

- Provisional agenda items were noted for the board meeting on 13 July 2026. However, the 'Prevention in Adult Social Care Strategy' item would be moved to the 26 October 2026 meeting.
- A workshop for board members on neighbourhood health had been arranged for 28 September 2026.

Resolved:

That the updated work programme be agreed.

58. DATE OF NEXT MEETING

It was noted that the date of the next scheduled board meeting in public would be [Monday 13 July 2026, 2.00 pm](#).

At the conclusion of the meeting, the Chairperson expressed gratitude to board members (and substitutes) for their attendance and noted the value of active, in-person participation wherever possible.

The meeting ended at 3.41 pm

Chairperson



Title of report: Best Start in Life - Good Level of Development (GLD) in children aged 5 years

Meeting: Health and Wellbeing Board

Meeting date: Monday 13 July 2026

Report by: Julia Stephens Public Health Lead and Liz Farr, Service Director, Education Development

Classification

Open

Decision type

This is not an executive decision

Wards affected

(All wards)

Purpose

To provide an update on one of the key priorities in The Best Start in Life (BSiL) Strategic Plan, name a Good Level of Development (GLD) in children aged 5 years.

Recommendation(s)

That:

- a) **The board considers the report and notes how a GLD effects the life course and the progress on the work being carried out to achieve a Good Level of Development (GLD) at the end of reception class for children aged 5 years in Herefordshire.**

Key considerations

1. The report highlights the progress in the delivery of one of the priorities within the BSiL plan, around children achieving a good level of development at 5 years old.
2. Strategic leads from internal and partner organisations across the system are responsible for ensuring children reach a good level of development and report quarterly to the BSiL/Early Years Partnership Board and the Children and Young People Partnership Board on progress.

3. The Early Years Foundation Stage Profile (EYFSP) is a statutory assessment completed for all children at the end of the reception year (approximately aged 5 years). It provides a national picture of each child's development and learning, drawing together practitioner judgements based on ongoing observation and assessment throughout the Early Years Foundation Stage (EYFS).
4. The EYFSP assesses children against 17 Early Learning Goals (ELGs) across seven areas of learning. These judgements are used to: Support transition into Key Stage 1; inform parents and carers about their child's development; provide local and national data about children's outcomes at the end of the EYFS reception baseline assessment (RBA) and are completed within the first six weeks of Reception.
5. A child is said to have achieved a Good Level of Development (GLD) if they meet the expected standard in all of the following areas:
 - Personal, Social and Emotional Development
 - Physical Development
 - Communication and Language
 - Literacy
 - Mathematics
6. GLD is a key national indicator used to understand how well children are prepared for learning at Key Stage 1. While GLD is not a statutory expectation for individual children, it is an important measure for evaluating the effectiveness of early years provision at local and national level.
7. By 2028, the Government requires 75% (a record proportion) of children to reach a good level of development by the end of reception. This is an increase from approximately 68%, meaning 40,000 to 45,000 more children each year will be better prepared for school and life.
8. Only 51.5% of children who qualify for free school meals reach a good level of development at age five, compared to 72% of children not eligible for free school meals. And only 19.7% of children with any special educational needs (SEN) reach this benchmark, compared to 75.6% of children without SEN.
9. In the academic year 2024-2025, 72% of Herefordshire children, achieve a good level of development overall by the end of Reception. In England 68.3% of children reach a good level of development by the end of Reception. Herefordshire has been set a target by the Government of 80% to be achieved by 2028.
10. In 2024-2025 51.7% of Herefordshire children eligible for free school meals achieved a good level of development. In England 51.3% of children eligible for free school meals achieve a good level of development by the end of Reception. The Government has set a new target of 57.2% by 2028.
11. At age 2.5 years children are assessed through a universal health check delivered by the Health Visiting Service. This health check looks at: speech, language and communication development, monitors physical growth and development, early identification social, emotional and behavioural concerns, promotes healthy eating, physical activity and oral health and signposts families to early support service where needed.
12. A new health review was introduced in Herefordshire for children age 3 years to further assess and support the child's readiness for school. This review again monitors the development before school entry and focuses on the review of pre identified early identification social,

emotional and behavioral concerns, preparation for nursery/school transitions, targeted support to improve school readiness and reinforcement of key health messages.

13. GLD can have a significant impact on adult life. Children who progress well at school are more likely to gain qualifications and skills valued by employers, access a wider range of career opportunities, have higher earning potential over their lifetime, experience lower rates of unemployment, improved physical and mental health, greater health literacy, make healthier lifestyle choices, have greater financial stability, improved self-confidence and self-esteem and better resilience and adaptability.
14. To support the most disadvantaged children in achieving GLD, Herefordshire has recruited an Early Years/Key Stage 1 Improvement Adviser for SEND to support schools and help deliver the Neuroinclusive Education Network (NEN) training programme, including bespoke Early Years packages. 90 delegates already trained across early years in schools in the county
15. Extra support is being rolled out through the Child Readiness Project, to enhance transition support and more regular Early Years School Network Meetings with strong engagement from schools, alongside the recruitment of a universal Portage worker.

Community impact

16. A good level of development in children has positive effects on the community because children who develop well are more likely to become healthy, confident, and productive members of society. Some key impacts include:
17. **Better educational outcomes:** Children who are ready to learn are more likely to succeed in school, leading to a more skilled and educated population.
18. **Improved health and wellbeing:** Healthy development in early childhood can reduce the risk of physical and mental health problems later in life, easing pressure on healthcare services.
19. **Stronger local economy:** As children grow into adults with good education and skills, they are better able to find employment, contribute to the workforce and support economic growth.
20. **Reduced crime and antisocial behaviour:** Children who receive positive support and develop strong social and emotional skills are less likely to engage in risky or criminal behaviour.
21. **Greater community involvement:** Children who develop confidence, communication and teamwork skills are more likely to volunteer, participate in community activities and build positive relationships.
22. **Breaking cycles of disadvantage:** Supporting children's development can improve opportunities for future generations and help reduce poverty and inequality over time.
23. In summary, when children achieve a good level of development, the whole community benefits through better education, improved health, stronger social connections, increased economic productivity and safer, more resilient neighbourhoods.

Environmental impact

24. A good level of development in children can lead to positive environmental outcomes by encouraging sustainable behaviours, increasing awareness of environmental issues, helping create cleaner, greener and more responsible communities.

Equality duty

25. Under section 149 of the Equality Act 2010, the 'general duty' on public authorities is set out as follows:
- A public authority must, in the exercise of its functions, have due regard to the need to –
- a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
 - b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
 - c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.
26. The public sector equality duty (specific duty) requires us to consider how we can positively contribute to the advancement of equality and good relations and demonstrate that we are paying 'due regard' in our decision making in the design of policies and in the delivery of services.
27. The principles of equality and the reversal of health inequalities are key strands of the plan. The Herefordshire Joint Local Health and Wellbeing Strategy 2023 – 2033 was endorsed by the board in April 2023.
28. To be effective in delivering good population outcomes and helping those most in need, the plan calls for intervention by working together at system, place and community levels to tackle issues reflecting whole system priorities as well as specific concerns at the right scale.

Resource implications

29. None.

Legal implications

30. In accordance with Health and Social Care Act 2012, health and wellbeing boards are responsible for encouraging integrated working between health and social care commissioners, including partnership arrangements such as pooled budgets, lead commissioning and integrated provision.
31. The functions of the Health and Wellbeing Board are set out in paragraph 3.5.25 of the constitution.

Risk management

32. There are no risk implications identified emerging from the recommendations in this report. The work to increase a GLD in children aged 5 years, requires system-wide agreement and collaborative working across partner agencies.

Consultees

33. Consultation on the monitoring and review of GLD is carried out through the Children and Young Peoples Partnership Board and the BSiL/Early Years Partnership Board.

Appendices

None.

Background papers

None.

Glossary of terms, abbreviations and acronyms used in this report:

BSiL	Best Start in Life
GLD	Good Level of Development
EYFSP	Early Years Foundation Stage Profile
SEND	Special Education Needs
RBA	Reception Baseline Assessment



Title of report: Gambling and Related Harms

Meeting: Health and Wellbeing Board

Meeting date: Monday 13 July 2026

Report by: Head of Resilient Communities

Classification

Open

Decision type

This is not an executive decision

Wards affected

All wards

Purpose

The purpose of this briefing is to provide an overview of the scale and impact of gambling-related harms, outline the aims, approach and key actions of the gambling harms prevention project, and its alignment with wider public health and community safety priorities. It will also present current understanding of harm, identify key challenges, risks and opportunities for further development, and seek the Board's feedback, challenge and support to strengthen delivery and overall impact.

Recommendation(s)

That:

- a) **The Health and Wellbeing Board is asked to note the contents of this briefing paper for information.**

Alternative options

1. None.

Key considerations

2. Gambling is defined under the Gambling Act 2005 as betting, gaming or participating in a lottery, where gaming involves playing a game of chance for a prize, including money or money's worth.

3. Gambling takes place both in person and increasingly online, and encompasses a wide range of activities such as sports betting, slot machines, fixed-odds betting, casino-style games like poker and bingo, and emerging forms such as 'loot boxes' in games, which are often targeted at children. While gambling is legal, the associated harms are a recognised public health issue, with significant impacts on individuals, families and communities.
4. It is estimated that nationally there is one gambling-related suicide per day, and gambling has been identified as one of six key risk factors within the National Suicide Prevention Strategy. The sector is characterised by aggressive digital marketing and psychologically informed design, and is often compared to 'Big Tobacco' in terms of its approach and influence.
5. The Department of Health and Social Care (DHSC) estimates that gambling costs the Government and wider society between £1.05 billion and £1.77 billion annually. Current legislation includes a statutory presumption in favour of permitting gambling applications, and unlike alcohol licensing, there is no statutory role for Public Health in gambling premises decisions.
6. The UK has one of the largest gambling markets globally, with the industry valued at £16.8 billion in 2024–2025; participation levels remain high, with 48% of adults reporting gambling in the previous four weeks and 30% of young people spending money on gambling in the last 12 months.
7. The statutory gambling levy in the UK is a mandatory charge applied to licensed gambling operators to fund research, prevention and treatment of gambling-related harms. This funding is distributed across three key areas, with allocations for research, prevention and treatment at a national level.
8. Local authorities participating in the Gambling Harms Prevention Programme, in line with the Memorandum of Understanding (MoU) with the Office for Health Improvement and Disparities (OHID), are expected to adopt a public health approach to reducing gambling-related harm. This includes developing a robust understanding of local need through needs assessment, improving data collection and recording, and embedding gambling harms within wider health and wellbeing strategies.
9. Authorities are required to work in partnership across sectors, strengthen early identification and referral pathways, and deliver proportionate prevention activity, particularly targeting vulnerable groups. The MoU also sets expectations around governance, reporting and evaluation, ensuring that funding is used transparently and that learning is captured and shared to inform both local and national policy and practice.

Community impact

10. In recent years, concern about the harms associated with gambling has been increasing. As set out within the independent public health framework developed by Langham et al¹, gambling harm is defined as any negative impact that reduces health or wellbeing.
11. This broadened definition recognises that harm extends beyond the individual who gambles to affect families, communities and wider society, and that such impacts can develop cumulatively, persist over time, and continue long after gambling behaviour has ceased.
12. The Health Survey for England 2024 (published January 2026) estimates that around 5% of adults have Problem Gambling Severity Index (PGSI) scores indicating at-risk or problem gambling, with fewer than 1% classified as problem gamblers. Higher rates are observed among men, particularly younger men, and among those who participate in online gambling.

¹ Langham, E., Thorne, H., Browne, M., Donaldson, P., Rose, J. and Rockloff, M. (2016) Understanding gambling-related harm: a proposed definition, conceptual framework, and taxonomy of harms. *BMC Public Health*, 16, 80. <https://doi.org/10.1186/s12889-016-2747-00>

Gambling-related harm is also socially patterned, with individuals living in more deprived areas significantly more likely to experience severe harm. This is compounded by a higher concentration of gambling premises and gaming machines in these communities.

13. The Problem Gambling Severity Index (PGSI) is the nationally recommended screening tool used to identify and assess gambling-related harm, comprising a series of questions that generate a score indicating levels of risk, from low-risk through to problem gambling. National and regional estimates suggest that around 5% of adults may be at risk or experiencing problem gambling, with local modelling indicating that this could equate to approximately 18,000 Herefordshire residents at some level of risk and over 3,000 experiencing more severe harm. However, these figures should be treated with caution, as the routine use of the PGSI within local services remains limited, and awareness of the tool is not yet widespread across frontline practitioners. As a result, gambling-related harm is likely to be under-identified, meaning current estimates may not fully reflect the true scale of need within the local population.
14. Gambling harms extend beyond the individual to affect families, friends and wider communities. It is estimated that around 7% of the population are negatively impacted by someone else's gambling, contributing to financial difficulties, relationship breakdown and poorer mental health. Harms are wide-ranging and can include impacts on employment, housing, criminality and suicidality. Problem gambling is recognised as an addictive behaviour within ICD10 diagnostic classifications, driven by similar brain reward mechanisms to substance misuse. Evidence also highlights a strong co-occurrence, with research suggesting that nearly 60% of individuals experiencing problem gambling also have a substance misuse issue, alongside a significant overlap with mental health conditions.
15. The evidence highlights that gambling participation and related harm are influenced by a range of demographic and behavioural factors. Higher levels of harm are associated with younger adults, males, those experiencing poor mental health, unemployment and individuals living in more deprived areas, with additional risks linked to high alcohol consumption and smoking. Of particular relevance locally, research indicates that military veterans may be significantly more vulnerable, with one study suggesting they are up to ten times more likely to gamble, which is an important consideration given Herefordshire's relatively large veteran population. These patterns reinforce the need for targeted prevention and early identification approaches focused on higher-risk groups.

Children and Young People

16. Evidence indicates a growing concern regarding gambling-related harm among children and young people. Data from the Gambling Commission show that the proportion of children classified as having a gambling problem has more than doubled since 2023, with an estimated 85,000 children currently affected ². This reflects increasing early exposure to gambling and the normalisation of gambling behaviours among younger age groups. These findings are supported by the Young People and Gambling Survey 2024 ³.

Local Licenced Premises

17. The Herefordshire Mental Health Needs Assessment (2025) identified 14 betting shops across the county, with the majority located in Hereford (8), followed by Ross-on-Wye (3), and one each in Ledbury, Leominster and Bromyard.
18. Since publication of this assessment, the overall number of licensed gambling premises has increased by 50% to 21, including 13 in Hereford, 5 in Ross-on-Wye, and one each in Bromyard, Ledbury and Leominster. Notably, many of these premises are situated within or

² <https://www.gamblingcommission.gov.uk/statistics-and-research/publication/young-people-and-gambling-2024-official-statistics>

³ <https://www.gamblingcommission.gov.uk/statistics-and-research/publication/young-people-and-gambling-2024-official-statistics>

adjacent to some of the most deprived areas of the county, further reinforcing the link between gambling availability and areas of higher vulnerability.

Support Services

19. Gambling support provision for Herefordshire residents is currently delivered through a combination of national and regional services rather than locally based provision. This includes access to Aquarius (offering virtual and telephone support), the West Midlands Gambling Harm Clinic—where the nearest in-person service is located in Stoke—and GamCare, which provides a 24/7 national helpline. While these services offer important support pathways, there is limited local, face-to-face provision, reflecting wider national challenges; evidence from the Office for Health Improvement and Disparities (OHID) indicates that only 35 of 153 upper-tier local authorities in England have a treatment provider physically located within their area.

Next Steps

20. Next steps focus on strengthening the local evidence base and developing a coordinated response to gambling-related harms in Herefordshire. There is currently a lack of consistent local data and recording, which limits the ability to fully understand need and target interventions effectively. A Herefordshire Gambling Harms Needs Assessment will be undertaken to establish the local picture in more detail, including prevalence, risk factors, affected groups and service demand, alongside mapping current provision and identifying gaps.
21. A recent discussion and mini-workshop with the Public Health team has provided an initial indication of where gambling-related harm is already being identified, for example through mechanisms such as the Crisis and Resilience Fund, as well as highlighting clear gaps in both identification and service provision. The needs assessment will build on this early insight, drawing together available data, stakeholder engagement and lived experience to inform priorities, strengthen pathways for identification and support, and guide future commissioning and prevention activity.

Environmental impact

22. Whilst this is a report detailing the ambitions of the Gambling Harms Prevention Project overall and plans for a localised assessment of need and will therefore have minimal environmental impacts, consideration has been made to minimise waste and resource use in line with the Council's Environmental Policy.

Equality duty

23. The Public Sector Equality Duty applies. The initial equality impact screening checklist indicates a minimal impact at this stage because this report concerns the development of a new project and assessment of localised need rather than direct service change.

Resource implications

24. The gambling harms prevention project requires some time and resource from Council officers, for the development of the local needs assessment.

Legal implications

25. The functions of the Health and Wellbeing Board are set out in paragraph 3.5.25 of the Council's constitution.

Risk management

26. None identified.

Consultees

27. None identified.

Appendices

None.

Background papers

None identified.



Title of report: The Better Care Fund (BCF) year-end report 2025/26

Meeting: Health and Wellbeing Board

Meeting date: Monday 13 July 2026

Report by Delivery and Improvement Lead

Classification

Open

Decision type

This is not an executive decision

Wards affected

(All Wards)

Purpose

To update the Health and Wellbeing Board (HWB) members on the Herefordshire's Better Care Fund (BCF) End of Year 2025/26 performance template and seek formal Health and Wellbeing Board approval.

Recommendation(s)

That:

- a) **the Better Care Fund (BCF) 2025/26 end of year report at Appendix 1 submitted to NHS England, be reviewed and approved retrospectively by the board; and**
- b) **the ongoing work to support integrated health and care provision that is funded via the BCF is noted by the board.**

Alternative options

1. The board could decline to sign off the submission. It is a national requirement that the BCF Plan is signed off by the Health and Wellbeing Board (HWB). The content of the return has already been approved by Hilary Hall, Corporate Director for Community Wellbeing by way of delegated authority and submitted prior to the meeting of the board, in accordance with national deadlines.
2. The HWB does not always align with national deadlines, however, this gives the board an opportunity to review and provide feedback.

Key considerations

3. The Better Care Fund (BCF) provides a mechanism for joint health, housing and social care planning and commissioning. It brings together ring-fenced budgets from Herefordshire and Worcestershire Integrated Care Board (HWICB) allocations, and funding paid directly to local government.
4. The national BCF team determines national reporting requirements on the overall BCF programme, with quarterly reports being submitted to NHS England (NHSE) and Health and Wellbeing Boards.
5. The year-end template requires confirmation that the BCF national conditions continued to be met throughout the year, confirmation of actual income and expenditure in BCF section 75 agreements for 2025/26 and details of significant successes and challenges during the year.
6. The deadline for the year end 2025/26 performance return has already passed (5 June 2026) and therefore the board is requested to note the completed template (**Appendix 1**), following its submission to NHS England.
7. The Year-End template (**Appendix 1**) consists of several elements:
 - i) Confirmation that National Conditions have been met
 - ii) Metrics and Performance
 - iii) Income and Expenditure Actuals
 - iv) Feedback on the impact of the BCF
8. Herefordshire has reported that all of the national conditions, as listed below, have been met.
 - i) A jointly agreed plan
 - ii) Implementing the objectives of the BCF
 - iii) Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care and Section 75 in place
 - iv) Complying with oversight and support processes
9. The BCF Plan 2025/26 was classified as ‘approved with local conditions’ in June 2025.
10. The local conditions are:

“A delivery plan to achieve metric goals be shared with the West Midlands Better Care Manager, by 15 August 2025. We would expect this plan to provide assurance to your place/system in terms of how:

 - 1) The metric goals set in the plan will be delivered within available resources.
 - 2) Impact will be monitored and responded to in terms of risks and further improvements, including in the context of 2025/26 BCF objectives and metrics.”

Key achievements for 2025/26 included:
11. A stronger shared vision and purpose have developed across acute, community and social care partners, with a clear system-wide commitment to the new D2A model and intermediate care pathways. This collective focus has supported quicker agreement on pathway criteria, MDT expectations and recovery-focused, time-limited interventions. Consistent messaging and shared ownership have also sped up decision-making and reduced variation in practice.

12. Improved multi-agency coordination and MDT working. Integrated MDT oversight and earlier therapy involvement have improved flow and reduced avoidable delays. Partners report better communication, clearer escalation routes and greater confidence in shared risk management. This demonstrates strong progress against SCIE enablers related to relationships, leadership and collaborative working cultures.
13. Herefordshire also reported two key challenges affecting progress in strengthening the enablers for integration during 2025/26.
14. Workforce capacity and capability constraints — Persistent pressure across therapy, social care and provider markets continues to limit the system’s ability to fully realise the benefits of the redesigned pathways. A new model is due to launch in June 2026 to help address these issues. This challenge aligns with SCIE enablers relating to workforce development, resource sufficiency and sustainable staffing models.
15. Data, digital and intelligence limitations — Fragmented data flows, inconsistent recording and limited real-time visibility of pathway performance make it difficult to track outcomes, forecast demand and proactively manage system pressures. This limits the system’s ability to embed learning loops and support evidence-based decision-making. It reflects gaps in SCIE enablers relating to shared information systems, interoperable digital tools and integrated performance management. A new D2A Case Tracker and dashboard is being developed to address these issues.
16. The end of year data for Herefordshire metrics are set out below:
 - 1) **Emergency admissions to hospital for people aged over 65 per 100,000 population**
17. At year end, Herefordshire’s performance on emergency admissions for 2025/26 was in line with the target, with a reported figure of 615.73 against a target of 616.
 - 2) **Average length of discharge delay for all acute adult patients, derived from a combination of:**
 - **proportion of adult patients discharged from acute hospitals on their Discharge Ready Date (DRD)**
 - **for those adult patients not discharged on their DRD, average number of days from the DRD to discharge**
18. Year-end performance data indicates that Herefordshire did not achieve the 2025/26 discharge delay metric. The average length of discharge delay was 0.93 days, against a target of 0.51 days. In addition, 85.8% of adults were discharged on their Discharge Ready Date, compared with a target of 91.4%, and for those not discharged on their Discharge Ready Date, the average delay was 6.47 days against a target of 5.98 days.
 - 3) **Long-term admissions to residential care homes and nursing homes for people aged 65 and over per 100,000 population**
19. Herefordshire reported as being on track to meet the target of 263.9 admissions with a year-end figure of 228 admissions per 100,000 population for the rate of permanent admissions to residential care per 100,000 (65+).
20. Performance at year-end 25/26 is demonstrating continued progress towards maintaining admissions below the 2025/26 target, with system partners working collaboratively to manage demand and improve outcomes. The introduction of the enhanced D2A model is strengthening pathway management, with a particular focus on Pathway 3 (P3) episodes to help reduce Length of Stay (LoS).

21. The system has delivered a year of clear, measurable progress in strengthening prevention, improving flow and embedding a more integrated approach to care across Herefordshire. The delivery plan demonstrated that partners have consolidated a more proactive, coordinated model that supports people earlier, helping to reduce avoidable escalation and ensures resources are used efficiently across the whole system.
22. Alongside operational improvements, the programme has delivered stronger governance, integration. Joint oversight through One Herefordshire Partnership has ensured consistent monitoring, risk management and alignment with wider system priorities. Commissioning oversight, improved provider engagement and clearer governance models have strengthened the sustainability of local provision and supported safer step-down from hospital.
23. Overall, the year has seen the BCF programme become more coordinated, data-driven and prevention-focused, with partners working in a more unified way to deliver the national metrics and improve outcomes for residents.

Community impact

24. The BCF plan is set within the context of the national programme of transformation and integration of health and social care. The council and HWICB will continue to work together to deliver on the key priorities within the plan to achieve savings and improve the delivery of services in order to achieve the priorities of the Health and Wellbeing Strategy in the most cost-effective way.
25. Talk Community brings together community, third sector and statutory services to connect with peers and share ideas and experiences within the local Primary Care Network (PCN) areas; working with communities to identify and address issues that affect them, increase sustainability of communities by facilitating the development of partnerships and collaborative approaches and helping identify any gaps in provision.

Environmental impact

26. Herefordshire Council provides and purchases a wide range of services for the people of Herefordshire. Together with partner organisations in the private, public and voluntary sectors we share a strong commitment to improving our environmental sustainability, achieving carbon neutrality and to protect and enhance Herefordshire's outstanding natural environment.
27. Whilst this is a report on programme delivery and will have minimal environmental impacts, consideration has been made to minimise waste and resource use in line with the council's Environmental Policy.

Equality duty

28. Due to the potential impact of this decision being low, a full Equality Impact Assessment (EIA) is not required.
29. The council and HWICB are committed to equality and compliance with the public sector equality duty. The public sector equality duty (specific duty) requires us to consider how we can positively contribute to the advancement of equality and good relations and demonstrate that we are paying 'due regard' in our decision making in the design of policies and in the delivery of services.
30. Whilst this paper is not seeking any project specific decisions, the quarter three report provides an overview of performance in relation to services funded by the BCF. The BCF programme aims to deliver better outcomes for older and disabled people and supports the council in proactively delivering its equality duty under the Equality Act. This is through improving the

health and wellbeing of people in Herefordshire by enabling them to take greater control over their own homes and communities.

31. Commissioned services funded by the BCF take into account the arrangements to assess and consult on how functions impact on protected characteristics. Services are undertaken in a manner which respects individuality of service users, patients etc. Where appropriate, an EIA is undertaken for separate schemes and services that are within the BCF.

Resource implications

32. In 2025/26 the BCF provides Herefordshire with total funding of £30.882mn.
33. The final financial position for the Better Care Fund for 2025/26 is overspending by £2.208mn, 7% of the total funding. This is due to overspending of £2.057m on services facilitating hospital discharge, £0.255m on services for Deprivation of Liberty Safeguards (DoLS) and Approved Mental Health Professionals (AMHP), and £0.173mn on Safeguarding, offset by underspending of £0.251mn on Disabled Facilities Grants (DFG) and net underspending of £0.036mn in other services.
34. Herefordshire Better Care Fund

Service	Final Actual Expenditure at Month 12			
	Planned Expenditure	Actual Expenditure	Variance to Plan	% Variance to Plan
Acorns Children's Hospice Carers Support	£34,942	£34,942	£0	0.00%
Advocacy	£155,084	£155,960	(£876)	(0.57%)
ASC Long-term Placements	£7,552,056	£7,552,056	£0	0.00%
Brokerage	£326,789	£325,813	£976	0.30%
Carers Support	£225,000	£225,000	£0	0.00%
Disabled Facilities Grant	£3,373,393	£3,122,048	£251,345	7.45%
Discharge to Assess	£8,326,105	£10,383,326	(£2,057,220)	(24.71%)
DoLS/AMHPs	£1,015,564	£1,280,708	(£265,144)	(26.11%)
Falls Response and Prevention	£226,197	£221,409	£4,787	2.12%
Partnerships and Integration Staffing	£231,533	£227,905	£3,629	1.57%
Safeguarding	£295,722	£468,472	(£172,750)	(58.42%)
St Michael's Hospice Carers Support	£283,998	£283,998	£0	0.00%
Trusted Assessors	£88,021	£63,041	£24,620	27.97%
Wye Valley Integrated Care Services	£9,054,591	£9,051,769	£2,822	0.03%
TOTAL	£31,188,995	£33,396,808	(2,207,812)	(7.08%)

All values are in £

(Red Brackets = Overspending)

35. The £2.208mn cost pressure of the overspending has been met by additional contributions to the pooled budget by Herefordshire Council and Wye Valley NHS Trust.

Legal implications

36. The relevant legal provisions for this decision can be found in the council's constitution, www.herefordshire.gov.uk/constitution.

- 37. The Care Act 2014 amended the NHS Act 2006 to provide the legislative basis for the BCF. It allows for the Mandate to NHS England to include specific requirements to instruct NHS England over the BCF, and NHS England to direct Integrated Care Boards to pool the necessary funding. The council is legally obliged to comply with grant conditions, which have been complied with.
- 38. Health and Wellbeing Boards are responsible for encouraging integrated working between health and social care commissioners, including partnership arrangements such as pooled budgets, lead commissioning, and integrated provision.
- 39. Their purpose is to establish collaborative decision making, planning and commissioning across councils and the NHS, informed by the views of patients, people who use services and other partners.
- 40. Overseeing the deployment of BCF resources locally is a key part of their remit. BCF plans have to be signed off by the Health and Wellbeing Board as well as the HWICB, which represents the NHS side of the equation.
- 41. Section 75 of the National Health Service Act 2006 contains powers enabling NHS bodies (as defined in section 275 and 276 of the NHS Act 2006) to exercise certain local authority functions and for local authorities to exercise various NHS functions. The parties entered into a Section 75 agreement in exercise of those powers under and pursuant of the NHS Regulations 2000.
- 42. The Local Authority Better Care Grant is paid directly to the council via a Section 31 grant from the Ministry of Housing, Communities and Local Government (MHCLG). The government has attached a set of conditions to the Section 31 grant to ensure it is included in the BCF at local level and will be spent on adult social care. The council are legally obliged to comply with the grant conditions set.

Risk management

- 43. Monitoring the delivery of the Herefordshire BCF Plan is undertaken by the council, WVT and the HWICB. Risks are managed through the community and wellbeing directorate risk register where necessary.
- 44. Strategic oversight is exercised by the One Herefordshire Partnership Health and Care Board, the BCF Partnership Board, and the Discharge to Assess (D2A) Strategic Board, which are responsible for setting priorities, approving plans, and holding partners collectively accountable for outcomes.
- 45. A formal Memorandum of Understanding (MoU) outlines shared principles, roles, financial commitments, and decision-making for pooled BCF resources between partner organisations. It clarifies accountability for delivery, supports transparent financial management, and strengthens joint governance, ensuring collective ownership of national performance and collaborative management of risks and pressures.

Risk / Opportunity

Mitigation

Failure to achieve national metrics ambitions.

A robust process for monitoring activity monthly is in place and will be monitored through the BCF Partnership Group

Risk / Opportunity	Mitigation
Increasing demand due to the demography of expected older age population.	A number of the schemes include both areas that support prevention and the urgent care parts of the system to spread the risk. In addition, the council continues to lead on development with communities.
Overspend, particularly on discharge capacity.	The council, WVT and HWICB are working with to revise and improve the service model for Discharge to Assess to be recurrently sustainable.

46. Assurance Statement:

The strategic and operational risks associated with the delivery of the Better Care Fund have been reviewed and are being managed in accordance with the Council's Risk Management Strategy. Oversight of risk mitigation will continue through the council's and partners' established governance frameworks to ensure that risks are effectively monitored, escalated, and addressed in support of integrated health and social care outcomes.

Consultees

47. The content of the report has been provided by partners within One Herefordshire Partnership Health and Care Board, the BCF Partnership Board, HWICB, WVT, Hoople Ltd and appropriate internal Herefordshire Council staff.

Appendices

Appendix 1 – Better Care Fund 2025/26 End of Year Reporting Template

Background papers

None

Glossary of terms, abbreviations and acronyms used in this report

Acronym	Description
AHMP	Approved Mental Health Professional
BCF	Better Care Fund
1HP	One Herefordshire Partnership
DRD	Discharge Ready Date
HWB	Health and Wellbeing Board
HWICB	Herefordshire and Worcestershire Integrated Commissioning Board
EIA	Equality Impact Assessment
D2A	Discharge to Assess
DFG	Disabled Facilities Grant
DoLS	Deprivation of Liberty Services
LoS	Length of Stay
MDT	Multi-Disciplinary Team
MHCLG	Ministry of Housing, Communities and Local Government
NHSE	NHS England
PCN	Primary Care Network
WVT	Wye Valley NHS Trust

Better Care Fund 2025-26 EOY Reporting Template

1. Guidance

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements for 2025-26 (refer to link below), which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health and Social Care (DHSC), Ministry for Housing, Communities and Local Government (MHCLG), NHS England (NHSE).

<https://www.england.nhs.uk/long-read/better-care-fund-planning-requirements-2025-26/#introduction>

<https://www.gov.uk/government/publications/better-care-fund-policy-framework-2025-to-2026/better-care-fund-policy-framework-2025-to-2026>

As outlined within the planning requirements, quarterly BCF reporting will continue in 2025-26, with areas required to set out progress on delivering their plans by reviewing metrics performance against goals, spend to date as well as any significant changes to planned spend.

The primary purpose of BCF reporting is to ensure a clear and accurate account of continued compliance with the key requirements and conditions of the fund. The secondary purpose is to inform policy making, the national support offer and local practice sharing by providing a fuller insight from narrative feedback on local progress, challenges and highlights on the implementation of BCF plans and progress on wider integration.

BCF reporting is likely to be used by local areas, alongside any other information to help inform HWBs on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including ICBS, local authorities and service providers) for the purposes noted above.

In addition to reporting, BCMs and the wider BCF team will monitor continued compliance against the national conditions and metric ambitions through their wider interactions with local areas.

BCF reports submitted by local areas are required to be signed off HWB chairs ahead of submission. Aggregated data reporting information will be available on the DHSC BCF Metrics Dashboard and published on the NHS England website.

Note on entering information into this template

Please do not copy and paste into the template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells/Not required

Note on viewing the sheets optimally

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance tab for readability if required.

The row heights and column widths can be adjusted to fit and view text more comfortably for the cells that require narrative information.

Please DO NOT directly copy/cut and paste to populate the fields when completing the template as this can cause issues during the aggregation process. If you must 'copy and paste', please use the 'Paste Special' operation and paste Values only.

The details of each sheet within the template are outlined below.

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF Team.

2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.

4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.

5. Please ensure that all boxes on the checklist are green before submission.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. Once you select your HWB from the drop down list, relevant data on metric goals from your BCF plans for 2025-26 will pre-populate in the relevant worksheets.

2. HWB Chair sign off will be subject to your own governance arrangements which may include a delegated authority.

3. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to:

england.bettercarefundteam@nhs.net

(please also copy in your respective Better Care Manager)

4. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. National Conditions

This section requires the Health & Wellbeing Board to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2025-26 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.

<https://www.england.nhs.uk/long-read/better-care-fund-planning-requirements-2025-26/>

This sheet sets out the four conditions and requires the Health & Wellbeing Board to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met for the year and how this is being addressed. Please note that where a National Condition is not being met, an outline of the challenge and mitigating actions to support recovery should be outlined. It is recommended that the HWB also discussed this with their Regional Better Care Manager.

In summary, the four National conditions are as below:

National condition 1: Plans to be jointly agreed

National condition 2: Implementing the objectives of the BCF

National condition 3: Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC) (and section 75 in place)

National condition 4: Complying with oversight and support processes

4. Metrics

The BCF plan includes the following metrics (these are not cumulative/YTD):

1. Emergency admissions to hospital for people aged 65+ per 100,000 population. (monthly)
2. Average number of days from Discharge Ready Date to discharge (all adult acute patients). (monthly)
3. Admissions to long term residential and nursing care for people aged 65+ per 100,000 population. (quarterly)

Plans for these metrics were agreed as part of the BCF planning process outlined within 25/26 planning submissions.

Populations are based on 2024 mid year estimates, please note this has been updated from the Q2 template to match the DHSC metrics dashboard.

Within each section, you should set out how the ambition has been reached, including analysis of historic data, impact of planned efforts and how the target aligns for locally agreed plans such as Acute trusts and social care.

☑

The bottom section for each metric also captures a confidence assessment on achieving the locally set ambitions for each of the BCF metrics.

The metrics worksheet seeks a short explanation if a goal has not been met - in which case please provide a short explanation, including noting any key mitigating actions.

You can also use this section to provide a very brief explanation of overall progress if you wish.

In making the confidence assessment on progress, please utilise the available metric data via the published sources or the DHSC metric dashboard along with any available proxy data.

https://dhexchange.kahootz.com/Discharge_Dashboard/groupHome

5. Income & Expenditure

This section requires confirmation of an update to actual income received in 2025-26 across each fund, as well as spend to date at Q3. If expenditure by activity has changed since the original plan, please confirm that this has been agreed by local partners. If that change in activity expenditure is greater than 5% of total BCF expenditure, please use this box to provide a brief summary of the change.

On the 'DFG' row in the 'Source of Funding' table, 'Updated Total Income for 25-26' this should include the total funding from DFG allocations that is available for you to spend on DFG in this financial year 2025-26. 'EOY Actual Expenditure' should include total amount that has been spent at year-end, even if the application or approval for the DFG started in a previous quarter or there has been slippage.

The template will automatically pre-populate the planned income in 2025-26 from BCF plans, including additional contributions. Please enter the update amount of income even if it is the same as in the submitted plan. Note that the extra £50m DFG top-up that had been introduced at the start of the year is now included in the total DFG amount therefore please include this in your total actuals expenditure.

Please also use this section to provide the aggregate End of Year Spend. This tab will also display what percentage of planned income this constitutes.



Better Care Fund 2025-26 EOY Reporting Template

2. Cover

Version 1.0

Please Note:

- The BCF quarterly reports are categorised as 'Management Information' and data from them will be published in an aggregated form on the NHSE website. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.

- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the BCE) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.

- All information will be supplied to BCF partners to inform policy development.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Herefordshire, County of	
Completed by:	Marie Gallagher and Adrian Griffiths	
E-mail:	Marie.Gallagher1@herefordshire.gov.uk	
Contact number:	01432 260435	
Has this report been signed off by (or on behalf of) the HWB Chair at the time of submission?	No	
If no, please indicate when the report is expected to be signed off:	Mon 13/07/2026	<< Please enter using the format, DD/MM/YYYY

Checklist
Complete:
Yes
Yes
Yes
Yes
Yes
Yes

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'.

Complete	
	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5. Income & Expenditure	Yes

For further guidance on requirements please refer back to guidance sheet - tab 1.

[<< Link to the Guidance sheet](#)

[^^ Link back to top](#)

Better Care Fund 2025-26 EOY Reporting Template

3. National Conditions

Selected Health and Wellbeing Board:

Herefordshire, County of

Confirmation of Nation Conditions		
National Condition	Confirmation	If the answer is "No" please provide an explanation as to why the condition was not met in the quarter and mitigating actions underway to support compliance with the condition:
1) Plans to be jointly agreed	Yes	
2) Implementing the objectives of the BCF	Yes	
3) Complying with grant and funding conditions, including maintaining the NHS minimum contribution to adult social care (ASC) and Section 75 in place	Yes	
4) Complying with oversight and support processes	Yes	

Checklist
Complete:

Yes

Yes

Yes

Yes

Better Care Fund 2025-26 EOY Reporting Template

4. Metrics for 2025-26

Selected Health and Wellbeing Board:

Herefordshire, County of

For metrics time series and more details:

[BCF dashboard link](#)

For metrics handbook and reporting schedule:

[BCF 25/26 Metrics Handbook](#)

4.1 Emergency admissions

Plan		Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
Emergency admissions to hospital for people aged 65+ per 100,000 population	Rate	1,279.8	1,326.5	1,279.8	1,176.1	1,212.0	1,113.2	1,257.6	1,162.9	1,170.4	1,121.0	1,121.0	1,121.0
	Number of Admissions 65+	659	683	659	606	624	574	648	599	603	577	577	577
	Population of 65+	51,516.0	51,516.0	51,516.0	51,516.0	51,516.0	51,516.0	51,516.0	51,516.0	51,516.0	51,516.0	51,516.0	51,516.0

Assessment of whether goal has been met in Q4:	On track to meet goal
<p>You may use this box to provide a very brief explanation of overall progress if you wish.</p>	Actuals - Admissions / Rate per 100K
	May 646 (1254)
	June 607 (1178)
	July 606 (1176)
	Aug 640 (1242)
	Sept 625 (1213)
	Oct 680 (1320)
	Nov 630 (1223)
	Dec 630 (1223)
	Jan 700 (1359)
	Feb 572 (1110)
	Mar 437 (848)

Checklist

Complete:

Yes

Yes

4.2 Discharge Delays

Original Plan	Apr 25 Plan	May 25 Plan	Jun 25 Plan	Jul 25 Plan	Aug 25 Plan	Sep 25 Plan	Oct 25 Plan	Nov 25 Plan	Dec 25 Plan	Jan 26 Plan	Feb 26 Plan	Mar 26 Plan
Average length of discharge delay for all acute adult patients (this calculates the % of patients discharged after their DRD, multiplied by the average number of days)	0.81	0.61	0.62	0.47	0.70	0.52	0.45	0.37	0.41	0.41	0.53	0.27
Proportion of adult patients discharged from acute hospitals on their discharge ready date	88.0%	88.4%	88.1%	90.7%	89.9%	91.1%	92.5%	92.8%	93.3%	93.4%	93.0%	95.4%
For those adult patients not discharged on DRD, average number of days from DRD to discharge	6.77	5.28	5.19	5.01	6.88	5.88	5.96	5.12	6.12	6.21	7.59	5.72

Assessment of whether goal has been met in Q4:	Not on track to meet goal
<p>You may use this box to provide a very brief explanation of overall progress if you wish.</p>	<p>Length of Discharge Delay/proportion/Not discharged on DRD (average no. days)</p> <p>May 0.9 83.8% 5.8</p> <p>June 1.0 85.2% 6.2</p> <p>July 1.0 84.6% 6.2</p> <p>Aug 0.9 86.5% 6.7</p> <p>Sept 0.8 86.0% 5.6</p> <p>Oct 0.9 86.4% 6.9</p> <p>Nov 1.0 84.5% 6.2</p> <p>Dec 1.0 86.3% 7.0</p> <p>Jan 1.0 85.5% 7.1</p> <p>Feb 0.7 88.1% 6.2</p> <p>Mar 1.0 86.9% 7.3</p>

Yes

Yes

4.3 Residential Admissions

Actuals + Original Plan		2023-24 Full Year Actual	2024-25 Full Year CLD Actual	2025-26 Plan Q1 (April 25- June 25)	2025-26 Plan Q2 (July 25- Sept 25)	2025-26 Plan Q3 (Oct 25-Dec 25)	2025-26 Plan Q4 (Jan 26-Mar 26)
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Rate	355.1	462.0	127.9	128.1	128.1	128.1
	Number of admissions	180.0	238.0	65.9	66.0	66.0	66.0
	Population of 65+*	51516.0	51516.0	51516.0	51516.0	51516.0	51516.0

Assessment of whether goal has been met in Q4:	On track to meet goal
<p>You may use this box to provide a very brief explanation of overall progress if you wish.</p>	<p>Due to timelines for reporting, figures have changed quarterly from originals reported.</p> <p>Q1 57 Q2 77 Q3 51 Q4 43</p> <p>Performance at Q4 is demonstrating continued progress towards maintaining admissions below the 2025/26 target, with system partners working collaboratively to manage demand and improve outcomes. The introduction of the enhanced D2A model is strengthening pathway management, with a particular focus on Pathway 3 (P3) episodes to help reduce LoS.</p>

Yes

Yes

Better Care Fund 2025-26 EOY Reporting Template

5. Income & Expenditure

Selected Health and Wellbeing Board:

Herefordshire, County of

Source of Funding	2025-26		DFG EOY Actual Expenditure
	Planned Income	Updated Total Income for 25-26	
DFG (including top-up)	£3,012,994	£3,012,994	£2,761,649
Minimum NHS Contribution	£19,447,855	£19,447,855	
Local Authority Better Care Grant	£8,367,748	£8,367,748	
Additional LA Contribution	£0	£2,459,158	
Additional NHS Contribution	£0	£0	
Total	£30,828,597	£33,287,755	

End of Year Actual Expenditure		% of Planned Income
	£33,036,408	99%

<p>If expenditure by activity has changed since the original plan, please confirm that this has been agreed by local partners. If that change in activity expenditure is greater than 5% of total BCF expenditure, please use this box to provide a brief summary of the change.</p>	<p>Revenue funding streams overspent by £2.459mn funded by additional contributions from Herefordshire Council: Hospital Discharge: £2.057mn Deprivation of Liberty Safeguards: £0.265mn Safeguarding: £0.172mn Various small offsetting underspending: £0.035mn</p> <p>Disabled Facilities Grant underspent by £0.251mn, this funding has been carried forward to 2026/27</p>
--	--

Checklist

Complete:

Yes

Yes

Yes

Yes

Yes

Yes

Yes

Better Care Fund 2024-25 EOY Reporting Template
6. Year End Impact Summary

Selected Health and Wellbeing Board:

Checklist
 Complete:

Confirmation of Statements		
Question statements	Confirmation	If the answer is "No" please provide an explanation:
Overall delivery of BCF has improved joint working between health and social care	Yes	
Our BCF schemes were implemented as planned in 2025-26	Yes	
The delivery of our BCF plan 2025-26 has had a positive impact on the integration of health and social care in our locality.	Yes	

Yes
Yes
Yes

Highlight success and challenges within reference to the most relevant enablers from SCIE logic model:

Logic model for integrated care - SCIE	
Success and Challenges	Narrative
2 key successes observed towards driving the enablers for integration	<p>Strengthened shared vision and purpose — A clear, system-wide commitment to the new D2A model and intermediate care pathways has emerged across acute, community, and social care partners. This shared purpose has enabled faster alignment on pathway criteria, MDT expectations, and the shift toward recovery-focused, time-limited interventions. The consistency of messaging and joint ownership has accelerated decision-making and reduced variation in practice.</p> <p>Improved multi-agency coordination and MDT working — The introduction of integrated MDT oversight, earlier therapy involvement has significantly improved flow and reduced avoidable delays. Partners report better communication, clearer escalation routes, and more confidence in shared risk-holding. This reflects strong progress against SCIE enablers relating to relationships, leadership, and collaborative working cultures.</p>
2 key challenges observed towards driving the enablers for integration	<p>Workforce capacity and capability constraints — Persistent pressure across therapy, social care, and provider markets continues to limit the system's ability to fully realise the benefits of the redesigned pathways. A new Model launching is being launched in June 2026 to tackle these issues. This challenge aligns with SCIE enablers around workforce development, resource sufficiency, and sustainable staffing models.</p> <p>Data, digital and intelligence limitations — Fragmented data flows, inconsistent recording, and limited real-time visibility of pathway performance make it difficult to track outcomes, forecast demand, and proactively manage system pressures. This constrains the system's ability to embed learning loops and evidence-based decision-making. It reflects gaps in SCIE enablers relating to shared information systems, interoperable digital tools, and integrated performance management. A new D2A Case Tracker and Dashboard is being developed to tackle these issues.</p>

Yes
Yes



Title of report: Herefordshire's Better Care Plan 2026/27

Meeting: Health and Wellbeing Board

Meeting date: Monday 13 July 2026

Report by: Delivery and Improvement Lead

Classification

Open

Decision type

This is not an executive decision

Wards affected

(All Wards)

Purpose

To update Health and Wellbeing Board members on Herefordshire's Better Care Fund (BCF) Plan 2026/27 and seek formal Health and Wellbeing Board approval.

Recommendation(s)

That:

- a) **The Herefordshire Better Care Fund 2026/27 Narrative Plan (Appendix 1) and Numerical Template (Appendix 2), submitted to NHS England, be reviewed and retrospectively approved; and**
- b) **the ongoing work to support integrated health and care provision that is funded via the BCF is noted by the board.**

Alternative options

1. The board could decline to sign off the submission. It is a national requirement that the BCF Plan is signed off by the Health and Wellbeing Board (HWB). The content of the return has already been approved by Hilary Hall, Corporate Director for Community Wellbeing by way of delegated authority and submitted prior to the meeting of the board, in accordance with national deadlines.

2. The HWB does not always align with national deadlines, however this gives the board an opportunity to review and provide feedback.

Key considerations

3. The Better Care Fund provides a mechanism for joint health, housing and social care planning and commissioning. It brings together ring-fenced budgets from Herefordshire and Worcestershire Integrated Care Board (HWICB) allocations, and funding paid directly to local government.
4. The national BCF team determines national reporting requirements on the overall BCF programme, with quarterly reports being submitted to NHS England (NHSE) and Health and Wellbeing Boards.
5. [The Better Care Fund Policy Framework and Planning Requirements for 2026 - 2027](#) were published on 17 February 2026. Similar to previous years, the Better Care Fund Policy Framework for 2026/27, requires that BCF plans consist of:
 - BCF Narrative Plan (**Appendix 1**)
 - BCF Numerical Template including planned expenditure, confirmation that national conditions are met, ambitions for national metrics and additional contributions to BCF section 75 agreements, revised ambitions and plans for performance against three BCF national metrics based on 2025/26 performance. (**Appendix 2**)
6. The deadline for submission of the updated BCF plan to NHS England was 19 May 2026.
7. BCF 2026/27 marks the first phase of national BCF reform and requires a clearer shift from maintaining existing arrangements to demonstrating impact through integrated, neighbourhood-based delivery. Compared to 2025–26, the focus moves beyond streamlined planning towards stronger alignment with neighbourhood health, clearer outcome goals and increased emphasis on adult social care investment.
8. For Herefordshire, this aligns well with local priorities around supporting people to live independently, strengthening Home First approaches and reducing reliance on hospital and long-term care settings. The 2026/27 framework places greater emphasis on reablement and intermediate care, requiring systems to show how BCF funding improves recovery, limits length of stay and reduces future demand for residential and nursing care.
9. BCF 2026/27 also requires clear progress towards neighbourhood health delivery, including closer alignment of BCF-funded services such as urgent community response, intermediate integrated care and support for people with frailty. While full integration is not required in this first year, systems must demonstrate pragmatic steps linking BCF investment to neighbourhood teams and pathways.
10. Finally, the framework introduces a stronger expectation of increased investment in adult social care, alongside tighter assurance of value for money, outcomes and governance. This reinforces Herefordshire's approach to using BCF as a vehicle for prevention, reablement and early intervention, rather than solely as a mechanism for managing hospital discharge pressures.
11. Assurance will be more focused this year on adherence to national conditions. The numerical return includes high level information on expenditure and impact/goals.
12. For 2026/27, Herefordshire's BCF funding is deliberately structured around three core workstreams that reflect how services operate across the system and where investment has the greatest impact on national metrics.

13. **Discharge, Flow and System Coordination**
Investment supports safe, timely discharge and system flow through brokerage, liaison, transport, housing support, and coordination functions. This provides operational grip, enabling early planning, consistent decisions, and timely care mobilisation, supported by shared data and oversight.
14. **Intermediate Integrated Care**
Funding delivers integrated bed- and home-based recovery and reablement pathways. This ensures time-limited, outcome-focused support that maximises independence and reduces length of stay and long-term care demand.
15. **Prevention, Carers and Community Support**
Investment addresses drivers of avoidable admission through falls services, carers support, safeguarding, DoLS/AMHP capacity, and DFG. Voluntary and Community Sector (VCSE) partners provide preventative, personalised support, strengthening community resilience.
16. This approach enables pooled resources to be targeted at whole-pathway solutions rather than fragmented service responses. It supports the Home First philosophy embedded within the Discharge to Assess (D2A) Operational Framework and strengthens joint accountability for outcomes across acute, community, social care and VCSE partners.
17. Delivery remains dependent on workforce capacity, care market provision, data/digital capability, and system alignment, with risks managed through joint governance.

Metrics

18. For 2026/27 areas are required to set improvement goals against two headline metrics carried forward from the previous year relating to:
 - non-elective hospital admissions for people aged 65 and over
 - the average length of discharge delay for all acute adult patients, derived from:
 - the proportion of adult patients discharged from acute hospitals on their discharge ready date (DRD)
 - for those adult patients not discharged on their DRD, the average (mean) number of days from the DRD to discharge
19. It is also encouraged to set local goals:
 - Long-term admissions to residential and nursing care homes for people aged 65 and over per 100,000 population;
and for ICBs and HWBs to monitor and drive improvements for:
 - the proportion of people aged 65 and over who were discharged from hospital into reablement and who remained in the community in the 12 weeks following discharge (as a new BCF metric for 2026/27 and an 'official statistic in development', partners are therefore not expected to set specific goals but may do so).

Community impact

20. The BCF plan is set within the context of the national programme of transformation and integration of health and social care. The council and HWICB continue to work together to deliver on the key priorities within the plan to achieve savings and improve the delivery of services in order to achieve the priorities of the health and wellbeing strategy in the most cost-effective way.
21. Talk Community brings together community, third sector and statutory services to connect with peers and share ideas and experiences within the local Primary Care Network (PCN) areas;

working with communities to identify and address issues that affect them, increase sustainability of communities by facilitating the development of partnerships and collaborative approaches and helping identify any gaps in provision.

Environmental impact

22. Herefordshire Council provides and purchases a wide range of services for the people of Herefordshire. Together with partner organisations in the private, public and voluntary sectors we share a strong commitment to improving our environmental sustainability, achieving carbon neutrality and to protect and enhance Herefordshire's outstanding natural environment.
23. Whilst this is a report on programme delivery and will have minimal environmental impacts, consideration has been made to minimise waste and resource use in line with the council's Environmental Policy.

Equality duty

24. Due to the potential impact of this plan being low, a full Equality Impact Assessment (EIA) is not required. An EIA Checklist has been completed.
25. The council and HWICB are committed to equality and compliance with the public sector equality duty. The public sector equality duty (specific duty) requires us to consider how we can positively contribute to the advancement of equality and good relations and demonstrate that we are paying 'due regard' in our decision making in the design of policies and in the delivery of services.
26. Whilst this paper is not seeking any project specific decisions, the Plan provides an overview in relation to services funded by the BCF. The BCF programme aims to deliver better outcomes for older and disabled people and supports the council in proactively delivering its equality duty under the Equality Act. This is through improving the health and wellbeing of people in Herefordshire by enabling them to take greater control over their own homes and communities.
27. Commissioned services funded by the BCF take into account the arrangements to assess and consult on how functions impact on protected characteristics. Services are undertaken in a manner which respects individuality of service users, patients etc. Where appropriate, a full EIA is undertaken for separate schemes and services that are within the BCF.

Resource implications

28. The Better Care Fund (BCF) is a national partnership programme between MHCLG, NHSE, LGA and DHSC. Locally, it is a mandatory pooled budget between Herefordshire Council and NHS Herefordshire and Worcestershire ICB, governed by a section 75 agreement.
29. In 2023/24, responsibility for planning and management of the Herefordshire BCF was delegated to One Herefordshire Partnership under a memorandum of understanding between NHS Herefordshire and Worcestershire ICB and Wye Valley NHS Trust.
30. Since 2025/26, delegation under the Memorandum of Understanding (MoU) includes ownership of financial risks and benefits arising from over or under spending within the BCF. This means that the risk-share provisions of the section 75 agreement pertaining to the ICB's responsibility for financial risks and benefits related to the Better Care Fund are delegated to Wye Valley NHS Trust to manage.
31. For 2026/27 the Better Care Fund allocation for Herefordshire represents £31.215mn of capital and revenue funding, all of which is ring-fenced and subject to grant conditions.

32. There are three funding allocations within the Better Care Fund:
- NHS Minimum Contribution- allocation of £20.032mn from DHSC to HWICB, of which £7.548mn must be transferred to Herefordshire Council
 - Disabled Facilities Grant (DFG)- allocation of £2.815mn capital funding from MHCLG to Herefordshire
 - Local Authority Better Care Grant (LABCG)- allocation of £8.368mn from MHCLG to Herefordshire Council

Better Care Fund Financial Plan 2026/27 – Sources of Funding	Source of Funding	2025/26 Total Allocation	2026/27 Growth %	2026/27 Increase in Funding Allocation	2026/27 Allocation
NHS Minimum Contribution (transfer to ASC)		£7,548,385	4.45%	£335,650	£7,884,035
NHS Minimum Contribution (retained by ICB)		£11,899,470	2.09%	£248,489	£12,147,959
Total NHS Minimum Contribution	DHSC	£19,447,855	3.00%	£584,139	£20,031,994
Disabled Facilities Grant 25/26		£3,012,994	0.00%	£0	£3,012,994
Disabled Facilities Grant	MHCLG	£3,012,994	0.00%	£0	£3,012,994
Local Authority Better Care Grant	MHCLG	£8,367,748	0.00%	£0	£8,367,748
BCF Underspend B/fwd		£0		£0	£0
TOTAL BETTER CARE FUND		£30,828,597	1.91%	£584,139	£31,412,736

33. Overall, the BCF funding allocation increased by £0.584mn compared to 2025/26. This is a net uplift of 1.91%
- NHS minimum contribution receives a net increase of 3%, which is lower than the weighted average of the main prevailing inflation rates for the costs of health and social care provision (NLW and CPI).
 - Disabled Facilities Grant and Local Authority Better Care Grant receive no increase for 2026/27, so there are real terms cuts in funding for these elements of the BCF.
34. Partners have applied estimated pay awards, contract uplifts, fee inflation, changes to staffing structures and other known changes to set their budgets for services funded by BCF. The overall impact of these changes is an increase in expenditure budgets of £0.706mn (2.3% increase overall). This is £0.121mn more than the increase in funding allocation (therefore an immediate pressure on the BCF budget).
35. The 2026/27 budgets set by partners do not include funding for overspending of £1.893mn in D2A services in 2025/26. Herefordshire Council budgets do include funding reductions for Hoople Care expenditure being held at budgeted levels (£0.244mn benefit compared to 2025/26 outturn) and Ledbury Intermediate Care Centre (LICU) D2A Premium payment ceasing at 31/03/26 (£0.139mn benefit compared to 2025/26). After the benefit of those reductions, 2025/26 overspending not accounted for in host partner budgets for 2026/27 leads to a total cost pressure of £1.632mn.
36. 2026/27 Plans include several changes to BCF services with a net impact of £0.576mn increase in expenditure:
- FYE of D2A Beds at Bromyard Hospital- £0.414mn increase in expenditure

- Estimated cost of fee uplift on spot purchase not included in budgets- £0.049mn increase in expenditure
 - New D2A Information System- £0.024mn increase in expenditure
 - Trusted Assessor redundancy costs- £0.019mn increase in expenditure
 - D2A Commissioning Officer- £0.035mn increase in expenditure
 - Integrated Care Division Director backfill- £0.035mn increase in expenditure
37. 2026/27 plans also include several mitigations to spending with a net impact of £0.916mn reduction in expenditure:
- D2A Pathway 1 Transformation- £0.286 reduction in expenditure
 - D2A Spot purchase overstays not to be funded by BCF- £0.473mn reduction in expenditure
 - Reduce D2A Length of Stay (LoS) in care home beds to 35 days- £0.158mn reduction in expenditure
38. After these changes there is an overall shortfall in BCF funding of £1.291mn. D2A Strategic Board and Better Care Partnership Board considered 6 options to balance the BCF plan to the available funding and resolved to set a realistic plan for D2A services by reducing the value of each of the block contributions to the costs of long-term placements in Adult Social Care and to the costs of community hospitals by £0.646mn.

Legal implications

39. The relevant legal provisions for this decision can be found in the council's constitution, www.herefordshire.gov.uk/constitution.
40. The Care Act 2014 amended the NHS Act 2006 to provide the legislative basis for the BCF. It allows for the Mandate to NHS England to include specific requirements to instruct NHS England over the BCF, and NHS England to direct Integrated Care Boards to pool the necessary funding. The council is legally obliged to comply with grant conditions, which have been complied with.
41. Health and Wellbeing Boards are responsible for encouraging integrated working between health and social care commissioners, including partnership arrangements such as pooled budgets, lead commissioning, and integrated provision.
42. Their purpose is to establish collaborative decision making, planning and commissioning across councils and the NHS, informed by the views of patients, people who use services and other partners.
43. Overseeing the deployment of BCF resources locally is a key part of their remit. BCF plans have to be signed off by the Health and Wellbeing Board as well as the HWICB, which represents the NHS side of the equation.
44. Section 75 of the National Health Service Act 2006 contains powers enabling NHS bodies (as defined in section 275 and 276 of the NHS Act 2006) to exercise certain local authority functions and for local authorities to exercise various NHS functions. The parties entered into a Section 75 agreement in exercise of those powers under and pursuant of the NHS Regulations 2000.
45. The Local Authority Better Care Grant is paid directly to the council via a Section 31 grant from the Ministry of Housing, Communities and Local Government (MHCLG). The government has attached a set of conditions to the Section 31 grant to ensure it is included in the BCF at local

level and will be spent on adult social care. The council are legally obliged to comply with the grant conditions set.

Risk management

- 46. Monitoring the delivery of the Herefordshire BCF Plan is undertaken by the council, WVT and the HWICB. Risks are managed through the community and wellbeing directorate risk register where necessary.
- 47. Strategic oversight is exercised by the One Herefordshire Partnership Health and Care Board, the BCF Partnership Board, and the Discharge to Assess (D2A) Strategic Board, which are responsible for setting priorities, approving plans, and holding partners collectively accountable for outcomes. This governance framework ensures that investment through the BCF is consistently aligned with system priorities, such as the Neighbourhood Health agenda, and that decisions are guided by integrated intelligence and performance data.
- 48. A formal Memorandum of Understanding (MoU) outlines shared principles, roles, financial commitments, and decision-making for pooled BCF resources between partner organisations. It clarifies accountability for delivery, supports transparent financial management, and strengthens joint governance, ensuring collective ownership of national performance and collaborative management of risks and pressures.

Risk / opportunity	Mitigation
Failure to agree a joint plan and meet the national conditions	The Plan has been developed in partnership. Delivery and progress to be monitored on an ongoing basis.
Fail regional/national assurance process	The council, WVT and HWICB have worked through the national guidance and requirements to ensure a robust response, and a comprehensive, detailed plan is submitted.
Failure to achieve national metric ambitions	A robust process for monitoring activity monthly is in place and will be monitored through the BCF Partnership Group.
Overspending, particularly on discharge capacity	The council, WVT and HWICB are working with to revise and improve the service model for Discharge to Assess to be recurrently sustainable.
Increasing demand due to the demography of expected older age population.	Several of the schemes include both areas that support prevention and the urgent care parts of the system to spread the risk. In addition, the council continues to lead on development with communities.

Assurance Statement:

The strategic and operational risks associated with the delivery of the Better Care Fund have been reviewed and are being managed in accordance with the Council’s Risk Management Strategy. Oversight of risk mitigation will continue through the council’s and partners’ established governance frameworks to ensure that risks are effectively monitored, escalated, and addressed in support of integrated health and social care outcomes.

Consultees

49. The content of the report has been provided by partners within One Herefordshire Partnership Health and Care Board, the BCF Partnership Board, HWICB, WVT, Hoople Ltd and appropriate internal Herefordshire Council staff.

Appendices

- Appendix 1 - Herefordshire BCF 2026/27 Narrative Plan
 Appendix 2 - Herefordshire BCF 2026/27 Numerical Template
 Appendix 3 - BCF Framework 2026 to 2027

Background papers

None.

Glossary of terms, abbreviations and acronyms

AMHP	Approved Mental Health Professionals
BCF	Better Care Fund
HWICB	Herefordshire and Worcestershire Integrated Care Board
HWB	Health and Wellbeing Board
DFG	Disabled Facilities Grant
D2A	Discharge to Assess
DHSC	Department of Health and Social Care
DoLS	Deprivation of Liberty and Safeguarding
DRD	Discharge Ready Date
EIA	Equality Impact Assessment
LoS	Length of Stay
MHCLG	Ministry of Housing, Communities and Local Government
NHSE	NHS England
WVT	Wye Valley Trust
MoU	Memorandum of Understanding
PCN	Primary Care Network
VCSE	Voluntary and Community Sector

Choose an item.



Better Care Fund 2026-27

Narrative return

Introduction and guidance

This return has been designed to enable ICBs and local authorities, working with Health and Wellbeing Boards (HWBs), to submit information which demonstrates how their plans for the Better Care Fund (BCF) meet the national conditions and planning requirements for 2026-27. Completing and submitting the BCF narrative return is a required part of the overall BCF submission process. Planning leads should ensure that all questions within this narrative return are fully addressed.

This year, the length of the narrative return has been reduced. This reflects feedback on the benefits of a more focused BCF assurance process. In completing the return, HWBs, ICBs and local authorities may wish to develop more detailed joint plans for BCF expenditure for their own use and/or draw on other joint plans.

Each question in the return has a suggested length of around a page (around 500 words) and we would generally expect the overall submission to be around 2500 words. These act as a guide to support a more focused assurance process rather than strict limits.

The narrative provided in this return should align with the expenditure plans and the ambitions for the national metrics set out in your BCF excel numerical return.

When completing the narrative return, please use the following documents for guidance and support, these can be found on the [BCF Exchange](#):

- **Planning Principles:** outlines what good practice looks like in relation to each narrative question and aligns with the relevant national conditions.
- **Metrics Handbook:** provides the formal technical specifications for the national metrics within the framework, including the rationale, methodology, required data inputs and worked examples.

Submission Requirements:

- Each HWB area must have its own BCF excel numerical return, but a single narrative BCF return covering multiple HWBs may be submitted where this reflects local integrated working arrangements.
- Each HWB area included in a combined narrative return should provide clarity and state any specific details relevant to the separate HWBs within the narrative questions (and more words may be required for this than a single HWB return). Local authorities, ICBs and HWBs for each area should formally sign off the shared narrative return and their individual numerical excel BCF return.

- The deadline for completing this narrative return is **19 May 2026**.
- Please submit this return to both: england.bettercarefundteam@nhs.net and your regional better care manager(s).

Submission details

Mandatory to complete, please do not submit a return without completing the details below:

<i>Adapt as necessary</i>	HWB area 1	HWB area 2
HWB	Herefordshire	
ICB	Herefordshire & Worcestershire	
ICB		
ICB		

1. Please provide a short statement setting out the rationale for using BCF funding to maximise delivery of integrated and preventative care linked to the relevant areas of neighbourhood health and social care services.

Please provide a concise statement of around one page (e.g. around 500 words). Please provide your response below:

The Better Care Fund (BCF) is the primary mechanism through which Herefordshire partners align NHS and local authority resources to deliver integrated, preventative and community-based care. For 2026/27, BCF funding is deliberately structured around **three core workstreams** that reflect how services operate across the system and where investment has the greatest impact on national metrics: **Discharge, Flow & System Coordination, Intermediate Integrated Care** and **Prevention, Carers & Community Support**.

This approach enables pooled resources to be targeted at whole-pathway solutions rather than fragmented service responses. It supports the Home First philosophy embedded within the Discharge to Assess (D2A) Operational Framework and strengthens joint accountability for outcomes across acute, community, social care and VCSE partners.

The **Discharge, Flow & System Coordination** workstream uses BCF funding to underpin safe, timely discharge and effective system flow. Funding supports brokerage, hospital liaison, discharge transport, housing-related discharge support, and system coordination functions. These services provide operational grip across pathways, ensuring discharge planning begins early, decisions are made consistently and packages of care are mobilised without delay. Shared data and performance oversight enable proactive management of pressures and reduce fragmentation between organisations.

The **Intermediate Integrated Care** workstream uses BCF funding to deliver a coherent recovery and reablement pathway across bed-based and home-based provision. This includes short-term rehabilitation beds, home-based reablement and enablement, and the clinical and operational infrastructure required to maximise recovery potential. Investment through this workstream ensures that individuals receive time-limited, outcome-focused support designed to restore independence and reduce unnecessary length of stay or premature admission to long-term care.

The **Prevention, Carers & Community Support** workstream focuses investment upstream, addressing the drivers of avoidable hospital admission and escalation of need. BCF funding supports falls prevention and response, carers support, advocacy, safeguarding, DoLS/AMHP capacity and the Disabled Facilities Grant. VCSE partners play a critical role within this workstream, providing preventative, personalised and low-level support that complements statutory services and strengthens community resilience.

BCF funding enables a shift from reactive, hospital-centred activity to proactive, preventative support delivered closer to home. It strengthens integration by aligning operating models, funding and oversight across organisations. Importantly, the use of BCF funding allows partners to collectively manage demand, flow and recovery rather than responding in isolation, ensuring that resources are used where they deliver the greatest benefit for people and the system.

BCF investment decisions have been shaped through a joint commissioning approach that prioritises interventions with the strongest evidence of impact on flow, independence and prevention. This includes explicit consideration of market sufficiency, workforce capacity and the ability of commissioned services to flex in response to changing demand. Local authority commissioning functions play a central role in shaping and stabilising the home care, reablement and community support market, ensuring that BCF funding is deployed where it can most effectively support sustainable capacity and quality. Partners will keep the balance of investment under review throughout 2026/27, with the option to reprofile funding where outcomes do not progress as expected.

Overall, structuring BCF investment around these three workstreams provides clarity, cohesion and confidence. It ensures that funding decisions are directly linked to delivery priorities, national metrics and measurable outcomes, while retaining the flexibility needed to respond to system pressures throughout the year.

- 2. Please provide a brief explanation of the rationale for how you have set out goals for the metrics of non-elective admissions (for those 65 years old and over) and delayed discharges. Please also set out how you will monitor and drive progress in preventing avoidable long-term care home admissions and improving outcomes from reablement, including through any locally agreed goals for long term admissions to residential care and nursing homes.**

Please provide a concise statement of around one page (e.g. around 500 words). Please provide your response below:

Goals for the BCF national metrics in 2026/27 have been set to reflect local demand pressures and the scale of change enabled through the Neighbourhood Health model and the D2A Operational Framework. Targets are informed by local baselines system learning and realistic trajectories of improvement as integrated neighbourhood delivery matures. Each metric is directly linked to the shift towards proactive community based care and the strengthening Neighbourhood Health Services.

For non-elective admissions among people aged 65 and over goals are grounded in a shift towards proactive neighbourhood based management of frailty and long term conditions. Local analysis shows that a significant proportion of admissions are linked to preventable deterioration falls medication issues and carer breakdown. The Neighbourhood Health model enables earlier identification of risk through shared intelligence MDT coordination and targeted interventions. Goals therefore assume a progressive reduction in avoidable admissions as the revised pathways become fully embedded. Targets reflect phased implementation rather than short term suppression of demand.

Goals for delayed discharges are underpinned by full implementation of the D2A Operational Framework and the Care Transfer Hub. Historic delays have been driven by variation in practice late decision making and fragmented assessment processes. The framework addresses these through early discharge planning consistent MDT led pathway allocation 72 hour wraparound support and daily operational oversight. Goals therefore reflect expected reductions in length of stay improved same day discharge rates and fewer delays related to assessment equipment or care mobilisation. These improvements are reinforced by neighbourhood teams who provide rapid post discharge support and continuity of care.

Goals for preventing avoidable long term care admissions are aligned to the Home First philosophy and the revised D2A Pathway 1 model. The formal distinction between Pathways 1a 1b and 1c ensures that recovery potential is maximised and that long term care decisions are made only after appropriate reablement or enablement in the community. Goals reflect reductions in direct admissions from hospital to long term care and increased proportions of people supported to return home or remain at home following short term support. Neighbourhood Health strengthens this ambition by ensuring that Intermediate Integrated Care provide ongoing stabilisation and proactive case management.

Reablement outcomes are a critical lever within the BCF goals. Locally the system has moved away from an assumed six week period of care towards outcome focused therapy led reablement under Pathway 1a. Goals reflect improvements in timely starts goal based delivery MDT review and clear transitions at the end of reablement. The expectation is that more people will require no ongoing care or lower level packages following reablement. Intermediate Integrated Care plays a central role in sustaining these gains through ongoing monitoring and support.

The goals have been developed through a commissioning lens, using local intelligence on demand drivers, market capacity and the expected impact of the Neighbourhood Health model. Targets reflect what can realistically be achieved through strengthened community capacity, improved MDT coordination and more consistent application of the D2A Operational Framework. Commissioners will monitor progress monthly and will adjust commissioning intentions or service specifications if anticipated improvements are not realised.”

Adult Social Care retains statutory responsibility for Care Act assessments, safeguarding and decision making around long-term care. The goals for delayed discharge and long-term care admissions therefore assume continued delivery of strengths-based, proportionate assessments that balance safe decision making with timely flow. This includes ensuring that DoLS, AMHP and safeguarding capacity is maintained within the Prevention, Carers and Community Support workstream.

Progress will be monitored through the D2A Performance Framework drawing on data from Maxims EMIS and MOSAIC. National metrics will be tracked alongside leading indicators such as pathway allocation reablement start times hub performance and 72 hour wraparound delivery. Performance will be reviewed through daily huddles monthly reporting and quarterly strategic oversight enabling early intervention and continuous improvement.

Key Milestones, Delivery Timelines and Dependencies

Delivery of the 2026/27 BCF plan is underpinned by clear milestones and sequencing across the three core workstreams, ensuring that changes in practice are implemented in a phased and manageable way. Between April and June 2026, partners will complete the full embedding of agreed operating models, including consistent application of the D2A Operational Framework and alignment with the Neighbourhood Health model. This period focuses on stabilising new ways of working, confirming roles and responsibilities and ensuring frontline teams are operating to consistent standards.

By July 2026, a shared discharge, recovery and neighbourhood performance dashboard will be implemented, providing real-time visibility of flow, pathway utilisation, reablement outcomes and emerging system pressures. This will support proactive operational management and enable earlier intervention where delivery is off-track. From July to September 2026, investment will focus on strengthening preventative and anticipatory functions within neighbourhood and community services, including falls prevention, rapid response and carer support, to reduce avoidable admissions and support timely discharge.

Between September and December 2026, interim review points will assess the impact of these changes on flow, length of stay, reablement outcomes and long-term care admissions. Learning from these reviews will inform any in-year adjustments to capacity, commissioning or operational processes. A formal impact assessment will be undertaken between January and March 2027 to evaluate delivery against the national metrics and inform future BCF priorities.

Delivery across all milestones is dependent on workforce capacity across health and social care, availability of care and VCSE provision, effective use of shared data and digital tools, and continued alignment between acute, community and neighbourhood operating models. These dependencies are actively monitored through joint governance arrangements and escalated where they present a risk to delivery.

3. Please provide a short explanation of the planned impact of BCF funding on achievement of goals.

Please provide a concise statement of around one page (e.g. around 500 words). Please provide your response below:

BCF funding has a direct and planned impact on achieving the 2026/27 goals by investing in integrated intermediate care and system infrastructure that reduce avoidable demand improve flow and maximise independence. The planned impact is structured around the core components of the Neighbourhood Health model and the D2A Operational Framework ensuring that investment strengthens proactive community based care and supports timely safe discharge.

For non-elective admissions BCF investment supports proactive anticipatory care through Integrated Neighbourhood Teams Urgent Neighbourhood Services and population health management. These functions enable early identification of risk coordinated MDT support and rapid response to deterioration. Investment in falls prevention medication optimisation community therapy equipment and carer support helps stabilise people at home and reduces escalation to emergency departments and admissions. The Neighbourhood Health model ensures that these interventions are targeted at the cohorts with the highest risk and greatest opportunity for impact.

For delayed discharges BCF funding underpins delivery of the D2A pathway model and the Care Transfer Hub. Investment in reablement enablement brokerage and community rehabilitation improves the speed and reliability of discharge support. Consistent operating standards shared digital tools and systemwide oversight reduce duplication and delays caused by organisational handoffs. This supports shorter lengths of stay improved patient experience and more predictable flow. Neighbourhood teams provide continuity of care following discharge ensuring that individuals receive timely support and reducing the risk of readmission.

In preventing avoidable long term care admissions BCF funding supports early intervention and recovery focused pathways. The revised D2A Pathway 1 model ensures that reablement capacity is targeted at recovery (1a) enablement supports stabilisation (1b) and Pathway 1c enables informed decision making where ongoing care is likely. This reduces premature transitions into long term care and increases the proportion of people supported to remain at home.

For reablement outcomes BCF investment strengthens the quality consistency and capacity of therapy led reablement and community rehabilitation. MDT oversight goal based planning and clear transition arrangements improve functional recovery and sustain independence. This is expected to increase the proportion of people with no ongoing care needs following reablement and reduce escalation to long term services. Neighbourhood teams play a key role in sustaining these gains through proactive follow up and personalised support.

Impact will be tracked through joint governance performance reporting and shared learning. Where expected impacts are not achieved BCF investment will be reviewed and reshaped ensuring continuous alignment between funding decisions and outcomes. The Neighbourhood Health model provides the structure for this continuous improvement ensuring that learning from neighbourhoods informs systemwide decision making. Commissioners will use in-year performance and financial data to test whether BCF-funded services are delivering the expected impact on flow, independence and demand reduction. Where productivity assumptions are not met, partners will consider reshaping or reprofiling investment to strengthen areas of greatest impact. This commissioning discipline ensures that BCF funding remains a dynamic tool for improving outcomes rather than a static allocation.

4. Please outline how ICBs and local authorities have confidence that the services funded through the BCF represent value for money, and how they will seek to raise the productivity of services.

Please provide a concise statement of around one page (e.g. around 500 words) please provide your response below:

Herefordshire partners have confidence that BCF funded services represent value for money because investment is explicitly aligned to outcomes that reduce high cost demand in acute and long term care. Resources are targeted at interventions with the greatest potential to improve flow independence and prevention rather than supporting fragmented activity.

Value for money is strengthened through implementation of the D2A Operational Framework which provides a single standardised operating model across the system. This reduces duplication unwarranted variation and inefficiency while improving consistency and safety. Central coordination improves productivity by matching capacity to demand reducing delays and supporting faster throughput. Ensuring resources are deployed efficiently and services both produce and receive timely accurate information to support post discharge care.

Productivity is further enhanced through the revised D2A Pathway 1 model which ensures that reablement and enablement are used appropriately and for as long as they add value. Outcome focused commissioning reduces over provision and supports timely escalation or de-escalation of care. Neighbourhood Health and VCSE engagement provide cost effective alternatives to statutory services while strengthening prevention. This aligns with the Neighbourhood Health ambition to shift activity upstream and reduce reliance on high cost acute and long term care.

BCF investment in anticipatory care rapid response and community rehabilitation reduces avoidable admissions and supports timely discharge. These interventions have strong evidence of cost effectiveness and deliver savings through reduced bed days improved flow and reduced long term care needs. Investment in equipment assistive technology and home adaptations supports independence and reduces reliance on formal care.

Commissioners will apply outcome-based expectations within service specifications, ensuring that providers are clear about the contribution their services are expected to make to flow, recovery and prevention. Where performance falls short, partners will use commissioning levers such as contract variation, targeted improvement support or reallocation of resource to higher-impact interventions. This approach provides assurance that BCF funding is used efficiently and that productivity gains are actively pursued.

Financial and performance data are reviewed together through joint governance enabling partners to identify underperformance and redirect funding. This ensures that the BCF remains a dynamic tool for improving outcomes and productivity. The new Governance Structure strengthens this by providing a clear structure for monitoring impact at neighbourhood level and ensuring that investment decisions are informed by local intelligence.

Alongside productivity, Adult Social Care will continue to ensure that statutory duties relating to safeguarding, DoLS and AMHP functions are met, and that strengths-based, person-centred assessments remain central to practice. This balances the focus on flow with assurance around quality and safe decision making

BCF funded services also contribute to workforce productivity by supporting multidisciplinary working reducing duplication and improving coordination. This approach enable professionals to work more efficiently by sharing information coordinating care and reducing unnecessary contacts.

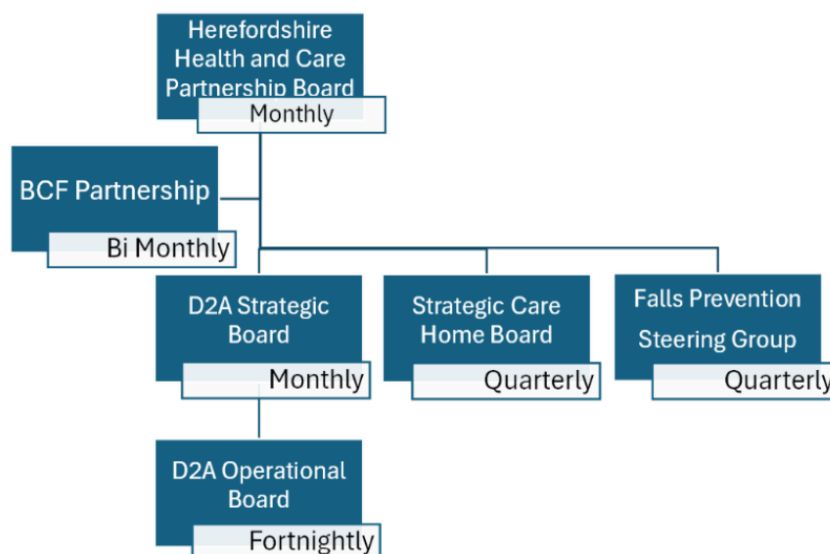
Overall BCF funding delivers value for money by supporting interventions that reduce high cost demand improve flow and strengthen prevention.

5. Please outline your robust joint governance for managing the expenditure of BCF funding, including assessing impact of funding, value for money and continuous improvement.

Please provide a concise statement of around one page (e.g. around 500 words). Please provide your response below:

BCF funding is managed through robust multi-tier joint governance that ensures transparency accountability and continuous improvement. Strategic oversight is provided through the 1HP Health and Care Board the BCF Partnership Board and the D2A Strategic Board which set priorities approve plans and hold partners collectively accountable for outcomes. This governance structure ensures that BCF investment is aligned to system priorities including the Neighbourhood Health agenda and that decisions are informed by shared intelligence and performance data.

Operational oversight is delivered by the D2A Operational Board supported by specialist groups including the Strategic Care Homes Board and the Falls Prevention Network. These forums monitor performance quality risks and expenditure and have clear escalation routes where corrective action is required. The Neighbourhood Health governance structure aligns with these arrangements ensuring that neighbourhood level intelligence informs systemwide decision making.



The D2A Performance Framework provides a shared approach to monitoring impact drawing on integrated datasets and regular reporting cycles. Data from Maxims EMIS and MOSAIC is used to track national metrics alongside leading indicators such as pathway allocation reablement start times hub performance and 72 hour wraparound delivery. This ensures that partners have real time visibility of performance and can intervene early where issues arise. Neighbourhood teams contribute to this intelligence by providing local insight into demand risk and outcomes. A new D2A Dashboard

will be developed by July 2026, that sits across all 3 systems to provide a single authoritative view of discharge activity recovery outcomes and neighbourhood level performance. The dashboard will integrate acute community and social care data into one shared platform enabling partners to track flow pressures identify variation and monitor the impact of reablement and enablement in real time. It will also support neighbourhood teams by providing granular intelligence on caseload complexity rising risk cohorts and post discharge outcomes ensuring that the teams can target support effectively and intervene earlier to prevent deterioration. The dashboard will form a core component of the Neighbourhood Health intelligence model strengthening shared accountability and enabling system leaders to make informed decisions about resource allocation performance improvement and future BCF investment.

Delivery is underpinned by a formal Memorandum of Understanding (MoU) between partner organisations. The MoU sets out shared principles, roles and responsibilities, financial commitments and decision-making arrangements relating to the use of pooled BCF resources. It provides clarity on accountability for delivery across the three core workstreams and confirms collective ownership of national metric performance. The MoU supports transparent financial management, information sharing and escalation, ensuring that partners act together to address system risks, manage in-year pressures and agree corrective action where required. This formal agreement strengthens joint governance and provides assurance that BCF funding is managed collaboratively and in line with national conditions and local priorities.

Joint governance ensures that BCF funding delivers value for money remains aligned to neighbourhood health priorities and continuously evolves to improve outcomes for residents and system sustainability. Financial and performance data are reviewed together enabling partners to identify underperformance and redirect funding. This ensures that the BCF remains a dynamic tool for improving outcomes and productivity.

Continuous improvement is embedded throughout the governance structure. Learning from frontline teams people using services and carers is actively incorporated into decision making. Neighbourhood Health provides a framework for capturing and acting on this learning ensuring that improvements are informed by local experience and that successful approaches are scaled across the system.

The governance structure also supports effective risk management. Clear escalation routes ensure that operational pressures are addressed promptly and that strategic risks are visible to senior leaders. The alignment between BCF governance D2A governance and Neighbourhood Health governance ensures that risks are understood across the system and that mitigation plans are coordinated.

Joint governance also provides a clear line of sight to commissioning decisions, enabling partners to test whether BCF-funded services continue to represent value for money and whether market capacity remains sufficient to meet demand. Local authority commissioning teams contribute

intelligence on provider stability, quality and workforce, ensuring that BCF investment supports a resilient and sustainable community market.

Overall, the joint governance arrangements provide a strong foundation for managing BCF expenditure impact and continuous improvement. They ensure that investment is aligned to system priorities that performance is monitored effectively and that learning is used to drive improvement. The integration of Neighbourhood Health within this structure strengthens local accountability supports proactive population based care and ensures that BCF funding delivers measurable impact for communities.



Better Care Fund 2026-27 Numerical Template

2. Cover

Version 1.0

Please Note:

The BCF numerical template is categorised as 'Management Information' and data from them will be published in an aggregated form on the NHS England website and gov.uk. This will include any narrative section. Some data may also be published in non-aggregated form on gov.uk. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.
 - At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the Better Care Exchange) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.
 - All information will be supplied to BCF partners (MHCLG, DHSC, NHS England) to inform policy development.
 - This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Governance and Sign off

Health and Wellbeing Board:	Herefordshire, County of	
Confirmation that the plan has been signed off by Health and Wellbeing Board ahead of submission - Plans should be signed off ahead of submission.	No	
If no indicate the reasons for the delay.	Governance timelines do not align	
If no please indicate when the HWB is expected to sign off the plan:	Mon 13/07/2026	<< Please enter using the format, DD/MM/YYYY

Complete:

Yes
Yes
Yes
Yes

Submitted by:	Marie Gallagher
Role and organisation:	Delivery & Improvement Lead, Herefordshire Council
E-mail:	Marie.Gallagher1@herefordshire.gov.uk
Contact number:	01432 260435
Documents submitted (please select from drop down) In addition to this template the HWB are submitting the following:	Narrative

Yes
Yes
Yes
Yes
Yes

	Role:	Professional title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:	Organisation
Health and wellbeing board chair(s) sign off	Health and wellbeing board chair	Cllr	Carole	Gandy	carole.gandy@herefordshire.gov.uk	
	Health and wellbeing board chair					

Yes

Named accountable person	Local authority chief executive	Mr	Paul	Walker	paul.walker@herefordshire.gov.uk	
	ICB chief executive 1	Mr	Simon	Trickett	simon.trickett@nhs.net	HWICB
	ICB chief executive 2 (where required)					
	ICB chief executive 3 (where required)					

Yes
Yes

Finance sign off	LA section 151 officer	Mrs	Rachael	Sanders	rachael.sanders@herefordshire.gov.uk	
	ICB finance director 1	Mr	Mark	Dutton	Mark.Dutton@nhs.net	HWICB
	ICB finance director 2 (where required)					
	ICB finance director 3 (where required)					

Yes
Yes

Area assurance contacts	Local authority director of adult social services	Mrs	Hilary	Hall	hilary.hall@herefordshire.gov.uk	
	DFG lead	Mrs	Hayley	Crane	hayley.crane@herefordshire.gov.uk	
	ICB place lead 1	Mr	Jon	Barnes	jon.barnes2@nhs.net	One Herefordshire Partnership
	ICB place lead 2 (where required)	Ms	Sarah	Shingler	sarah.shingler2@nhs.net	Wye Valley Trust
	ICB place lead 3 (where required)					

Yes
Yes
Yes

Please add any additional key contacts who have been responsible for completing the plan

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your better care manager(s).

	Complete:
2. Cover	Yes
3. Income	Yes
4. Expenditure	Yes
5. Metrics	Yes
6. National Conditions	Yes

^^ Link back to top

Better Care Fund 2026-27 Numerical Template

3. Income

Selected HWB: Herefordshire, County of

Local authority contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Herefordshire, County of	£2,815,031
DFG breakdown for two-tier areas only (where applicable)	
Total Minimum local authority contribution (exc local authority BCF grant)	£2,815,031

Complete:

Local authority better care grant (LABCG)	
Herefordshire, County of	£8,367,748
Total Local authority better care grant	£8,367,748

Are any additional local authority contributions being made in 2026-27? If yes, please detail below Yes

Yes

Local authority additional contribution	Contribution	Comments - Please use this box to clarify any specific uses or sources of funding
Herefordshire, County of	£251,345	2025/26 DFG underspend
Total additional local authority contribution	£251,345	

Yes

NHS minimum contribution	
NHS Herefordshire and Worcestershire ICB	£20,031,994
Total NHS minimum contribution	£20,031,994

Are any additional NHS contributions being made in 2026-27? If yes, please detail below No

Yes

Additional NHS contribution	Contribution	Comments - Please use this box to clarify any specific uses or sources of funding
Total additional NHS contribution	£0	
Total NHS contribution	£20,031,994	

Yes

	2026-27
Total BCF pooled budget	£31,466,118

Funding contributions comments
For any useful details please use the text box below (for no additional comments, insert 'NA')

NA

Yes

4a. Expenditure Guidance

Guidance for completing expenditure sheet

1. Please enter spend information in the bottom table starting cell B30 including the category of spend which is a dropdown containing the categories listed in the table below. You must also enter scheme-level detail for the line of spend in 'Description of Scheme' with the appropriate level of information keeping this relatively succinct, for example 'Community Health Rehabilitation' or 'MSK services' or 'Integrated Crisis and Rapid Response' would be sufficient. Please also enter source of funding which determines the total spend appearing in the source of funding table at the top. Ensure a 'Number' is entered in the 'Expenditure for 2026-27 (£)' so that the validation boxes can be marked as complete.
2. Please ensure 'Adult Social Care Spend' is marked 'Yes' when the money is spent on Adult Social Care across any funding source.

Scheme Types

Number	Category of scheme	Description
1	Assistive technologies and equipment	Using technology in care processes to support self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Housing related schemes	This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
3	DFG related schemes	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place.
4	Wider support to promote prevention and independence	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and wellbeing.
5	Short-term home-based intermediate care (rehabilitation, reablement and recovery services)	Short-term (up to 6 weeks), therapy-led services in the person's usual residence (home or care home), following the 'Home First' principle. For adults 18+ to regain independence post-illness/injury/discharge (step-down) or prevent admissions/long-term care (step-up). Person-centred, with initial assessment and regular reviews; led by registered therapists (physiotherapists, occupational therapists, speech/language therapists) plus support from unregistered workers and other professionals (nurses, doctors, social workers). Outcomes: better function, confidence, wellbeing; less carer reliance and long-term care demand. Domiciliary social care (personal care, domestic help) included only within a rehab/reablement-focused package.
6	Short-term home-based social care (excluding rehabilitation, reablement and recovery services)	Short-term domiciliary social care (e.g. personal care, help with domestic tasks, voluntary sector support), except where it is provided as part of a package that also includes rehabilitation, reablement and/or recovery services.
7	Long-term home-based social care services	Ongoing social care services (e.g. personal care, help with domestic tasks), helping people continue to live at home and maintain independence.
8	Long-term home-based community health services	Ongoing health services provided in people's own homes or in other non-residential community-based settings.
9	Bed-based intermediate care (short-term bed-based rehabilitation, reablement or recovery)	Short-term (up to 6 weeks), therapy-led services in a community bed-based setting (e.g. community hospital, care home bed or designated facility). For adults 18+ to regain independence post-hospital stay (step-down) or prevent avoidable admission/long-term residential care (step-up from community). Person-centred, with initial assessment and regular reviews; led by registered therapists (physiotherapists, occupational therapists, speech/language therapists) plus multi-disciplinary support (unregistered workers, nurses, doctors, others as needed). Where safe and appropriate, transition to home-based intermediate care is required to continue recovery at usual residence. Outcomes: improved function, confidence, wellbeing; reduced acute admissions, readmissions and long-term social care demand. May include mixed health and social care interventions.
10	Long-term residential or nursing home care	Ongoing care provided in a residential care home or nursing home for people who need more intensive or specialised support than can be provided at home.
11	Discharge support and infrastructure	Services and activity to enable discharge. Examples include multi-disciplinary/multi-agency discharge functions or Home First/Discharge to Assess process support/ core costs.
12	End of life care	Schemes specifically designed to provide care and support for people nearing the end of life.
13	Support to carers, including unpaid carers	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
14	Evaluation and enabling integration	Schemes that monitor or evaluate the impact of integrated care schemes. Schemes or services that enable integrated care, such as (but not necessarily limited to): - Joint commissioning arrangements - Integrated care planning - Helping people navigate services - Workforce development or recruitment and retention
15	Urgent Community Response	Urgent community response teams provide urgent care to people in their homes which helps to avoid hospital admissions and enable people to live independently for longer. Through these teams, older people and adults with complex health needs who urgently need care, can get fast access to a range of health and social care professionals within two hours.
16	Personalised budgeting and commissioning	Various person centred approaches to commissioning and budgeting, including direct payments.
17	Other	This should only be selected where the scheme is not adequately represented by the above scheme types.

Better Care Fund 2026-27 Numerical Template

5. Metrics for 2026-27

Selected Health and Wellbeing Board:

Herefordshire, County of

5.1 Non-Elective admissions

		Apr 25 Actual	May 25 Actual	Jun 25 Actual	Jul 25 Actual	Aug 25 Actual	Sep 25 Actual	Oct 25 Actual	Nov 25 Actual	Dec 25 Actual	Jan 26 Actual	Feb 26 Actual	Mar 26 Actual
Non elective admissions to hospital for people aged 65 and over per 100,000 population	Rate	1,301	1,369	1,301	1,359	1,242	1,378	1,359					
	Number of admissions 65+	670	705	670	700	640	710	700					
	Population of 65+*	51,516	51,516	51,516	51,516	51,516	51,516	51,516	51,516				
	Apr 26 Plan	1,339	1,419	1,374	1,285	1,384	1,151	1,468	1,330	1,510	1,351	1,122	1,324
	Rate	690	731	708	662	713	593	756	685	778	696	578	682
	Population of 65+	51,516	51,516	51,516	51,516	51,516	51,516	51,516	51,516	51,516	51,516	51,516	51,516

Complete:

Yes

Source: <https://digital.nhs.uk/supplementary-information/2025/non-elective-inpatient-spells-at-english-hospitals-occurring-between-01-04-2020-and-30-11-2024-for-patients-aged-18-and-65>

5.2 Discharge delays

		Apr 25 Actual	May 25 Actual	Jun 25 Actual	Jul 25 Actual	Aug 25 Actual	Sep 25 Actual	Oct 25 Actual	Nov 25 Actual	Dec 25 Actual	Jan 26 Actual	Feb 26 Actual	Mar 26 Actual
*Dec Actual onwards are not available at time of publication													
Average length of discharge delay for all acute adult patients (this calculates the % of patients discharged after their DRD, multiplied by the average number of days)		0.88	0.98	0.93	0.93	0.82	0.80	0.94	0.96				
Proportion of adult patients discharged from acute hospitals on their discharge ready date		87.1%	84.1%	85.5%	84.8%	87.0%	86.4%	86.4%	84.7%				
For those adult patients not discharged on DRD, average number of days from DRD to discharge		6.8	6.1	6.4	6.2	6.3	5.9	6.9	6.3				
		Apr 26 Plan	May 26 Plan	Jun 26 Plan	Jul 26 Plan	Aug 26 Plan	Sep 26 Plan	Oct 26 Plan	Nov 26 Plan	Dec 26 Plan	Jan 27 Plan	Feb 27 Plan	Mar 27 Plan
Average length of discharge delay for all acute adult patients		0.82	0.92	0.90	0.92	0.75	0.77	0.90	0.88	0.92	0.98	0.87	0.86
Proportion of adult patients discharged from acute hospitals on their discharge ready date		88.0%	85.0%	86.0%	85.0%	88.0%	87.0%	87.0%	86.0%	87.0%	86.0%	87.0%	89.0%
For those adult patients not discharged on DRD, average number of days from DRD to discharge		6.81	6.15	6.43	6.16	6.27	5.90	6.90	6.27	7.04	6.98	6.71	7.83

Yes

Yes

Source: <https://www.england.nhs.uk/statistics/statistical-work-areas/discharge-delays/discharge-ready-date/>

5.3 Admissions to residential and nursing care homes

		Rolling 12 month total until end of quarter date indicated							
		Actual Ending 31 12-2024	Actual Ending 31 03-2025	Actual Ending 30 06-2025	Actual Ending 30-09-2025	2026-27 Plan Ending 30-06-2026	2026-27 Plan Ending 30-09-2026	2026-27 Plan Ending 31-12-2026	2026-27 Plan Ending 31-03-2027
Long-term admissions to residential and nursing care homes for people aged 65 and over per 100,000 population	Rate	524.1	485.3	438.7	450.3	446.5	436.8	436.8	427.1
	Number of admissions	270	250	226	232	230	225	225	220
	Population of 65+*	51,516	51,516	51,516	51,516	51,516	51,516	51,516	51,516

Yes

*Population of people aged 65 and above are based on the latest available mid-year estimates from the ONS

Better Care Fund 2026-27 Numerical Template
 6: National Condition Planning Requirements
 Health and wellbeing board

National Condition	Planning requirement	Assurance statement	Yes/No to assurance statement	Where the planning requirement or assurance statement is not met, please note the actions in place towards meeting the requirement	Timeframe for resolution
National Condition 1: effectively support the delivery of integrated and preventative care ICBs and local authorities must develop joint plans, agreed by health and wellbeing boards, outlining how ICBs and local authorities intend to use BCF funding to deliver more integrated and preventative care, linked to the relevant areas of neighbourhood health and social care services.	ICBs and local authorities must have considered how to use the BCF most effectively to support the delivery of more integrated and preventative services, particularly supporting those with more complex health and social care needs. This must include setting out how the funding will be used to develop the quality, efficiency and outcomes from intermediate care.	Named ICB and local authority chief executives and named HNB chair must confirm that BCF expenditure is agreed and aligned with wider strategic objectives for neighbourhood health and social care.	Yes		
	ICBs and local authorities must set out plans that: - show reasonable progress in the metrics of non-elective admissions (for people aged 65 and over) and delayed discharges - show how they will monitor and drive progress in preventing avoidable long-term care home admissions and improving outcomes from reablement - include the specific contribution of BCF-funded services.				
	ICBs and local authorities must demonstrate that their plans for the use of the BCF represent value for money and improve overall productivity				
National Condition 2: comply with expenditure and grant conditions ICBs and local authorities must comply with all national grant and funding conditions and deliver in accordance with their approved return. ICBs must maintain the NHS minimum contribution to adult social care and pool NHS BCF contributions into a section 75 (of the NHS Act 2006) pooled fund.	ICBs and local authorities must pool their designated minimum contribution (in the case of ICB partners) and the Local Authority Better Care Grant and DFG (in the case of local authority partners). ICBs and local authorities are able to voluntarily pool additional funding through the BCF where they consider this is likely to lead to an improvement in the services being funded.				
	The NHS minimum contribution to adult social care must be met and maintained by the ICB in line with the published BCF allocations. This represents an increase of 4.4% in each health and wellbeing board area.	ICBs and local authorities confirm compliance with BCF national grant and funding conditions, and that they will deliver in accordance with approved spend and BCF numerical return, including maintaining the NHS minimum contribution to adult social care.	Yes		
	Local authorities must comply with the grant conditions of the Local Authority Better Care Grant and the DFG, including the pooling of funding.	ICBs and local authorities confirm they will pool funds through Section 75 agreements by 30th September 2026.	Yes		
National Condition 3: - effective governance, reporting and engagement ICBs and local authorities must comply and engage with BCF planning, governance and reporting requirements including adherence to any assurance and oversight processes.	ICBs and local authorities must have effective joint governance in place to ensure local accountability for delivery of outcomes, including reviewing performance against plan objectives and local goals, and taking action if necessary to bring delivery back on track.				
	ICBs, local authorities and health and wellbeing boards are required to engage with BCF reporting, oversight and support processes	ICBs and local authorities confirm full compliance with BCF planning and reporting requirements and will adhere to the BCF oversight and support processes.	Yes		

Complete:

Yes

Yes
Yes

Yes



Department
of Health &
Social Care



Ministry of Housing,
Communities &
Local Government

Guidance

Better Care Fund framework 2026 to 2027

Published 17 February 2026

Applies to England

Contents

Introduction

Context: BCF and the neighbourhood health service

Purpose of the BCF

Phases of BCF reform

Minimum financial contributions to the BCF

Specific factors to consider during planning

Local goals and monitoring progress

Assurance and oversight

BCF national funding conditions

Legal framework



© Crown copyright 2026

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gov.uk.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

This publication is available at <https://www.gov.uk/government/publications/better-care-fund-framework-2026-to-2027/better-care-fund-framework-2026-to-2027>

Introduction

As set out in the [10 Year Health Plan for England \(https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future\)](https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future), we are committed to reforming the Better Care Fund (BCF) to provide a more consistent and effective approach to funding services that it is essential to deliver in a fully integrated way. As a first step in this reform journey, we are making an initial set of changes to the BCF in 2026 to 2027 to help local areas go further in joining up delivery of health and social care services, in line with the government's objectives for neighbourhood health and devolving more responsibilities.

This guidance sets out how we expect integrated care boards (ICBs) and local authorities to plan and agree expenditure for 2026 to 2027, working with local partners, and how these plans will be assured. Plans will need to be developed collaboratively and agreed by health and wellbeing boards as in previous years.

These new arrangements include asking health and wellbeing boards, ICBs and local authorities to more closely align plans for integrated health and social care services to the development of relevant areas of neighbourhood health services, such as intermediate care. They should do so while taking care not to disrupt the delivery of critical services that rely on BCF funding and, vitally, increasing investment in adult social care.

We are also asking ICBs and local authorities to agree local goals with their health and wellbeing boards for non-elective admissions (for people aged 65 and over) and delayed discharges. Alongside this, we are asking them to focus on improving reablement outcomes (reablement is short-term care to help people regain independence after, for example, a hospital stay, illness or fall), and reducing demand for long-term residential and nursing home care. This should link to wider commissioning plans - including the ICB 5-year strategic commissioning plan - rather than being limited to the impact of pooled budgets.

The NHS, local authorities, health and wellbeing boards and partners will already have been developing outline plans for neighbourhood health, including more integrated care for people with complex health and social care needs. We will be working with health and wellbeing boards, ICBs and local authorities over the coming year to support them to develop more detailed plans for neighbourhood health.

We recognise that, for this first year of BCF reform, it will not be possible to comprehensively integrate BCF planning and neighbourhood health planning. However, we ask health and wellbeing boards, ICBs and local authorities to take a pragmatic approach to linking BCF plans with local priorities for more integrated health and social care. For example, there may be opportunities this year to:

- improve joint commissioning of integrated neighbourhood teams and bring together urgent community response, intermediate care and other community services at a multi-neighbourhood level
- ensure that services funded from the BCF are part of wider plans to support people living with frailty and others with more complex health and social care needs
- improve shared understanding and transparency about the outcomes and impact of the current BCF locally
- lay a strong shared foundation for future reform of the BCF and begin alignment with neighbourhood health services

It is essential that the BCF maintains funding for adult social care and delivers the 4.4% increase in the NHS minimum contribution to adult social care in 2026 to 2027. The BCF should support local authorities and ICBs in meeting their respective statutory responsibilities while increasing the focus on integration.

Allocations for NHS minimum contribution, the Local Authority Better Care Grant and Disabled Facilities Grant (DFG) have been published for 2026 to 2027. See the 'Minimum financial contributions to the BCF' section below for details.

In line with national BCF conditions listed later in this guidance, ICBs and local authorities must submit agreed BCF assurance returns by email to the national BCF team and regional better care manager by 19 May 2026.

The BCF assurance returns must include:

- assurance statements showing how they have met the national BCF conditions, including:
 - how their BCF spending plans link to wider strategic objectives for neighbourhood health and social care
 - the rationale for the goals they are setting and how they will drive progress in preventing avoidable long-term care home admissions and improving outcomes from reablement services
 - the expected impact of BCF-funded activities and value for money
- a breakdown of their planned BCF expenditure by category of spend and funding source, including delivering the NHS minimum contribution to social care

The assurance return this year is designed to be more focused, reflecting feedback and recognising the need for a more outcomes-led approach. Plans for BCF expenditure must build on, and align with, recently completed NHS returns for medium-term planning.

This guidance constitutes the formal planning requirements, national conditions for expenditure and legal framework. We will also provide more detail through the work of regional better care managers, webinars and support materials, which can be accessed through the [BCF Exchange \(https://future.nhs.uk/bettercareexchange\)](https://future.nhs.uk/bettercareexchange) (NHS Futures login required). We are grateful for the continued collaboration of ICBs and local authorities in improving integration of health and care services.

Context: BCF and the neighbourhood health service

The neighbourhood health service is a central policy in the 10 Year Health Plan. It will:

- bring more care into local communities
- unite professionals from different organisations into teams aligned around people's needs
- join up services
- focus health and care services increasingly on the prevention of ill health

Over time, it will shift the NHS from hospital to community, from sickness to prevention, and from analogue to digital. The overarching goal is to help people live more healthy and independent lives and transform their experience of health and care services.

The neighbourhood health service will be built around where people live, work, learn and connect. It will support people through every stage of life, with a focus on improving health and wellbeing and reducing health inequalities. It will encompass a wide range of existing community-based services, working together in a different way to provide more personalised, preventative and joined-up services. It will require an exceptionally strong commitment to:

- joint working across the NHS, local government, the voluntary sector and other local partners
- working in close partnership with local people

For 2026 to 2027, one of the early steps in developing the neighbourhood health service will be to introduce more systematic and effective support for people with complex health and social care needs.

The initial focus will be on priority cohorts including those with frailty and those nearing the end of life. This will include further development of

integrated neighbourhood teams for these groups, bringing together primary care, community health services, social care providers and others to provide more joined-up, person-centred care. It will also involve developing appropriate capacity and optimal use of community-based urgent response and intermediate care services (encompassing both health and social care, as appropriate) to prevent avoidable hospital and care home admissions and support timely hospital discharge.

Further information of the wider development of neighbourhood health services will be published in due course.

In agreeing plans for the use of pooled funding under the BCF, health and wellbeing boards, ICBs and local authorities are asked to consider how they can support relevant neighbourhood health ambitions. This may include, for example, alignment around critical service developments, such as integrated neighbourhood teams, and contributing to wider strategies for priority groups, such as those living with frailty. As noted above, it will be important to do this while avoiding disruption to critical services, maintaining funding for social care and increasing the NHS minimum contribution to adult social care in each of the next 3 financial years.

As ICBs plan BCF expenditure jointly with local authorities, they should consider the link with the wider expectation that the NHS will shift the balance of funding from hospital to neighbourhood services. NHS England will also work with local systems to test payment approaches that support and incentivise the development of neighbourhood health services and reductions in avoidable hospital activity.

Purpose of the BCF

The aim of the BCF is to support ICBs and local authorities in designing and delivering more integrated and preventative care, particularly for people with more complex health and social care needs, helping people stay independent for longer.

This includes - but is not limited to - developing integrated intermediate care services that help people retain or recover their independence. It also covers other health and social care services that support independence, prevent avoidable admission to hospital or long-term residential care, and enable timely and effective acute, community and mental health hospital discharge. BCF funding should be deployed in ways that help deliver the 3 shifts outlined in the 10 Year Health Plan.

ICBs and local authorities will need to ensure that their BCF plans represent value for money and improve overall productivity. Collectively, NHS trusts

need to deliver a 2% year-on-year improvement in productivity over the next 4 years. ICBs will need to provide specific assurance that BCF spending plans represent value for money overall and on how they contribute to trust productivity improvements.

Achieving value for money and improving overall productivity should be a collective endeavour between the NHS, local government and partners. Strong governance arrangements should be in place to monitor efficiency, effectiveness, resource allocation and improvement. Local areas should reach collective agreement on how to address resource pressures and deliver better outcomes.

Phases of BCF reform

For this initial year of BCF reform (the 2026 to 2027 financial year), we are asking local areas to start to align their plans for pooled funding with their wider approach to development of relevant areas of neighbourhood health plans, such as intermediate care. There will be no changes to the current system of minimum funding contributions.

For 2027 to 2028 onwards, we intend to consider whether local areas should be given more flexibility in deciding the level of pooled funding needed to support better integrated services. There will be a consultation on any proposed changes to minimum NHS and local authority contributions. We will also work with the NHS and local government to develop clearer expectations for the types of services that, as a minimum, should be subject to pooled funding. This will build on the success that many local areas have already seen by taking a more strategic approach to pooled funding.

Indicative ICB allocations for 2027 to 2028 and 2028 to 2029 have been provided to local areas. If the consultation results in giving local areas more flexibility and a lower minimum required level of pooling (from 2027 to 2028 at the earliest), the relevant funding will remain in NHS and local authority budgets and will continue to be spent on health and social care services respectively. We will not introduce any changes to the NHS and local authority minimum contributions to the BCF before financial year 2027 to 2028. The government is increasing the NHS minimum contribution to adult social care between 2026 to 2027 and 2028 to 2029 in line with the [Spending Review 2025 \(https://www.gov.uk/government/publications/spending-review-2025-document\)](https://www.gov.uk/government/publications/spending-review-2025-document) settlement - and this will be preserved in any new arrangements for 2027 to 2028 onwards.

Local Authority Better Care Grant allocations remain the same in 2026 to 2027 as they were in 2025 to 2026. The government will confirm the distribution and allocations of the Local Authority Better Care Grant from

2027 to 2028 onwards, as well as how places undergoing local government re-organisation can transition to new funding arrangements, in due course.

Minimum financial contributions to the BCF

As for the 2025 to 2026 BCF, the 2026 to 2027 BCF is composed of the following funds:

- the NHS minimum contribution, including the minimum contribution to adult social care
- Local Authority Better Care Grant
- Disabled Facilities Grant

Table 1: minimum contributions to the 2026 to 2027 BCF

BCF funding contributions	Amount (£ million)
Minimum NHS contribution	5,791
Local Authority Better Care Grant	2,640
Disabled Facilities Grant	723
Total	9,154

On 17 November 2025, NHS England published the [ICB allocations of the minimum NHS contribution to BCF for 2026 to 2027](https://www.england.nhs.uk/publication/better-care-fund-2026-27-to-2027-28-minimum-nhs-contributions-from-integrated-care-boards/) (<https://www.england.nhs.uk/publication/better-care-fund-2026-27-to-2027-28-minimum-nhs-contributions-from-integrated-care-boards/>) and indicative contributions for 2027 to 2028 and 2028 to 2029. For 2026 to 2027, the NHS minimum contribution to adult social care has been uplifted by 4.4%, with the remaining ICB contribution uplifted by 2.1%.

On 9 February 2026, the Ministry of Housing, Communities and Local Government (MHCLG) confirmed the [allocations for the Local Authority Better Care Grant for 2026 to 2027](https://www.gov.uk/government/publications/core-spending-power-table-final-local-government-finance-settlement-2026-27-to-2028-29) (<https://www.gov.uk/government/publications/core-spending-power-table-final-local-government-finance-settlement-2026-27-to-2028-29>) for each local authority.

On 17 February 2026, MHCLG confirmed the allocations for the DFG - see annex A of the response to the [Changing the way government allocates DFG funding to local authorities in England](#)

<https://www.gov.uk/government/consultations/changing-the-way-government-allocates-disabled-facilities-grant-funding-to-local-authorities-in-england>) consultation.

ICBs and local authorities are also encouraged to voluntarily pool additional funding where they have confidence this represents value for money.

Specific factors to consider during planning

In addition to the purpose of the BCF set out above, health and wellbeing boards, ICBs and local authorities are asked to consider the following specific factors when agreeing BCF expenditure.

Intermediate care services

ICBs and local authorities should consider how to work with community health and social care providers to develop more integrated and effective intermediate care services. These services should have sufficient capacity to meet demand and be supported by funding pooled through the BCF.

Intermediate care should meet short-term rehabilitation, reablement and recovery needs, both for people needing 'step-up' care to avoid a hospital or long-term care home admission and for those needing 'step-down' care following discharge from hospital. The aim of intermediate care is to enable as many people as possible to retain or recover their independence. This in turn will help reduce non-elective admissions, delayed discharges and levels of long-term social care needs.

Local areas are particularly encouraged to:

- review the balance of home-based and bed-based intermediate care, to increase home-based intermediate care capacity and optimise the use of bed-based intermediate care capacity where appropriate
- review the design of intermediate care packages to ensure people receive sufficiently intensive support to optimise their recovery and independence, and ensure timely transition from intermediate care services
- review commissioning arrangements for intermediate care to ensure that:
 - appropriate economies of scale can be achieved

- contracts are suitably long term to allow providers to improve outcomes and productivity
- strong strategic partnerships are developed with local providers
- assess how changes in capacity, quality and efficiency (including through use of technology) are expected to contribute to reductions in unnecessary hospital admissions, long-term care home admissions and discharge delays

Disabled Facilities Grant

Home adaptations delivered through the DFG help with the costs of making changes to people's homes to enable them to stay well and remain independent for longer. Subject to a means test, eligibility criteria and needs assessment, local housing authorities have a statutory duty to provide grants, up to an upper limit (currently £30,000), for adaptations for older people and disabled people of all ages.

Government funding for the DFG can also contribute to a more generous local housing assistance policy or other social care capital projects that support independent living, once statutory duties are met.

Local authorities should continue to bring together relevant teams across adult and children's social care, housing and the NHS to jointly plan the use of the DFG budget through health and wellbeing boards and agree how it can help improve outcomes for priority cohorts.

Local authorities and their partners are encouraged to deliver the DFG through an integrated team to ensure that people receive joined-up, person-centred assessments and support with their housing needs.

Supporting unpaid carers

Unpaid carers provide vital care and support for people. Carers should be actively involved as partners in planning care and support for those they care for, with their consent. In developing BCF plans, ICBs and local authorities should consider how pooled funding can help the NHS and local authorities meet their duties in relation to unpaid carers and help ensure that partners work together to:

- systematically identify unpaid carers and their responsibilities

- provide carer's assessments as required and support unpaid carers (for example, through respite support and peer support)

Partnership with the voluntary, community and social enterprise sector

The voluntary, community and social enterprise (VCSE) sector should be seen as a strategic partner in developing and delivering neighbourhood health and use of the BCF, in line with the [Civil Society Covenant](https://www.gov.uk/government/publications/civil-society-covenant) (<https://www.gov.uk/government/publications/civil-society-covenant>). VCSE organisations provide support to people with a range of health and wellbeing needs and have deep and trusted connections with their local areas and marginalised groups. VCSE services can provide support in ways that the NHS and local government cannot do on their own, offering a more holistic approach and helping to tackle health inequalities.

The VCSE sector can play a vital role in:

- helping people sustain their health and independence for longer
- addressing social determinants of health, for example by:
 - offering befriending opportunities to strengthen social connection and tackle loneliness
 - providing debt management advice
 - supporting unpaid carers
 - alleviating child poverty
 - helping to solve housing problems

In developing plans for the use of BCF funding, ICBs and local authorities should consider how the NHS and local government work effectively with the local VCSE sector to support more integrated care and people with health and social care needs.

Local goals and monitoring progress

ICBs and local authorities must set specific goals, agreed with health and wellbeing boards, to reduce avoidable non-elective admissions for people aged 65 and over and reduce discharge delays, against 2 metrics:

- non-elective hospital admissions for people aged 65 and over

- the average length of discharge delay for all acute adult patients, derived from:
 - the proportion of adult patients discharged from acute hospitals on their discharge ready date (DRD)
 - for those adult patients not discharged on their DRD, the average (mean) number of days from the DRD to discharge

ICBs and local authorities are also encouraged to set goals, agreed with health and wellbeing boards, in relation to long-term admissions to residential care homes and nursing homes for people aged 65 and over. Whether or not a specific local goal is set, ICBs, local authorities and health and wellbeing boards should monitor and drive progress in preventing avoidable long-term care home admissions.

These local goals should take into account both plans for deploying BCF funding and wider local action to help people stay independent for longer and prevent avoidable time spent in hospital and long-term residential or nursing home care.

We also expect ICBs, local authorities and health and wellbeing boards to monitor and drive improvements on the proportion of people aged 65 and over discharged from hospital, with reablement provided partly or solely by local authorities, who remained in the community within 12 weeks of discharge.

Assurance and oversight

ICBs and local authorities, working with health and wellbeing boards, must submit an assurance return to demonstrate how they have complied with the national funding conditions and planning requirements for 2026 to 2027 as set out in the next section of this guidance.

The return must include information on the use of BCF expenditure, local goals and assurance statements, including in relation to value for money. These returns must be submitted by email to the BCF national team and regional better care managers by 19 May 2026. Submission details can be found on the [BCF Exchange \(https://future.nhs.uk/bettercareexchange\)](https://future.nhs.uk/bettercareexchange) (NHS Futures login required).

Following receipt of the returns, regional NHS and local government colleagues will undertake a joint assurance process to confirm that all ICBs, local authorities and health and wellbeing boards can achieve the national conditions in line with the planning requirements as set out later in this guidance.

As in previous years, final approval for the use of the NHS minimum contribution will be obtained from NHS England, drawing on regional recommendations. NHS England may:

- approve ICBs to spend in line with their approved return
- place local conditions on an ICB
- not approve the return if national conditions have not been met and further work is required

As part of this process, regional BCF leads will work with local areas to help provide assurance that local goals relating to metrics on non-elective hospital admissions (for people aged 65 and over) and delayed discharges:

- reflect both their plans for deploying BCF expenditure and their wider neighbourhood health plans
- align with trajectories for non-elective hospital admissions and delayed discharges in NHS medium-term plans
- are realistic and achievable, with evidence of measurable improvement over time

Health and wellbeing boards will need to have effective governance and processes to:

- monitor progress against locally agreed goals and value for money
- identify opportunities for improvement

Health and wellbeing boards have access to the BCF dashboard where they can monitor performance against metrics for:

- non-elective hospital admissions (for people aged 65 and over)
- average length of discharge delays
- long-term care home admissions
- outcomes following reablement

As part of developing neighbourhood health, health and wellbeing boards will have scope to amend expenditure plans as long as these are in line with national conditions and approved by regional better care managers.

Once plans are approved, regional better care managers may provide oversight and support to the most challenged local areas, focusing on improvement and managing risk.

The Discharge and Admissions Group (DAG), which is co-led by the Department of Health and Social Care (DHSC) and NHS England, will work with a small subset of local areas that are experiencing challenges with

delayed discharges and system flow, guided by local performance against these metrics. DAG will work closely with:

- regional BCF leads
- the Local Government Association (LGA)
- the Association of Directors of Adult Social Services (ADASS)
- local authority and NHS experts

Escalation may be triggered if national conditions are not met or there is a material risk that they will not be met. In such a situation, regional BCF leads and national partners (NHS England, DHSC and MHCLG) will follow a clear escalation process that will be available on the BCF Exchange.

Further information will also be made available on the BCF Exchange about how assurance and oversight, including regular monitoring of performance against the metrics, will work for 2026 to 2027, both in relation to BCF spending plans and to local goals for non-elective hospital admissions and delayed discharges.

BCF national funding conditions

The specific national funding conditions that must be demonstrated as part of the assurance process are set out below.

National condition 1: effectively support the delivery of integrated and preventative care

ICBs and local authorities must develop joint plans, agreed by health and wellbeing boards, outlining how ICBs and local authorities intend to use BCF funding to deliver more integrated and preventative care, linked to the relevant areas of neighbourhood health and social care services.

The planning requirements are as follows.

ICBs and local authorities must:

- have considered how to use the BCF most effectively to support the delivery of more integrated and preventative services, particularly supporting those with more complex health and social care needs. This must include setting out how the funding will be used to develop the quality, efficiency and outcomes from intermediate care

- set out plans that:
 - show reasonable progress in the metrics of non-elective admissions (for people aged 65 and over) and delayed discharges
 - show how they will monitor and drive progress in preventing avoidable long-term care home admissions and improving outcomes from reablement
 - include the specific contribution of BCF-funded services
- demonstrate that their plans for the use of the BCF represent value for money and improve overall productivity

To demonstrate these requirements:

- named ICB and local authority chief executives and a named health and wellbeing board chair must confirm that BCF expenditure is agreed and aligned with wider strategic objectives for neighbourhood health and social care
- the BCF assurance return must include a short statement setting out how BCF funding will support wider strategic objectives, including those referenced in the ICB 5-year strategic commissioning plan. This statement must include:
 - a short explanation for any substantial changes in allocations compared with the 2025 to 2026 BCF funding and, if doing so, set out how ICBs and local authorities are ensuring continuity of critical services
 - a summary of assessments in the demand and capacity needed for intermediate care
- the assurance return must also:
 - set out local goals for non-elective hospital admissions for people aged 65 and over and discharge delays and the rationale for these goals, including alignment with local NHS provider medium-term planning assumptions. It should also set out plans to drive progress in preventing avoidable long-term care home admissions and improving outcomes from reablement and, if agreed locally, the rationale for local goals for long-term admissions to care homes
 - include an explanation of how BCF-funded services will contribute to meeting these goals
 - set out how ICBs and local authorities have confidence that the services funded through the BCF represent value for money, and how they will seek to raise the productivity of services. The value for money section of the return must reference how the joint governance set out under national condition 3 will review value for money and productivity
 - must be submitted to the national BCF team and regional better care managers by email, using the provided template on the [BCF Exchange](#)

National condition 2: comply with expenditure and grant conditions

ICBs and local authorities must comply with all national grant and funding conditions and deliver in accordance with their approved return. ICBs must maintain the NHS minimum contribution to adult social care and pool NHS BCF contributions into a section 75 (of the NHS Act 2006) pooled fund.

The planning requirements are:

- ICBs and local authorities must pool their designated minimum contribution (in the case of ICB partners) and the Local Authority Better Care Grant and DFG (in the case of local authority partners). ICBs and local authorities may voluntarily pool additional funding through the BCF where they consider this is likely to lead to an improvement in the services being funded
- the NHS minimum contribution to adult social care must be met and maintained by the ICB in line with the published BCF allocations. This represents an increase of 4.4% in each health and wellbeing board area
- local authorities must comply with the grant conditions of the Local Authority Better Care Grant and the DFG, including the pooling of funding

To demonstrate the requirements:

- the BCF assurance return must set out:
 - planned expenditure against core categories
 - the sources of this expenditure from different components of the BCF, including the NHS minimum contribution to social care
- assurance statements in the return will ask ICBs and local authorities to confirm that funding conditions have been met
- ICBs and local authorities must confirm that they will place the funding into one or more pooled funds under section 75 of the NHS Act 2006 once the BCF 2026 to 2027 assurance return is approved. They must do this no later than 30 September 2026

National condition 3: effective governance, reporting and engagement

ICBs and local authorities must comply and engage with BCF planning, governance and reporting requirements, including adherence to any assurance and oversight processes.

The planning requirements are:

- ICBs and local authorities must have effective joint governance in place to ensure local accountability for delivery of outcomes, including reviewing performance against plan objectives and local goals, and taking action if necessary to bring delivery back on track
- ICBs, local authorities and health and wellbeing boards are required to engage with BCF reporting, oversight and support processes

To demonstrate these requirements:

- the BCF assurance return must set out robust joint governance for managing the expenditure of BCF funding, including assessing impact of funding, value for money and continuous improvement
- ICBs and local authorities will need to confirm through assurance statements that they will engage with BCF oversight and support processes if necessary

Legal framework

The Secretary of State for Health and Social Care will issue the [National Health Service \(Expenditure on Service Integration\) Directions](https://www.gov.uk/government/publications/national-health-service-expenditure-on-service-integration-directions) (<https://www.gov.uk/government/publications/national-health-service-expenditure-on-service-integration-directions>) to NHS England to ring-fence £5,791 million to form the minimum contribution to the BCF in 2026 to 2027. The direction will be issued on or before 31 March 2026.

The Better Care Fund will be implemented by DHSC, MHCLG and NHS England using their powers under:

- [section 223GA of the NHS Act 2006](https://www.legislation.gov.uk/ukpga/2006/41/section/223GA)
(<https://www.legislation.gov.uk/ukpga/2006/41/section/223GA>)
- [section 31 of the Local Government Act 2003](https://www.legislation.gov.uk/ukpga/2003/26/section/31)
(<https://www.legislation.gov.uk/ukpga/2003/26/section/31>)

The requirements set out above are the national funding conditions that apply to funding that is made available by NHS England to local authorities and ICBs for the BCF. If an ICB does not comply with any of those national funding conditions, NHS England may:

- withhold payment of the NHS minimum contribution to the relevant ICBs
- recover payment of the NHS minimum contribution from the relevant ICBs, where the funding has already been released
- direct the relevant ICB as to the use of the NHS minimum contribution for purposes related to service integration or making payments towards community services

Grants to local government - the Local Authority Better Care Grant and the DFG - will be paid to local government under section 31 of the Local Government Act 2003, with the conditions that they are pooled into local BCF budgets and the national funding conditions set out above will be met.

MHCLG will publish a grant determination letter for both the Local Authority Better Care Grant and the DFG in due course. This letter will confirm that the conditions of the grants will align with the national funding conditions set out above.

Both the Local Authority Better Care Grant and DFG must be spent in accordance with an agreed BCF spend, goals and assurance return. If a local authority does not comply with any of the national funding conditions set out within the individual section 31 grant determinations, the government may:

- reduce, suspend or withhold grant payments
- by notification in writing to the authority, require the repayment of the whole or any part of the grant



Health and Wellbeing Board: Work Programme 2026-27

Monday 13 July 2026, 2.00 pm – Board meeting in public [Report deadline: Monday 29 June 2026 / Agenda publication: Friday 3 July 2026]				
Agenda item	Report from	Frequency	Purpose	Notes
Neighbourhood Health update	Zoe Clifford / Joanne Hodgetts	Quarterly	Information	<i>Standing item</i>
Best Start in Life – Good Level of Development (GLD) in children aged 5 years	Lindsay MacHardy / Julia Stephens	Ad hoc	Information	
Gambling and Related Harms	Kayte Thompson-Dixon	Ad hoc	Information	
The Better Care Fund (BCF) year-end report 2025/26	Marie Gallagher / Adrian Griffiths	Annual	Decision	<i>Standing item</i>
Herefordshire's Better Care Plan 2026/27	Marie Gallagher / Adrian Griffiths	Annual	Decision	<i>Standing item</i>

Monday 28 September 2026, 1.00 pm – Board workshop in private				
Focus				
Neighbourhood health, including best use of existing mechanisms to capture lived experience				

Monday 26 October 2026, 2.00 pm – Board meeting in public [Report deadline: Monday 12 October 2026 / Agenda publication: Friday 16 October 2026]				
Agenda item	Report from	Frequency	Purpose	Notes
Neighbourhood Health update	Zoe Clifford / Joanne Hodgetts	Quarterly	Information	<i>Standing item</i>
Prevention in Adult Social Care Strategy	David Collyer / Mohamed Essoussi	Ad hoc	Decision	
Annual report of the Herefordshire Safeguarding Adults Board 2025 to 2026	Joanna Newton / Angela Wilson	Annual	Information	
2026 Health Protection Annual Report	Sophie Hay / Rob Davies	Annual	Information	
Better Care Fund: Quarter 1 report	Marie Gallagher / Adrian Griffiths	Quarterly	Decision	<i>Standing item</i>
Better Care Fund: Quarter 2 report	Marie Gallagher / Adrian Griffiths	Quarterly	Decision	<i>Standing item</i>

Monday 25 January 2027, 2.00 pm – Board meeting in public [Report deadline: Monday 11 January 2027 / Agenda publication: Friday 15 January 2027]				
Agenda item	Report from	Frequency	Purpose	Notes
Neighbourhood Health update	Zoe Clifford / Joanne Hodgetts	Quarterly	Information	<i>Standing item</i>

OFFICIAL

Update on delivery of measurables in the Wye Valley NHS Trust Five to Ten Year Strategy	Sarah Shingler	Ad hoc	Information	<i>Arising from board request on 18 May 2026</i>
Better Care Fund: Quarter 3 report	Marie Gallagher / Adrian Griffiths	Quarterly	Decision	<i>Standing item</i>

Monday 24 May 2027, 2.00 pm – Board meeting in public [Report deadline: Monday 10 May 2027 / Agenda publication: Friday 14 May 2027]				
Agenda item	Report from	Frequency	Purpose	Notes
Neighbourhood Health update	Zoe Clifford / Joanne Hodgetts	Quarterly	Information	<i>Standing item</i>
Better Care Fund: End of year report	Marie Gallagher / Adrian Griffiths	Quarterly	Decision	<i>Standing item</i>

Potential agenda items to be scheduled				
Director of Public Health Annual Report	Zoe Clifford	Annual	Information	
Oral Health Improvement Board Update	Public Health	Annually	Information	
Pharmaceutical Needs Assessment (PNA) Recommendation Action Matrix	Public Health	Annual	Information	<i>Arising from PNA 2025 item, 15 September 2025.</i>
Refresh of the Health and Wellbeing Strategy	Zoe Clifford	Ad-hoc	Decision	
Tobacco Alliance Annual Report	Isobel Adams	Annual	Information	<i>Arising from Tobacco Control Plan item, 17 March 2025.</i>