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Department of Health & Social Care | Ministry of Housing, Communities & Local Government | NHS England

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:

Adapt as necessary	**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.

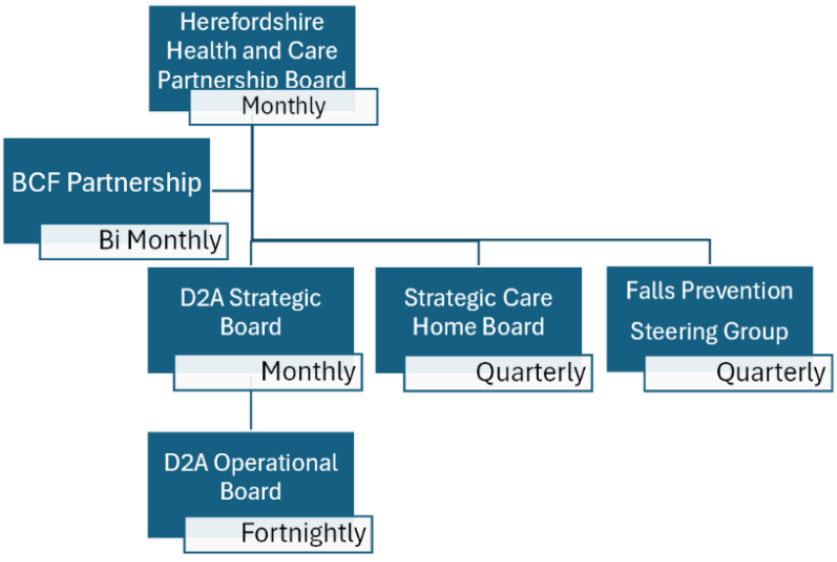
Overall BCF funding delivers value for money by supporting interventions that reduce high cost demand improve flow and strengthen prevention.

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.