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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	**Kingston Upon Hull**	
ICB	**Humber and North Yorkshire**	
ICB		
ICB		

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:

Our rationale for deploying BCF funding is to maximise delivery of neighbourhood-based models of care that reduce fragmentation, tackle health inequalities and intervene earlier to prevent avoidable escalation of need. Hull's Better Care Fund plan for 2026-27 supports the local health and social care system to improve performance in reducing emergency admissions to hospital admissions, tackling delayed discharge and reducing long term admissions to residential and nursing care. We do this by sharing information, aligning pathways and jointly managing risk. Our aim is to ensure partners can intervene earlier, reduce duplication and avoid escalating needs by providing local conditions for long term health and independence.

A core priority is shifting from reactive to preventative models of care. We will do this by embedding prevention within integrated neighbourhood teams and linking individuals to local assets to address the wider determinants of health. In Hull these include social isolation, housing support and financial insecurity. The approach aims to support people to remain independent for longer and reduce demand for acute and long-term services.

The BCF is central to our joint approach to safe and timely hospital discharge through investment in discharge-to-assess pathways, home-based reablement and step-down provision. The plan builds on capacity and demand work carried out in 2025/6. This work has highlighted the importance of building capacity in intermediate care at home to support hospital discharge. This progress has enabled providers to reduce bedded capacity and increase care delivered by our home first services.

The plan for 26-7 includes increased funding for avoiding admissions and we are working with our acute hospital colleagues to review the current frailty SDEC (same day emergency care) and increase capacity to connect the services with community frailty services. This work forms part of our programme with the National Frailty Collaborative as one of the 7 national implementation sites. The BCF plan also provides greater resource for advocacy in hospital and more funds to support management of IPC (infection prevention control) which has affected discharge and transfer of care in 2025/6.

Integrated discharge arrangements will continue to be co-designed by local authority and NHS partners to ensure that people leave hospital as soon as clinically appropriate with the right support in place.

Our BCF funding will also focus on inclusion health groups and unpaid carers. Close collaboration with the VCSE sector is central to our pathways and plan to strengthen community resilience and provide ongoing accessible support in the community.

The Governance arrangements in Hull have been reviewed considering organisational changes in the ICB. The BCF investment continues to be strategically aligned to the Joint Health and Wellbeing Strategy and overseen by the Hull Health and Wellbeing Board. The Hull Health and Care Partnership will lead on the development of the delivery model for integrated neighbourhood health and care and review the associated pooled budgets and associated performance metrics to identify integration opportunities and improve population health outcomes.

In summary, the rationale for using BCF funding is to accelerate integration at neighbourhood level, embed prevention across the system and deliver sustainable improvements in outcomes and experience. We will do this by coordinating our investment in community-based support that is informed by population health intelligence by building a more resilient health and care system that is responsive to the needs of our population focused on keeping people well and independent at home.

1. **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:

Our BCF Metric targets have been set in collaboration with ICB and HCC staff and benchmarked across the whole of the Yorkshire and Humber area. During 26-7 there will be continued provision of performance data through BCF quarterly monitoring and ongoing local reporting to the Health and Care partnership and local committees alongside Hull's Health and Wellbeing Board. The local authority collects data from the Business Intelligence Unit funded in the BCF plan and the equivalent team at the ICB.

For 2026-7, the BCF metrics have been revised and set on available data and with respect to previous performance in 2025-6 and before with respect to the reintroduced metric on reablement For emergency admissions, we have set targets based on average monthly data since 2020. Performance in 25-6 has been on or below target reflecting accurate setting for this year and we have followed the same process for 26-7.

With respect to the discharge delay metric, only four quarters of previous national data was available to support target setting so local SUS data has been used instead with learning developed using the target for 25-6. Again performance in 25-6 was on target reflecting accurate preparation and the same methods have been followed for 26-7.

The Residential Admissions metric was predicted to be relatively steady within the 2025-6 plan as performance in 2023-4 was much stronger than predicted. However, data cleaning and resubmission during 25-6 coupled with more short term admissions being redefined as long term ones led to an increase in Q2 not matched in other quarters. Bar this sole quarter, we believe the target for the rest of 25-6 will be met and have set the targets for 26-7 using the same methodology with a slight reduction of targets factored in. i.e. predicting fewer long term residential admissions year on year.

Our discharge plan priorities remain largely the same as 2025-6 supporting discharge infrastructure, promoting admission avoidance and ensuring safe and timely discharges. We have continued the support for the role of our local VCSE in supporting discharges for people returning home on a Pathway Zero through settling in calls, and the substantial increase in home based intermediate care is continued in line with our priority to promote home based Intermediate Care over bed based. We are looking to fund more support for avoiding admissions and providing advocacy to those in hospital.

Preventative support is secured through funding for the Red Cross and the Alzheimers society and extra capacity for supporting people with complex Mental Health needs and Homelessness remains, along with personalised commissioning support. Overall investment in the 2026-7 in the previously discharged funded schemes remains at the same levels or more than in 2025-6.

Our metrics have been informed by previous trends, demographic growth and system capacity. The Better Care Fund (BCF) is our main mechanism for aligning health, social care and community services around a shared ambition: improving outcomes through integrated, preventative and person-centred care. Our rationale for deploying BCF funding is to maximise delivery of neighbourhood-based models of care that reduce fragmentation, tackle health inequalities and intervene earlier to prevent avoidable escalation of need.

Consideration has been given to alignment with NHS planning trajectories in particular a local agreement to support Humber Health Partnership in a performance improvement transition plan with a commitment to prioritising all ICB transformation programmes related to UEC to reduce LOS at Hull hospitals by 1 day and reducing readmissions for respiratory patients through ED.

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 investment will strengthens proactive prevention and the development of our neighbourhood health and care delivery model. The planned impact of the BCF funding in 206/27 is to shift the balance of care towards prevention, independence and community-based support.

Our approach to identifying which population groups will benefit most from proactive and integrated interventions is informed by population health management (PHM), risk stratification and neighbourhood-level intelligence. We have started to use population health data to segment our population according to clinical risk, frailty, multimorbidity, deprivation and patterns of service use. This process has enabled us to identify cohorts with the greatest risk of avoidable hospital admission, delayed discharge or long-term care dependency. We have been testing out this approach with our PCNs and system partners as part of the development of our neighbourhood health and care model with pilots and 'care at home ' and respiratory care that will be scaled up across the city in 2026/27.

The analysis shows that the cohorts getting greatest benefit from proactive, integrated interventions include: people aged 65+ living with moderate to severe frailty and individuals with multiple long-term conditions (particularly cardiovascular disease and COPD). We have also identified inclusion health groups and individuals with co-existing physical and mental health needs as priority populations due to higher rates of unplanned care and poorer outcomes and will align this planning with our Hull **Changing Futures** programme.

In order to reduce the number of people aged 65 and over entering hospital via emergency admission the plan currently funds:

- Services supporting older people to remain independent and well including older persons preventative support offering a mix of advice and activity to help people stay active, avoid falls and manage respiratory health in community settings closer to home.
- Services helping those who have fallen with assessment and aids and adaptations to prevent recurrence and possible admission.
- A new scheme avoiding admissions as part of Hull's work around anticipatory assessment for frailty and a new model for frailty SDEC including social care.
- Community rehabilitation and assessment services to offer specialist help near where people live.

We also will continue to help people get discharged on time from hospital and limit the wait for discharge by:

- Funding in hospital locality teams including occupational therapists and social workers.
- Voluntary sector immediate help to speed up discharge and ongoing support to avoid readmission
- Funds to help with making sure property and care is available to minimise stays and speed up discharge.

The plan continues to fund services promoting active recovery and reablement in the community:

- Bee at Home's enhanced intermediate home care which has reduced reliance on bedded intermediate care
- The supporting independence team offering contingency care and short-term post discharge support (reablement).
- Hull's integrated team for older people offering specialised assessment and support for those in the community with specialist needs.
- Mental health support through community mental health teams, award winning advanced mental health professionals and locality teams across Hull.

Long term residential and nursing admissions are also discouraged under our plan by:

- Following a Home First approach
- Getting best value for nursing and residential care
- Promoting community-based rehabilitation provided by CHCP, Red Cross and Age UK

All activities funded under the plan are reviewed annually by our section 75 oversight group in addition to existing contracting arrangements with the ICB and Local Authority commissioning teams and overseen by the Health and Care Partnership and the Hull HWBB.

2. **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:

The total value of the Better Care Fund activities in Hull has remained relatively static since 2023 with no reduction in service delivery, and despite the payment of nationally mandated salary increments and the rising cost of living. Value for money is consequently a core principle of the plan and it's governance. Multiple schemes have been soft market tested to benchmark costs before any recommissioning and retendering, and all activities are subject to annual reviews under the joint governance of the section 75 oversight group. In deciding on the shape of the 26-7 plan, scheme reviews and suggestions for change were analysed and discussed in joint governance for a in order to decide on the priorities for this year.

Outcomes of these processes include new arrangements for community equipment services shared with our colleagues in the East Riding with ongoing shared implementation meetings reviewing contract delivery with a new provider and reported to the local authority's Disabled Facilities Grant Steering Group. Interim bed placements have been renewed after cost benchmarking and contract extensions for older person and other preventative services granted following the same process with service delivery maintained and costs minimised.

Similarly, pilots have been undertaken and proposed for better delivery of services under the plan. In our assistive technology service, a pilot included dedicated social work input to support provision and help maximise system savings in terms of better VFM solutions such as substituting telecare devices for care provision. We have considered whether greater subsidy of telecare provision may help reduce social care demand with partners in housing services, and as mentioned previously acted to replace bedded intermediate care with care that enables people to remain at home and in their community.

Savings made by overhauling our brokerage team have been reinvested into our locality teams, meaning direct delivery has benefitted as efficiencies have been found in infrastructural functions. The local authority has also carried out regrading of roles under the plan to achieve better value for money appropriate to job skills and requirements.

Additionally, our plan funds compliance activity which reviews home care, community wellbeing and active recovery support and has managed to recoup £100,000 plus of overpaid care costs for reinvestment elsewhere.

The ICB commissioned the contract for community services in 2024/25 and have been working with the provider throughout 2025/26 on a joint Community Services Transformation and Efficiencies Board that included adult social care and public health. The contract delivers most of Hulls community health services including the frailty services, virtual ward, 2UCR, intermediate and reablement services, therapy and community nursing. The Boards remit has been review of the services and development of transformation plans to ensure efficiency. quality and effectiveness. As the services move into a business as usual plan in 2026/27 they will be incorporated into plans for development of the neighbourhood health model with our overall aim of achieving productivity gains through integration and reduced duplication.

3. 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:

Hull has established joint governance arrangements to ensure that Better Care Fund (BCF) funding is strategically aligned

Better Care Funding is overseen in Hull by the section 75 Oversight group which is made up of members from the local authority and the Integrated Care Board including finance personnel from both. The oversight group provides quarterly reporting on performance to local authority committees including the Health and Care Partnership and the Health and Wellbeing Board, and finance members provide reporting to the current place director and executive director of adult social care and health.

Our Integrated Neighbourhood team oversight group – A delivery group made of up of all key stakeholders reporting into the Health and Care Partnership is working on the design and delivery of the integrated neighbourhood health and care model.

Hull recently expressed an interest and were successful in receiving BCF support from the national team. The support will assist Hull in our ambition to strengthen strategic governance in readiness for sign off on our Neighbourhood health and care plans. In addition to providing support to further develop our leadership and governance arrangements and assist with aligning our resources effectively across health and local government to optimise our current 75 and BCF integration with neighbourhood health plans.

Current performance reporting summarises activities as part of annual service reviews and provides quarterly thematic reviews based upon the metrics of the BCF to invite discussion and oversight from our Health and Care partnership. This supports existing local authority performance and finance reporting arrangements including management information dashboards which identify expenditure and performance issues alongside each other to better give oversight of value for money. Similar dashboards are developed and maintained at the ICB by the Business Intelligence team specific to BCF metrics in addition to NHS planning metrics. The BCF/section 75 is signed off by the ICB Board and a quarterly report on performance and quality is provided to the ICB executive.

BCF scheme reviews specifically identify numbers of beneficiaries, impact on the wider system and BCF metrics and value for money. This supports existing contract meetings held by both the ICB and Local authority with providers where progress towards output indicators and opportunities for co-production and added value are also addressed. In respect of Disabled Facilities Grant, a specific steering group reviews progress toward annual targets of grants and funded schemes whilst overseeing financial outturns.

Impact assessment is embedded within our performance management framework. We operate a shared dashboard tracking key BCF metrics, including non-elective admissions (65+), delayed discharges, reablement effectiveness (91-day independence), and permanent admissions to residential and nursing care. Data is reviewed monthly at section 75 oversight meetings, with deeper thematic reviews undertaken as agreed.

Quality assurance and continuous improvement is addressed through contract management which may vary depending on who holds the contract for commissioned services. Any contract escalation relating to joint performance indicators and outcome measures are brought to the Section 75 oversight group. Learning from complaints, audits and peer review is shared and systematically incorporated into service improvement plans as required.

The formal Section 75 agreement between the HCC and the ICB sets out risk-sharing arrangements, financial contributions, scope of services, and dispute resolution mechanisms. Financial reporting on the section 75 is undertaken jointly on a monthly basis, with detailed monitoring of expenditure against plan, forecast outturn and variance analysis.