Report

To: Coventry Health and Wellbeing Board **Date: 8 July 2026**

From: Pete Fahy – Director of Adult Care, Health and Housing

Title: Better Care Fund – 2025/26 review and 2026/27 planning approval

1 Purpose

The purpose of this report is to:

a) Provide a review of the 2025/26 Better Care Fund programme including what has been achieved

b) Seek approval for the 2026/27 Better Care Fund programme submission to NHSE

2 Recommendations

Coventry Health and Wellbeing board are recommended to:

a) Note the review comments regarding the 2025/26 Better Care Fund programme

b) Endorse the 2026/27 Better Care Fund programme submission to NHSE

3 Information/Background

3.1 The Better Care Fund (BCF) commenced in 2015 with an aim of bringing together NHS, social care and housing services so that older people, and those with complex needs, can manage their own health and wellbeing and live independently in their communities for as long as possible.

3.2 It is based on the concept of a pooled budget between Integrated Care Boards and Local Authorities with one party agreeing to 'host' the pool which is managed by a s75 legal agreement. The Coventry BCF pool is hosted by Coventry City Council and is overseen by the Coventry Care Collaborative.

3.3 BCF planning periods are established by NHSE which tend to be on one year or two-year cycles.

3.4 As well as submission of Better Care plans to correspond with the planning cycles the local authority, as lead agency is also required to submit quarterly performance returns to NHSE demonstrating progress against the BCF metrics.

3.5 The body with overall local responsibility for the BCF is the Coventry Health and Wellbeing board.

4 Review of progress against the 2025/26 BCF plan

4.1 The pooled fund associated with the 2025/26 plan totalled approximately £148m which delivered against 73 separate lines of expenditure across Health and Social Care. Areas of expenditure included social care residential care, learning disability support, dementia, carers, disabled facilities grant and support to enable effective hospital discharge.

4.2 The metrics associated with the plan as set by NHSE were:

- Emergency admissions to hospital for people aged 65+ per 100,000 population
- 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); and, for those adult patients not discharged on DRD, average number of days from DRD to discharge)
- Long-term admissions to residential care homes and nursing homes for people aged 65+ per 100,000 population.

4.3 The two BCF Objectives had the following six agreed BCF Plan priorities:

4.4 BCF Objective 1: reform to support the shift from sickness to prevention

4.4.1 Priority one: The Community Integrator programme aims to improve support for people in the community by using population health management to identify those most at risk and better coordinate care. It is Coventry's response to the Neighbourhood Health model, focusing on integrating services for people with complex needs.

Progress builds on the 2024 transfer of adult physical health community services to UHCW, strengthening integration across health and care. The programme aligns with the Government's 10-year plan (July 2025), promoting neighbourhood-based care, reduced reliance on acute services, and the development of Integrated Neighbourhood Teams (INTs).

Key developments include:

- *Launch of the first INT in December 2025 (west Coventry), targeting individuals with complex needs and high service use.*

- *Plans for citywide INT rollout by June 2027.*
- *Improved early intervention through population health management.*
- *Greater integration across primary care, community services, adult social care, and the voluntary sector.*

Delivery is overseen by the Coventry Care Collaborative, supporting system-wide coordination and effective resource use. Coventry is also part of the national implementation programme, enabling it to shape and test the neighbourhood health model.

Additionally, the Coventry Coordination Hub has been introduced as a single point of triage, improving access, reducing duplication, strengthening information sharing, and supporting INTs to deliver coordinated, proactive care.

4.4.2 Priority Two: Develop our approach to the use of home adaptations and technology and progressing improvements in our home adaptations response as a result of working with Foundations (support organisation to MHCLG)

Good progress has been made in maximising the use of Disabled Facilities Grant (DFG) funding, with increased emphasis on targeting resources towards those most in need and ensuring timely delivery of adaptations. Activity levels have improved and there is a continued focus on reducing waiting times and improving the end-to-end customer journey.

A programme of service transformation and restructure took place to create a more streamlined and integrated home adaptations service. This is strengthening coordination between housing, adult social care and health partners, improving oversight of demand and capacity, and enabling a more efficient and responsive service offer. The service restructure in conjunction with new Housing assistance policy has improved waiting times and streamlined the process.

This approach is informed by our work with Foundations (the national body supporting MHCLG), with a focus on simplifying pathways, improving performance, and embedding best practice. Collectively, these changes are supporting a more preventative, person-centred model, ensuring adaptations and technology are considered earlier, reducing escalation of need, and supporting independence, hospital discharge and reduced reliance on long-term care.

Further work underway is the development of an enhanced digital offer for equipment and adaptations, supporting more streamlined access and improved customer experience. This includes expanding self-service options where appropriate, enabling individuals, and professionals to request and track equipment online, and improving visibility of available solutions. The digital approach will help to speed up assessment and delivery, reduce unnecessary handoffs, and support more timely provision of low-level equipment. It also supports a more preventative model, enabling people to access straightforward

solutions quickly while ensuring that more complex cases receive targeted professional input.

4.4.3 Priority Three: Improve our support for unpaid carers through remodelling the support provided from the voluntary sector and ensuring we are giving unpaid carers more flexibility over the support services they receive through increasing the proportion of direct payments. This also includes ensuring that services for carers commissioned through the Accelerated Reform Fund are of tangible benefit to unpaid carers.

Coventry has recommissioned its carers support services following extensive engagement, aligning the new model with the Coventry Carers Action Plan 2024–2026. The redesigned service focuses on what carers say matters most, including flexible breaks, personalised and timely support, and better access to information, advice and guidance.

Launched in October 2026 and delivered by Carers Trust Heart of England, the service works with partners to provide coordinated, preventative support. It continues to promote carers direct payments, alongside support funded through the Accelerated Reform Fund.

My Time Project (since April 2025) offers one-off breaks such as hotel stays and day trips, matched to carers' preferences through donated opportunities. By April 2026, 213 carers had benefited, reporting improved wellbeing, reduced isolation, and feeling valued. Over 40 businesses have contributed.

Bridgit Online Support Tool (since December 2024) provides AI-driven information and over 90 support modules. Between December 2024 and April 2025, 6,591 users created 9,471 self-help plans, most commonly accessing information on Carer's Allowance, caring responsibilities, and assessments.

UHCW Carer Support has been strengthened through an additional hospital liaison worker funded by the Accelerated Reform Fund. This supports carers in hospital pathways and improves identification through a Carer Card, offering benefits such as extended visiting hours and access to support. Engagement activities include ward presence and drop-in sessions, with positive feedback from the hospital.

4.5 BCF Objective 2: reform to support people living independently and the shift from hospital to home

4.5.1 Priority One: The work completed under the previous BCF plan through the Improving Lives programme has had a demonstrable impact on preventing avoidable hospital admissions. This work will be built on and further embedded over this BCF plan.

The Improving Lives programme and development of the OCIT model has continued to demonstrate positive impact in reducing avoidable hospital admissions, with key interventions now more systematically embedded across health and care pathways. Over the course of this BCF period, there has been

a sustained focus on early intervention, multidisciplinary working, and proactive care planning for individuals at higher risk of hospital admission.

Expansion and improved coordination of community services have enabled more people to be supported safely at home, reducing reliance on acute care settings. Alignment with discharge processes has ensured that individuals leaving hospital receive appropriate ongoing support, and reinforcing prevention.

4.5.2 Priority Two: Integrating P3 and Fast Track approaches with other D2A discharge capacity to ensure people are supported in the most appropriate manner and to achieve more timely and effective discharge from acute and community, including end of life care.

Coventry continues to develop an integrated Discharge to Assess (D2A) model, ensuring Pathway 3 (P3) and Fast Track Continuing Healthcare (CHC) are aligned with wider system capacity to enable timely, person-centred discharge from acute and community settings.

We have dedicated staffing aligned to P3 beds to provide a consistent and timely response. We continue to collaborate with system partners to support timely discharges and ensure people are supported via the right pathway and support is available and timely once discharged.

System pressures continue to exist with regards to therapy support to ensure people's independence is maximised at every opportunity and closer working with UHCW colleagues, ICB and OCIT continues to support discharge flow.

4.5.3 Priority Three: Reviewing our commissioning capacity to ensure this is appropriately sized and resourced to support demand. Our Improving Lives programme has evidentially reduced the numbers of people requiring ongoing residential care following discharge from hospital so ensuring the changes are embedded and the benefits maximised will form a key part of this plan.

The Improving Lives Programme *has delivered demonstrable impact across Coventry, with evidence showing a sustained shift in discharge outcomes. There has been an increase in the number of people returning home with short-term home support services, rather than entering short-term residential provision. This reflects a continued move towards strengths-based practice, increased utilisation of community-based support, and a stronger focus on recovery, independence, and prevention.*

Commissioning capacity has been actively reviewed and adjusted to support this shift, ensuring sufficient provision within domiciliary care and community services to meet changing demand. For 2026/27 further work has commenced to explore alternative options to short term home support service as a discharge alternative to support people to return home.

The number of people requiring ongoing residential care has remained consistent with the previous year, indicating further work is required to fully realise the preventative ambition of the programme. This will be further

supported by the continued development of Integrated Neighbourhood Teams, which will play a key role in strengthening early intervention and preventative support, enabling more people to remain independent at home. Alongside this, maintaining a strong focus on timely hospital discharge and effective reablement will be critical.

4.6 **In respect of delivery against the metrics the position at end of 2025/26 was as follows:**

4.6.1 Rate of emergency admissions to hospital for people aged 65+ per 100,000 population – **Target met**

Emergency Admissions (rate per 100k)	Q1	Q2	Q3	Q4
Target	2,124	1,997	2,142	2,171
Performance	2,054	1,918	2,060	2,028

Factors contributing to the achievement of this target include the work developing the OCIT model along with the development of the care co-ordination Hub, alongside ongoing work with West Midlands Ambulance Service (WMAS) on 'Call Before Convey' to avoid conveyances and hospitalisations.

4.6.2 Average length of discharge delay for all acute adult patients – **Target met**

Length of discharge delay (av. days)	Q1	Q2	Q3	Q4
Target	1.13	1.10	1.10	1.10
Performance	0.75	0.81	0.86	0.87

As with target one the work associated with the OCIT model and WMAS has also contributed to this target being met. Interfaces between UHCW and OCIT has also supported improved discharge flow.

4.6.3 Long term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100k population (65+) – **Target not met**

Length of discharge delay (av. days)	Q1	Q2	Q3	Q4
Target	76	76	76	75
Performance	63	106	75	94

Annual count of admissions for 65 + cohort was 338 against a target of 303. Although the target wasn't met this year, we are predicting a lower number of residential admissions in 26/27. Work is ongoing to increase the number of people being discharged from hospital to home, rather than bedded facilities. In the community we are making best use of technology to support people to remain at home where possible. We also have a strong Housing with Care market to reduce the need for some residential placements. Our integrated work in developing integrated neighbourhood teams will also support the preventative agenda to support more people to remain at home.

5 Summary of the 2026/27 BCF plan

5.1 The Better Care Fund Plan for 2026/27 required submission to NHSE by Tuesday 19 May 2026. As there was not an available HWBB meeting to correspond with this timescale, this update on the 2026/27 plan is retrospective. As the NHSE timescales for completion of the 2026/27 plan were compressed, retrospective reporting is not unusual for this planning round.

5.2 Once submitted the BCF plan goes through a regional assurance process before confirmation of approval is received. As at 26 June 2025 no communication had been received from the regional BCF team to confirm approval or otherwise. As it is a 12-month plan for which three months have now elapsed we are continuing on the assumption that the plan has been approved.

5.3 The length of the narrative plan return has been reduced significantly for 2026/27 reflecting LA and ICB feedback on the benefits of a more focused BCF assurance process. The narrative plan is appended to this report and below are some key points to note in relation to changes to the BCF for 2026/27.

5.4 Although BCF plans cover distinct periods of time much of the work does not sit neatly within a 12- or 24-month cycle so there is a large degree of continuity between plans. Our progress as a set of Health and Care partners does progress and as such the key changes since the 2025/26 plan are:

5.5 A review of some health and social care funded programmes was conducted to ensure the funding responsibility aligned with organisational responsibilities and intended outcomes.

5.6 For 2026/27 the total value of the BCF fund is approximately £157M which is deployed to deliver 51 separate lines of activity and services. Although this is a significant sum of money it is all allocated against existing service spend. Details of the £9.6M increase in BCF funding total are set out below but the increase does not represent new spending power.

- The minimum NHS contribution for Coventry has increased by £1M (2.89%). Of this the minimum contribution which has to go to ASC has increased by £0.5M (4.4%). This is new money, but it is entirely consumed by inflation on services funded via BCF.

- The additional LA contribution has increased by £1.7M. This is mainly due to additional contributions into the BCF Pooled Budget in 2025/26 from the ICB which are one-off in nature, this is offset by a reclassification of some budgets as 'non-BCF' in recognition of the move towards neighbourhood health plans. A further adjustment relates to including the full DFG reserve in the BCF. This is a technical change as advised by NHSE but doesn't change spending plans.

- The additional NHS contribution has increased by £7.2M mainly due to the increase in budget for out of hospital residential nursing care. This is a budget adjustment to better reflect the true expenditure level - it does not represent new spending.

5.7 The 2026/27 plan contains the following priority actions against the 2 overarching BCF objectives:

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.

5.8 Objective 1: Reform to support the shift from sickness to prevention

5.8.1 Progress the delivery of Community Integrator Programme and Neighbourhood Health Model

- Scale the Community Integrator Programme to improve system-wide community support to improve system wide effectiveness

- Embed population health management to identify risk early and enable prevention.

- Strengthen alignment with the Neighbourhood Health model through multidisciplinary working.

- Improve outcomes by reducing avoidable admissions, delays, and demand via targeted community interventions.

5.9 Objective 2: reform to support people living independently and the shift from hospital to home

5.9.1 Assistive Technology and digital offer.

- Further develop and implement a strategic approach to assistive technology, focusing on prevention, independence, and timely hospital discharge.

- Increase the uptake and integration of technology-enabled care solutions to support people to remain safely and independently in their own homes.

- All priorities will contribute to reducing inequalities, improving independence, and delivering sustainable demand management across health and care, with a focus on outcomes, co-production, and value for money.

5.10 The BCF metrics will as always form a significant part of the quarterly reporting requirements. The target metrics for 2026/27 have been set using intelligence from both commissioners and providers in the NHS and social care and are aligned with NHS planning submissions. Targets within the BCF are considered locally to be challenging but achievable in the context of currently known factors. The assurance process will provide appropriate challenge as to whether targets are acceptable to NHSE.

5.11 <u>The three metrics are summarised below and set out in detail within the narrative plan:</u>

5.11.1 Emergency hospital admissions for people aged 65+ per 100,000 population:

- The implementation and evolution of OCIT and particularly Integrated Neighbourhood Teams will help to better manage the demand for services from our older population but will require time to fully embed and align to relevant services to optimise performance delivery.

- In addition, partners are mindful of the relatively high population growth rates for 65+ year olds (and even higher for 75+, 85+ etc) and the resulting, absolute increases in frail elderly and complex unplanned care episodes.

- Both ambition and target data reflect this current position in terms of demographic data and service development, and targets will be reviewed and adjusted following completion of the NHS Planning exercise, given the interdependency with BCF planning.

5.12 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 DRD, average number of days from DRD to discharge:

- The 2026/27 plan for ‘proportion discharged on DRD’ is derived from the NHS acute provider plans and shows an improvement of 0.7% to 82.9%. This represents an approximate 50% bridge of the gap to the peer group

average. The plan presents a delivery challenge that will require service change which will be supported by community developments including the ongoing evolution of the recently initiated (December 2025) Care Co-ordination Hub and related OCIT improvements supporting discharge flows.

- The 2026/27 plan for 'average number days of discharge delay' is based on straight-line forecast from historical averages, with further reductions planned for the following two years. Community workstreams outlined above will also positively impact this metric along with ongoing hospital and collaborative workstreams to reduce discharge delays. As NHS planning guidance and provider mitigations are finalised, targets will be revised to reflect improved positions and changing circumstances.

5.13 Long-term admissions to residential care homes and nursing homes for people aged 65+ per 100,000 population:

- As a result of our Improving Programmes, the number of starts in P2 beds has declined significantly, with the expectation for this trend to continue into 2026/27. This reduction reflects the effectiveness of delivery against the 2025/26 plan, resulting in fewer P2 bed placements. Our target for 2026/27 is to maintain this improved position and further reduce the use of spot beds that support peaks in service demand across UCHW's system.

- Due to increases in demand maintaining this performance at the rate of 340 Long-term admissions to residential will be achieved by building on the success of our short-term reablement approach, increasing P0 discharges, and reducing reliance on spot-purchased reablement beds. Recommissioning our Long-Term Home Support offer and expanding Direct Payments will further support this, while the introduction of neighbourhood teams will enable more people to be supported at home or without formal care.

5.14 Governance and Oversight

5.15 For the 2026/27 BCF plan the Coventry Care Collaborative will be the primary place of oversight for Coventry with reports to the Coventry HWBB to correspond with quarterly submissions to NHSE.

5.16 Changes to the BCF in respect of areas of spend will be kept under review as services develop and demands change.

6 Options Considered and Recommended Proposal

6.1 The recommendations are contained at section 2 of this report.

6.2 There are no other options or recommendations related to the content of this report.

Appendices:
Appendix 1 - 2026/27 BCF narrative plan

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