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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

Adapt as necessary	**HWB area 1**	**HWB area 2**
HWB	**Coventry**	
ICB	**Coventry, Warwickshire, Herefordshire and 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.**

The Coventry and Warwickshire Integrated Care System (ICS) Five Year Joint Forward Plan places the maintenance of independence at home for local residents at the very centre of our system-wide approach. The aims of the ICB cluster strategy (diagram below) is also supported by the BCF which will also be aligned with the ICB commissioning strategy which is currently in development.

Through highly effective joint working and collaboration, partners from across the Integrated Care Board (ICB), Local Authority (LA), and University Hospitals Coventry and Warwickshire (UCHW) are harnessing the opportunities afforded by the Better Care Fund (BCF) to strengthen integrated and preventative care within neighbourhood health and social care services.

The BCF is pivotal in enabling these organisations to align their priorities, pool resources, and deliver coordinated support that tackles health inequalities, prevents the escalation of need, and improves outcomes for the people of Coventry and Warwickshire. This collaborative approach is particularly vital within our neighbourhoods, where demand for community-based health and social care is rising and the complexity of needs continues to grow. By working together, the ICB, LA, and UCHW can ensure that services are not only responsive to local requirements but also delivered in a way that is both sustainable and effective.

Central to this joint endeavour is the enhancement of multidisciplinary neighbourhood teams, which bring together expertise from social care, community health, primary care, housing, and the voluntary sector. These teams, developed as part of the Community Integrator programme, exemplify the Coventry response to the Neighbourhood Health model. The Community Integrator programme, led by NHS partners and supported by social care, is designed to improve the effectiveness of community services in supporting independence and reducing unnecessary hospital admissions.

Through population health management, partners are now able to identify those most at risk of escalating health needs, allowing for targeted interventions that prevent crisis and promote wellbeing.

The rationale for using BCF funding to maximise delivery is rooted in its focus on prevention, demand management, and improved access to support close to home. Targeted BCF-funded initiatives—such as reablement, community support, and services for carers—are delivered through joint commissioning and operational collaboration. These initiatives directly reduce avoidable hospital admissions, support timely discharge, and prevent premature entry into long-term care through providing support that enables people to regain levels of functioning and supporting unpaid carers effectively. By prioritising cost-effective alternatives to acute and crisis services, partners can promote independence, resilience, and enhanced wellbeing for service users.

Moreover, BCF investment strengthens neighbourhood-level capacity by supporting workforce integration and shared infrastructure across the ICB, LA, and UCHW. This includes joint training programmes, the development and use of shared data and digital tools, aligned care planning, and the co-location of teams. These enablers create a unified and responsive system, able to adapt quickly to changing population needs and local priorities. The close working relationships fostered by the BCF ensure that health and social care pathways are seamless, and that service users and carers experience joined-up, high-quality support.

BCF resources are also directed towards core priorities such as reducing delayed discharges, improving hospital flow, supporting people with complex conditions, and raising the overall quality of care. Through collaborative commissioning and delivery, the ICB, LA, and UCHW can manage system pressures more effectively, reducing the need for escalation to acute services and delivering better experiences for those who use our services. Regular pathway reviews, multidisciplinary team discussions, and strengths-based assessments ensure that decisions about long-term care are made appropriately and only when all other options have been explored.

In summary, the BCF is essential for maximising integrated and preventative care because it provides the flexibility, collaboration, and sustainability required to transform neighbourhood services. The joint working and collaboration between the ICB, LA, and UCHW is fundamental to this success, ensuring that health and social care partners can jointly address local needs, reduce inequalities, and support people to live independently for longer. Through targeted, place-based investment, the BCF continues to drive system-wide improvements, strengthen community resilience, and deliver better outcomes for the residents of Coventry and Warwickshire.

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.

The objectives for non-elective admissions among those aged 65 and over, as well as targets for reducing delayed discharges, have been established using a blend of local baseline data, population health insights, and system-wide imperatives for enhancing flow across health and social care. These targets are intentionally ambitious yet realistic, considering the demographic challenges associated with an ageing population. The overarching aim is to improve outcomes, minimise avoidable escalation of need, and preserve system resilience while ensuring care remains person-centred and effective.

Targets for delayed discharges have been formulated to optimise patient flow, shorten unnecessary hospital stays, and reduce the risk of deconditioning for older adults. This is achieved by refining discharge processes, expanding capacity within reablement and home-care pathways, and reinforcing collaborative arrangements between hospitals, community services, and social care. The rationale is grounded in “discharge to assess” principles, ensuring that individuals remain in hospital solely for clinical reasons, and aligning system-wide capacity planning to mitigate bottlenecks that can contribute to delays.

Local targets for reducing long-term admissions to residential and nursing care are underpinned by investment in preventative services, strengths-based practice, and community alternatives designed to help people maintain their independence for longer. Routine pathway reviews, multidisciplinary team discussions, and strengths-based assessments ensure that decisions regarding long-term care are appropriate and only taken when all other options have been exhausted. Central to this approach is the enhancement of reablement outcomes, with a focus on expanding capacity, improving responsiveness, and embedding therapy-led models that empower individuals to regain independence following illness or crisis.

Our work through the Improving Lives Programme in Coventry is founded upon the principle of enabling people to live independently at home. With the introduction of a new operating model in June 2024, the focus over the 2026/27 BCF plan period will be on embedding this model fully and enhancing its effectiveness, aligning it with the neighbourhood model approach to ensure consistency and sustained impact.

We anticipate continued success in supporting more people at home and reducing reliance on P2 beds. Over 2026/27, ongoing capacity requirements will be reviewed considering evolving demand, ensuring that services remain responsive and effective.

Coventry has managed and maintained a robust and responsive care market with a significant degree of elasticity. This means we are in the fortunate position of being able to source and arrange care and support quickly to facilitate hospital discharge and avoid admissions. We do not experience a market that is unable to respond to demand. There are however pockets of activity we have identified to explore and determine whether they are operating at the optimum level of effectiveness over this plan, for example the commissioning of P3 and Fast Track services will be assessed to

confirm their integration within the local care system and ensure they complement the overall model of support. The opportunities to increase P0 discharges will also be explored along with the support required to achieve an increase in P0 and therefore reduce demand for pathway discharges that require care and support services.

Coventry Health and Social Care partners participate in the 'Community Integrator' programme, an NHS-led initiative aimed at enhancing the effectiveness of community services in promoting independence and reducing hospital admissions. This ambitious programme, with social care as an integral component, is monitored through clear deliverables and robust oversight.

1. Emergency hospital admissions for people aged 65+ per 100,000 population

The current target may appear unambitious as appears to be a maintenance of the performance output achieved in 2025/26. However, our provider planning has gone beyond using a single year baseline to define seasonality, so a simple adjustment using 25-26 has not been observed. The submitted plan at an annual level does however show an **improvement** on 25-26.

In addition, population growth is not yet fully factored into our calculations however 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.

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.

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.

2. Average length of discharge delay for all acute adult patients

2.1 Proportion of adult patients discharged from acute hospitals on their discharge ready date (DRD)

The 2026/27 plan 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.

In agreeing this target commissioners note that DRD benchmarking has challenges including variable DQ nationally (9% of providers not submitting acceptable data). Also UHCW migrated their Electronic Patient Record (EPR) in the latter half of 2024 with some unavoidable disruption to data completeness, making comparisons to 25-26 less valid. Again, we are deriving our BCF plan from the NHS Provider plans which in the specific case of the DRD metrics is especially valid to ensure

consistent understanding and reality to the plan. The submitted plan at an annual level does however show an **improvement** on 25-26 of 0.7% to 82.9%.

It is recognised that this target may not be considered particularly stretching but it will however present 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.

There will be a focus increasing the % of Pathway 0 discharges, currently 72% against the national average of 85%.

2.2 For those not discharged on DRD, average days from DRD to discharge

The target of 5.5 days is better than the peer group average of 5.8. It is based on a straight-line forecast from historical averages (with further reductions planned for the following two years).

Community workstreams to support 2.1 will also positively impact 2.2, along with ongoing hospital and collaborative workstreams to reduce discharge delays.

Population growth has not yet been accounted for. As NHS planning guidance and provider mitigations are finalised, targets will be revised to reflect improved positions and changing circumstances.

3. Long-term admissions to residential 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 is service demand across UCHW's system.

Due to increases in demand maintaining this performance at the rate of 340 Long-term admissions to residential This 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.

BCF funding continues to underpin a range of preventative initiatives supporting people in their own homes and promoting a ‘home first’ ethos. This includes investment in affordable warmth schemes, initiatives to combat loneliness, and targeted support for deprived communities through programmes such as Healthier Communities Together.

Our integrated approach to commissioning pathway support places reablement, strengths-based working, and independence at the forefront, offering both step-up and step-down support to optimise outcomes.

Pathway 1 home support services were recommissioned in Spring 2024, with a renewed emphasis on improving independence outcomes. This commissioning was informed by collaborative work across the system to enhance experiences for those at risk of, or admitted to, hospital.

We are undertaking a piece of work during 2026/27 to look at the measurement of this indicator and how it aligns with that of other systems to ensure we are consistent with the approaches being taken more widely. We are aware that currently our stat includes moves between Nursing and Residential, as well as depleted funds cases, for example, when arguably these don’t represent real ‘new’ admissions.

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

Coventry City Council aims to maximise the impact of Better Care Fund (BCF) investment by prioritising prevention and independence-focused support. This approach is designed to reduce the number of people progressing into crisis, hospital admission, or long-term care. BCF-funded initiatives, such as integrated community services, reablement, home-first/discharge to assess models, carers’ support, and preventative schemes such as tackling loneliness and affordable warmth, are coordinated to help residents remain at home for longer and decrease reliance on residential and nursing placements. The recommissioned pathway 1 home support now places greater emphasis on independence, further supporting these objectives.

Coventry and Warwickshire Integrated Care Board (ICB) leverages BCF funding to improve system flow and alleviate pressure on acute services. Investment is directed towards integrated neighbourhood and community services, which are key to preventing avoidable admissions—particularly for those aged 65 and over—and facilitating timely discharges. The Community Integrator programme supports multidisciplinary neighbourhood teams, aligning BCF targets with NHS planning to maintain improvements in discharge performance and reduce long-term care admissions through joint commissioning and shared oversight.

The BCF enables health and social care partners—including the ICB, local authorities, and NHS providers—to pool resources and deliver coordinated, preventative care within neighbourhood health and social care services. This collaborative approach addresses health inequalities, prevents escalation of need, and improves outcomes for residents. By supporting multidisciplinary teams, BCF funding enhances community service effectiveness and reduces unnecessary hospital admissions through targeted interventions and population health management.

BCF funding is allocated to reablement, community support, carers' services, and initiatives utilising the expertise of the voluntary sector. These are delivered via joint commissioning and operational collaboration, aiming to reduce avoidable admissions, support timely discharge, and prevent premature entry into long-term care. The fund also supports workforce integration, joint training, shared digital tools, and aligned care planning, resulting in a unified, responsive system that can adapt to changing population needs. This ensures seamless health and social care pathways and promotes joined-up support for service users and carers.

In terms of BCF metrics, the funding underpins efforts to reduce non-elective admissions among those aged 65+, minimise delayed discharges, and prevent unnecessary long-term care home admissions.

Over the 2026/27 two specific proposals will be progressed to achieve a proof of concept for further scaling in future years as follows:

1. **Non-elective admissions:** Though our plan we will be investing in increased physiotherapy to be targeted at discharge through our One Coventry Integrated Teams (OCIT). One of the ASCOF indicators linked to non-elective admissions is 'readmissions within 12 weeks' which has been identified as an area for improvement. Through improving the physiotherapy offer at discharge we plan to impact of non-elective admissions through specifically targeting readmissions.
2. **Discharge delays:** In Coventry we are in the fortunate position of having a robust and responsive care market so rarely experience significant delays due to market capacity. There is however the potential to make more effective use of market capacity through testing whether lower level support options could increase P0 discharges and therefore contribute to a further reduction in delays.

Alongside these two specific proposals we will continue to -invest in preventative services to support a reduction in admissions and our strengths-based practice approach helps people to build resilience and maintain independence, while enhanced reablement outcomes support individuals to regain independence after illness or crisis. Recommissioned home support and expanded direct payments further reduce reliance on institutional care and sustain improvements in community-based support.

Robust governance arrangements, such as Coventry's Section 75 partnership and the Care Collaborative, ensure effective oversight of expenditure, impact monitoring, and continuous improvement. This guarantees that BCF-funded schemes deliver value for money and meet local needs, reduce inequalities, and support residents to live independently for longer. Through targeted, place-based investment, the BCF drives system-wide improvements, strengthens community resilience, and delivers better outcomes for Coventry and Warwickshire residents.

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.**

Value-for-money assurance is embedded through Coventry's long-standing **Section 75 pooled budget arrangements**, providing both partners with full visibility of expenditure, activity and outcomes across adult social care, community health, reablement, intermediate care and discharge pathways. Expenditure and impact are jointly scrutinised, enabling challenge, shared learning and timely corrective action. The costs of care and support are also benchmarked regionally through our West Midlands ADASS (Association of Directors of Adult Social Services) networks and annual regional and national LGA benchmark data on costs of care and support along with numbers of people in receipt of care and support – both costs and population in receipt of support are important indicators of value for money. At an individual provider level our procurement processes are focussed on value for money (quality and cost) and subject to contract management activity to ensure impact is delivered.

System-level oversight and accountability

The **Better Care Programme governance** and wider **Care Collaborative** arrangements link operational delivery with strategic oversight across the ICB, Local Authority and Health and Wellbeing Board. These arrangements ensure BCF investment is aligned to agreed priorities, monitored against outcomes and held to account through formal decision-making routes.

Outcome-focused use of resources

Confidence in value for money is underpinned by clear evidence of impact from BCF-funded pathways, including:

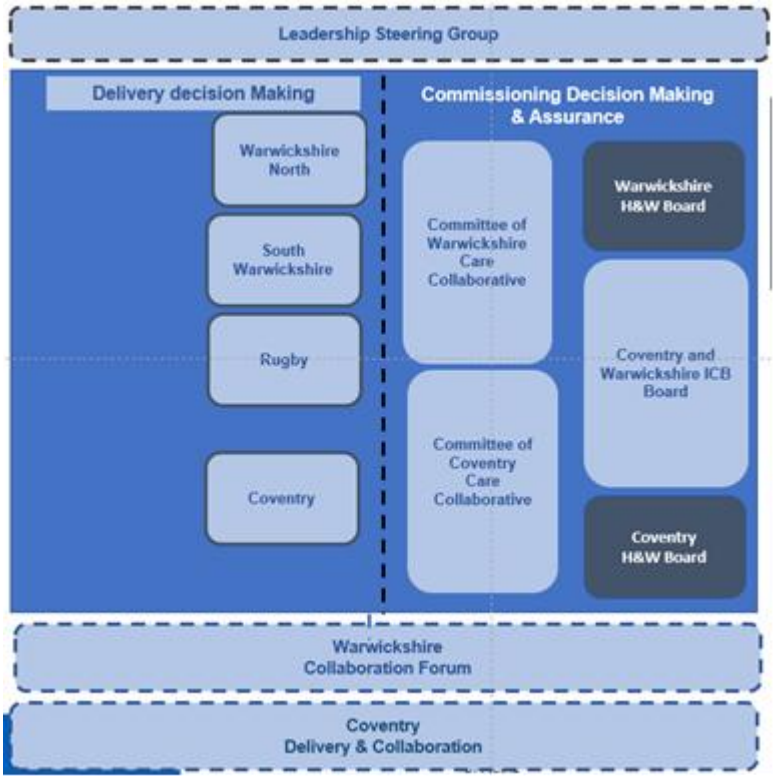
- sustained improvements in discharge performance.
- reduced reliance on long-term residential and nursing care; and
- increased use of short-term reablement and "home-first" approaches.
  Investment decisions prioritise services that demonstrably prevent escalation, reduce avoidable hospital utilisation and support independence.

Continuous review and adaptation

Partners operate in a dynamic way, flexing BCF plans in response to system pressures and learning from delivery. This "learning by doing" approach—successfully applied through the Improving Lives programme—provides assurance that funding continues to be directed to interventions that deliver the strongest outcomes relative to cost. A demonstration of our pursuit of continuous improvement to constantly drive value for money and improved productivity is the recent review of OCIT delivery undertaken by the City Council and UHCW. This review specifically led to the two proposals in question 2, above which covered issues of capacity, workforce, pathway effectiveness and performance. In addition as a local authority we have been developing our approach to the use of Technology Enabled Care (TEC) which although is outside of the BCF will provide learning on opportunities for use of TEC for consideration in future years plans.

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.**

Coventry has established a comprehensive and mature joint governance framework to oversee, manage, and continually enhance the expenditure of Better Care Fund (BCF) resources. These arrangements are shown graphically below.



The core elements of this governance structure are:

1. The Committee of Coventry Care Collaborative is a formal subgroup of the Integrated Care Board and is where the ICB oversight of BCF and ICB sign-off is achieved. The Committee encompasses partner members from the following organisations and as such takes broad view on BCF ambition and progress.

- Coventry City Council
- Coventry and Warwickshire Integrated Care Board
- Coventry and Warwickshire Partnership Trust
- University Hospital Coventry and Warwickshire
- Voluntary, Community and Social Enterprise (VCSE) sector
- Coventry Healthwatch
- Primary Care

2. The Delivery decision making group in the graphic above is then accountable for enacting the decisions of the Committee, which include BCF. This has membership from the same organisations as the committee but at a less senior level.

3. Section 75 governance through Adult Commissioning Group – the day-to-day governance of BCF implementation is managed through the Adult Commissioning Group, which operates as the agreed Section 75 partnership governance mechanism. This group provides robust oversight of expenditure, monitors the impact of funding, and ensures value for money through continuous evaluation and improvement.

4. The Health and Wellbeing board retains primary oversight and sign-off for BCF plans and activity which ensures accountability and strategic alignment with wider health and wellbeing priorities for the city.

The Care Collaborative governance model, illustrated by our governance diagram, demonstrates clear links between the Integrated Care Board and the Health and Wellbeing Board. This integrated approach supports the effective management of BCF resources, robust assessment of impact, and a relentless focus on delivering value for money and continuous improvement across Coventry's health and care system.

In delivering within this governance structure our approach to BCF planning is firmly rooted in the ethos of integrated health and care organisations working in partnership to support individuals. Operating within a dynamic environment, we have demonstrated the ability to adapt and modify BCF

plans responsively to support emerging pressures and shifting priorities. This adaptability is made possible by constructive engagement with NHS partners, ensuring that our plans remain relevant and effective. At the heart of this process is a commitment to collaboration and a user- and patient-centred focus, ensuring that governance arrangements are always aligned with the needs of those we serve.