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Better Care Fund 2026-27

Narrative return

Introduction and guidance

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

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

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

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

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

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

Submission Requirements:

- Each HWB area must have its own BCF excel numerical return, but a single narrative BCF return covering multiple HWBs may be submitted where this reflects local integrated working arrangements.
- Each HWB area included in a combined narrative return should provide clarity and state any specific details relevant to the separate HWBs within the narrative questions (and more words may be required for this than a single HWB return). Local authorities, ICBs and HWBs for each area should formally sign off the shared narrative return and their individual numerical excel BCF return.
- The deadline for completing this narrative return is **19 May 2026**.

- Please submit this return to both: england.bettercarefundteam@nhs.net and your regional better care manager(s).

Submission details

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

<i>Adapt as necessary</i>	HWB area 1	HWB area 2
HWB	Middlesbrough (Live Well South Tees combined Board)	Redcar & Cleveland (Live Well South Tees combined Board)
ICB	North East and North Cumbria	North East and North Cumbria

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:

Building on emerging neighbourhood health work, South Tees is using Better Care Fund (BCF) funding in 2026–27 to accelerate the delivery of more integrated, preventative and neighbourhood-based models of care, particularly for people aged 65 and over and those with complex health and social care needs.

South Tees benefits from long-standing pooled funding and joint commissioning arrangements between Middlesbrough Council, Redcar & Cleveland Borough Council and the North East and North Cumbria Integrated Care Board. These arrangements have enabled BCF funding to be used flexibly to maintain essential out-of-hospital services, strengthen intermediate care and support prevention. This provides a stable platform for further neighbourhood development without destabilising core provision.

In addition, we are using BCF funding to grow our assistive tech offer and develop proactive & preventative solutions to care and support, embedding ‘tech-first’ approaches within social care practice. Development of our Independent Living Centre is supporting this as an accessible hub in the community to demonstrate and promote tech solutions.

Over the past year, partners have begun transitioning from service-specific pilots to a more deliberate neighbourhood health operating model. This includes proactive frailty approaches in both localities; MDT expansion aligned to Primary Care Networks through ARRS roles; strengthened coordination through the Integrated Single Point of Access (iSPA) and Transfer of Care Hub; and closer alignment between primary care, community nursing, mental health services and adult social care. These developments align with the Neighbourhood Health Framework and the Live Well South Tees Health & Wellbeing Strategy’s emphasis on prevention, independence and place-based working.

Recognising that effective neighbourhood delivery depends on how services operate together in practice, South Tees has adopted a test → learn → refine → scale approach. In 2026–27 this includes small-scale neighbourhood MDT prototypes working with real patient cases to understand how people are identified before crisis, what information is already held across the system and where gaps exist, how roles and responsibilities align across organisations, where blockages occur within pathways, and what additional wrap-around support is required above individual practices. This practical learning directly informs how BCF-funded services are deployed, refined and scaled.

BCF funding supports proactive community services, frailty intervention, admission avoidance and MDT coordination, helping identify risk earlier, reduce duplication and prevent escalation into avoidable hospital admission. In Redcar & Cleveland and Middlesbrough, preventative services form a key part of BCF spend, investment in carer support services, with a new jointly commissioned All Age Carer Support Service being co-produced with unpaid carers in 2026/27 for commencement in April 2027. Both Local Authorities are using BCF funding to grow assistive tech offer and develop proactive & preventative solutions to care and support. Development of Redcar’s Independent Living Centre is supporting an accessible hub in the community to demonstrate and promote tech solutions.

In Middlesbrough our prevention approach is driven through our BCF which funds a range of community-based schemes, assisted technology, all designed to keep people well, connected, and independent. These services play a key role in reducing social isolation and supporting safe, timely hospital discharge.

Middlesbrough Independent Living Services:

<https://www.middlesbrough.gov.uk/adult-social-care/middlesbrough-independent-living-services/>

Redcar & Cleveland's ASC Prevention Strategy:



Adult Social Care
Prevention Strategy

Planning reflects differing population needs across South Tees. Middlesbrough experiences higher levels of deprivation and complex need, requiring strong prevention-focused and community-based models. Redcar & Cleveland has a disproportionately older population, driving sustained demand for reablement, rehabilitation and intermediate care. Existing intermediate care pathways have been assessed as sufficiently flexible to manage peaks in demand, with no current systemic capacity constraints identified.

In 2026–27, BCF funding will maintain and strengthen these arrangements through continued support for MDT coordination; protection of essential community services; flexible, cost-effective intermediate care delivery; the No Place Like Home initiative; the Mobile Rehabilitation Unit in Middlesbrough; and the Meadowgate Intermediate Care Centre in Redcar & Cleveland, alongside ongoing investment in prevention and Disabled Facilities Grant-funded services. There are no material changes to recurring BCF-funded schemes in 2026/27. Changes relate only to the cessation of time-limited, non-recurrent pilot schemes funded in previous years. No core services have been decommissioned as a result of BCF planning, and any services ending have either concluded as planned or continued under alternative funding streams to avoid disruption to residents.

- 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:

The borough-specific deployment of BCF-funded schemes, combined with learning from neighbourhood MDT prototypes, underpins the proposed trajectories for non-elective admissions (65+), delayed discharges, reablement outcomes and long-term care admissions reflect both local population need and the demonstrated impact of existing and evolving neighbourhood-based models.

Non-Elective Admissions (65+)

In 2025/26, South Tees did not consistently achieve planned reductions in non-elective admissions for those aged 65+, reflecting demographic growth, increased frailty and system pressure.

Our Non-Elective Admissions (NEL) trajectory is based on historic performance – rolling 12-month baselines. Our 26/27 trajectory is based on the average 3-year growth/performance highlighting the continued expected impact of existing BCF funded schemes. These projections have been profiled across the year based on historical seasonality trends and also include the historic 2.9% efficiencies we have seen. The position proposed maintains this consistent positive reduction in NEL across Middlesbrough and a slight improvement in Redcar & Cleveland. Although we expect some growth in our population, specifically within the target cohort, we believe that we can perform in line with the trajectory in both Middlesbrough and Redcar & Cleveland via the schemes we have in place and plans to continually monitor and expand these wherever possible throughout the year.

Our NEL ambition builds on our positive historic performance around this metric where we have continued to see the beneficial impact of BCF funded schemes supporting this area, strengthened reablement capacity, improved GP-PCN alignment, and admission avoidance services such as Frailty Intervention Teams and UCR and our extensive support to care home schemes help to reduce avoidable admissions. The CHERRs service which provides urgent response to any residents who are acutely unwell has seen a significant reduction in care home residents attending and being admitted to hospital.

Delayed Discharges (DRD %)

In 2025/26, performance against the DRD metrics improved overall, supported by strengthened Transfer of Care arrangements, enhanced iSPA coordination and expanded community services; however, rising acuity and complexity meant performance varied across the year. The 2026/27 goals reflect a slight tightening against 2025/26 actuals, with the system seeking to reduce both the proportion of delayed discharges and the average number of days delayed, supported by revised D2A oversight and enhanced community capacity.

Both Middlesbrough and Redcar & Cleveland saw increases in the number and acuity of patients being discharged - these increases have been reflected in the trajectories for 2026/27 and profiled across the year using historic seasonality trends.

These have already contributed to strong performance relative to England, regional and peer group averages and the system will maintain and refine these pathways

Long-Term Residential and Nursing Care Admissions

BCF-funded prevention and reablement services support reduced reliance on long-term care across both boroughs. Although setting a local long-term care admissions goal is not mandatory, South Tees has retained a 2026/27 projection aligned to 2025/26 levels. This reflects the system's disproportionately older population in Redcar & Cleveland and recent increases in permanent admissions. The ambition is to reduce conversion rates from temporary step-up and step-down placements into permanent care through targeted reablement and alternative housing-based solutions, rather than increasing overall admissions.

In Redcar & Cleveland, this includes streamlined Trusted Assessor processes, enhanced tracking of D2A Pathway 2 placements, and two pilots:

One focusing on step-down placements on Pathway 2, focused case management and reablement support from our hospital social work and OT Teams and selected residential care facilities who will support in delivery of the reablement plan.

The second pilot will focus on step-up respite and carer breakdown cases. Two flats within extra care schemes will be used for short-term step-up placements, working with the Back-on-Track team to prevent conversion to permanent care and support a return to baseline, with stays limited to a maximum of six weeks

Middlesbrough continues to review admissions and our 26/27 projection is not far from our 25/26 outturn. Through our scheme of delegation we are ensuring consistency, we are also maximising the use of residential reablement to maximise people regaining independence to return home.

Across both boroughs, investment in tech-enabled care and Disabled Facilities Grant-funded adaptations supports people to remain safely at home and avoid premature escalation. In Redcar and Cleveland the aim is to invest in technology to supplement a care package on hospital discharge for residents where a residential care placement, or a home care package, may have otherwise been the only viable option.

Reablement Outcomes

- Reablement is a central pillar of BCF investment across South Tees, supporting recovery, independence and reduced reliance on hospital and long-term care, aligned to a strong *Home First* approach.
- Reablement services operate seven days a week and are closely aligned with intermediate care, community nursing, therapy services and neighbourhood MDT working.

- Investment in digital systems and assistive technology is improving case allocation, demand management and oversight.
- Reablement pathways across South Tees continue to deliver positive outcomes, performing in line with or above regional benchmarks, including the metric for the proportion of people aged 65+ remaining at home 91 days after discharge into reablement.

Middlesbrough

- BCF funding supports community reablement services and the Middlesbrough Mobile Rehabilitation Unit (MMRU), providing time-limited step-up and step-down rehabilitation.
- Community reablement operates 7am–10pm, seven days a week, supporting growing demand, with weekly caseloads typically around 37.
- Close alignment between reablement and MMRU supports timely discharge, prevents deconditioning and enables return home.
- Telecare and tech-enabled care are embedded within reablement pathways to support independence and risk management.

Redcar & Cleveland

- BCF investment supports expanded community reablement capacity alongside the Meadowgate Intermediate Care Centre, providing 40 purpose-built reablement beds.
- Community reablement has expanded to 20 teams, supporting rising demand.
- Meadowgate has consistently delivered high occupancy and throughput, with outcomes exceeding regional and national benchmarks.
- The Independent Living Centre at Meadowgate supports embedding assistive technology within reablement pathways.

Continuous Improvement

- Ongoing service evaluation and workforce development, including enhanced case management and digital support roles, will further strengthen outcomes and support independence across South Tees.

Data Quality

Data quality and performance are overseen through a joint Intermediate Care and Discharge Dashboard, drawing from acute, community and local authority datasets. This dashboard is reviewed routinely through the BCF Implementation & Monitoring Group, with issues escalated as required to the South Tees System Directors Meeting. Regular data validation, triangulation with operational intelligence and deep-dive reviews into outliers ensure data quality concerns are identified early and addressed collaboratively across partners.

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 funded services across South Tees contribute directly to the national metrics and support a clear shift to prevention, home-first and neighbourhood-aligned care. Our funding is targeted on services which support our population needs (as outlined in response 1)

Reducing Non-Elective Admissions

Across both localities, the continuation and strengthening of integrated BCF funded community services will help reduce acute escalation:

- **Frailty Intervention Teams:** Provide rapid assessment and intervention both at the acute front door and in community settings, supporting same-day discharge, admission avoidance and proactive management of frailty.
- **Urgent Community Response (UCR):** Working alongside primary care and community services to provide rapid alternatives to hospital admission. This includes the CHERRs service providing urgent care to care home residents.
- **Support to Care Homes:** BCF-funded schemes such as medication optimisation, MUST, IPC and therapy support reduce avoidable admissions from care homes.

Reducing Delayed Discharges

Our analysis has shown that these integration initiatives and services, part or wholly BCF funded, contribute significantly to effective timely discharges and funding will be maintained:

- Our multi-agency Transfer of Care Hub within acute services, supporting safe early discharge and pathway optimisation
- Our Acute Trust's Home First Service which provides a bridging service from acute to community and social care. This expedites discharges out of hospital for patients on pathway 1 back to their own home. The service helps to reduce lengths of stay in hospital, preventing hospital associated deconditioning, and supports the patient at home until they are either able to function without support or social care commences.
- The appointment of a Strategic Project Lead – Transfers of Care who will cover both our acute and mental health Trusts and lead on improvements to discharge pathways and processes
- A Rehabilitation Co-ordinator who supports smoother transfer to rehabilitation and recovery services.
- Additional investment in our Tees Community Equipment Services to improve faster discharges by ensuring essential equipment is in place quickly.
- Carer support services which play a significant role in avoiding delays linked to carer breakdown or lack of home support.

Improving Reablement Performance

Reablement is a central pillar of South Tees BCF investment. We have enhanced our reablement capacity, embraced digital innovations to track capacity and our assistive technology and prevention services enhance independence and reduce reliance on long-

term care.

Reducing Long-Term Care Admissions

Both Middlesbrough and Redcar & Cleveland expect to reduce (or significantly mitigate growth in) permanent admissions despite demographic pressures.

In addition to the initiatives outlined above, South Tees has undertaken a targeted review and evaluation of Discharge to Assess (D2A) arrangements to improve system flow, reduce delays and minimise conversion from short-term placements into permanent residential or nursing care.

The review has focused on **improving resource allocation** and strengthening the system's ability to manage demand and capacity across D2A pathways. Key learning has highlighted the need for clearer decision-making at discharge, stronger oversight of short-term placements, and more consistent coordination between health, social care and therapy services to support timely assessment and progression.

As a result, improvements are being taken forward to reduce breaches within D2A pathways, make more effective use of reablement and rehabilitation capacity, and reduce reliance on higher-cost bedded care. This includes targeted action to reduce conversion rates from short-term D2A placements into long-term residential care, particularly where enhanced reablement input, therapy involvement or community-based solutions can better support independence.

Progress will continue to be monitored through established multi-agency governance arrangements during 2026–27, ensuring D2A improvements contribute to reductions in delayed discharges, improved reablement outcomes and avoidance of premature long-term care admissions.

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:

South Tees has a mature evidence-based approach to reviewing BCF schemes through its long established joint integrated governance. Decisions on BCF funding allocations and priorities are agreed jointly between the ICB and both Local Authorities. This allows for the development of South Tees wide posts and services, which supports equity and consistency in services, shared learning and economies of scale.

BCF-funded services are routinely reviewed for efficiency, outcomes, delivery and spend. The BCF Implementation & Monitoring Group scrutinises schemes monthly, supported by finance leads from both councils and the ICB, enabling cost-benefit assessment, financial accountability and strong challenge if necessary.

Demonstrating Value for Money

Many schemes provide measurable prevention benefits:

- Telecare and falls-response services reduce ambulance conveyances, ED attendance and hospital admissions.
- Home First service delivers strong outcomes (40% requiring no ongoing care upon completion).
- Reablement success in both localities reduces long-term care reliance and supports independence.
- Funding for some schemes which have not delivered the benefits anticipated is being ceased. Only non-recurrent, time-limited pilot schemes have been decommissioned where evaluation showed insufficient impact. For example, the Pathway 0 'Home from Hospital' service was discontinued after failing to secure sufficient referrals to demonstrate value for money. No core or high-impact BCF-funded services have been withdrawn, and several preventative functions (including postural support, ASK Sara and carers' counselling) have continued through alternative funding sources.

Productivity Improvements

In 2026–27, productivity gains will be sought through:

- Wider deployment of digital systems (care records, rota optimisation, real-time monitoring).
- Strengthened MDT integration which reduces duplication and improves caseload management.
- Use of neighbourhood teams to streamline proactive care and reduce high-cost reactive activity.
- Shared learning from D2A review, No Place Like Home Initiative outcomes and intermediate care developments.

This aligns with the national requirement for NHS productivity improvements of 2% per year, with BCF-funded services contributing to reduced inpatient bed use, avoided admissions, reduced delays and improved flow.

Benchmarking & Continuous Review

South Tees will continue using:

- National BCF dashboard benchmarking to compare performance to peer areas.
- Local multi-agency review processes to identify efficiencies and best practice.
- Review of expenditure patterns to ensure resources continue to flow to the highest-impact interventions.
- Local benchmarking of discharge pathways and reablement throughput across Middlesbrough and Redcar & Cleveland to inform service design and capacity modelling.
- Comparison against regional and peer BCF metrics (NELs, DRD, reablement outcomes) through national dashboards to guide prioritisation and productivity improvements.
- Jointly commissioned schemes to enable direct comparison of unit costs and outcomes across boroughs, supporting continuous improvement.

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:*

South Tees has robust, long-standing governance arrangements supporting strong partnership working and shared accountability, consistent with national expectations for effective BCF oversight.

Governance Structure:

- **BCF Implementation & Monitoring Group (IMG):**
Monthly operational meeting involving commissioners, finance leads, pooled fund managers and system integration colleagues from both Local Authorities and the ICB. Oversees scheme delivery, performance metrics, expenditure and risk management.
- **South Tees System Directors Meeting:**
Acts as the formal pooled fund partnership board. Provides director-level oversight, approves funding allocations, ensures alignment with system priorities and provides escalation where risks are identified.

South Tees Place-Based Governance (ICB and System Arrangements)

As ICB governance arrangements evolve, place-based oversight of integrated care, neighbourhood health and intermediate care is being maintained through refreshed system partnership structures. These arrangements provide strategic oversight of BCF investment in the context of neighbourhood health development, population health and integrated community services, ensuring alignment with ICB commissioning intentions and national policy direction.

- **Live Well South Tees Health & Wellbeing Board:**
Formally signs off BCF plans and will now play an enhanced stewardship role, as

expected nationally, ensuring visible leadership, neighbourhood alignment and oversight of pooled resources and outcomes.

Assurance, Monitoring & Continuous Improvement

Governance groups will:

- Monitor performance against 2026–27 metric goals and intervene early where delivery risks emerge.
- Assess scheme impact, outcomes and value for money regularly.
- Maintain compliance with national funding and reporting requirements, including the NHS minimum contribution and pooled fund deadlines.
- Oversee learning loops between acute, community, VCSE, housing and social care providers
- Continue benchmarking performance with peer localities
- Ensure alignment between BCF planning and the wider Integrated Care Strategy, Live Well South Tees Health and Wellbeing Strategy and neighbourhood health development.
- Explore opportunities to jointly commission services such as Carer Support, Meds Optimisation, MUST, IPC and other support-to-care-home schemes to enable direct borough-to-borough benchmarking on cost, outcomes and delivery models, strengthening assurance and shared learning across South Tees.

Work is currently underway across South Tees to ensure governance remains fit for purpose in the context of the evolving national policy landscape, including changes to ICB roles, the publication of the Neighbourhood Health Framework, and the strengthened stewardship expectations placed on Health & Wellbeing Boards. This includes reviewing how place-based and neighbourhood governance aligns with pooled funding arrangements, clarifying roles and escalation routes across system partners, and ensuring that neighbourhood health development, integrated community services and BCF investment are overseen through coherent and streamlined structures. This work is being undertaken collaboratively with system partners, with the aim of reinforcing strong joint leadership, avoiding duplication, and ensuring that decision-making and accountability arrangements continue to support effective delivery of integrated and preventative care.