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 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:

1. **Planning Principles:** outlines what good practice looks like in relation to each narrative question and aligns with the relevant national conditions.
2. **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	**South Tyneside**	
ICB	**North East and North Cumbria ICB**	
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.

South Tyneside's approach to the Better Care Fund in 2026/27 is centred on completing the transition from the former Care Closer to Home programme to a fully embedded Neighbourhood Model by 2027/28. This shift reflects both national policy direction—expecting local systems to organise integrated, multidisciplinary teams at neighbourhood footprints of 30,000–50,000—and the progress and learning generated locally throughout 2025/26.

The South Tyneside Health and Care Partnership now provides the collective governance, shared accountability and enabling workstreams required to deliver neighbourhood-based, preventative, and personalised care in a systematic and sustainable way. This Better Care Fund plan sits as a core delivery component of the Health and Care Partnership's emerging operating model and neighbourhood health agenda, rather than as a standalone programme.

This Better Care Fund plan has been developed as an enabling vehicle for priorities already agreed, or emerging, through the South Tyneside Health and Care Partnership. While the BCF has statutory governance through the Health and Wellbeing Board, the plan is intentionally aligned to Partnership-led neighbourhood health ambitions and is being used to fund and accelerate delivery rather than to set new strategic direction. Engagement and system awareness are therefore supported through existing Partnership routes, ahead of formal BCF sign-off, to ensure neighbourhood delivery plans are collectively understood and owned across organisations.

Engagement and system alignment are supported through partnership governance, ensuring shared oversight, challenge and awareness of neighbourhood delivery plans across partners.

The rationale for this year's BCF investment is rooted in the significant strides made in 2025/26, as well as the challenges that became visible as integrated working scaled up. Over the last year, strengthened multidisciplinary working across primary care, social care, community health, mental health, acute care, and the voluntary sector has shown the benefit of coordinated, community-focused support. Enhanced intermediate care and reablement capacity at Borrowdale and Haven Court, has demonstrated the value of identifying risk earlier, coordinating care around the person, and helping more people return to or remain at home. These developments now provide the operational foundation for fully functioning neighbourhood teams with shared caseloads, shared data, and proactive case-finding as core practice.

Enhanced intermediate care and reablement capacity at Borrowdale and Haven Court, has demonstrated the value of identifying risk earlier, coordinating care around the person, and helping more people return to or remain at home

Equally important are the lessons from aspects of 2025/26 performance that did not meet expectations. Variability in same-day discharge, delays between discharge-ready and actual discharge dates, pressures in home care and reablement throughput, and inconsistencies in data flows between acute, community and social care services all highlighted areas requiring

focused improvement. As part of strengthening our discharge pathways, the borough's Guiding You Home programme continues to support timely, safe transitions from hospital into the community and will be aligned more closely with Home First and neighbourhood MDTs throughout 2026/27. These system weaknesses informed the design of the 2026/27 BCF, ensuring that investment is directed to strengthening Home First pathways, increasing return-to-independence capacity, stabilising home care provision, and embedding consistent decision-making across organisations. Improved data sharing with the local Foundation Trust, shared documentation, and standardised discharge criteria are key priorities that flow directly from this learning.

Prevention and early intervention remain core principles underpinning all BCF-funded activity. By targeting risk earlier, neighbourhood teams will be able to identify people at greatest risk of deterioration, plan proactive outreach, and intervene before needs escalate into crises.

Integrated care continues to be central to this approach, ensuring that health, social care, and voluntary sector partners work seamlessly together in a 'team-of-teams' model with clear accountability for neighbourhood outcomes.

Personalised support and care delivered at or close to home are equally important, reducing reliance on hospital settings, sustaining independence, and improving people's overall experience of care.

The BCF also supports the continued scaling of initiatives that proved effective in 2025/26. Strengthened connections between Urgent Community Response and Virtual Wards will ensure rapid, safe alternatives to hospital admission, while aligned community therapy and social care pathways will improve recovery and reduce duplication. Enhanced analytical capability will support risk stratification that guides MDT prioritisation and targeted interventions across neighbourhoods.

Digital transformation forms a critical strand of this year's rationale. Expanding the use of speech-to-text tools, AI-enabled assessment technologies and remote monitoring will help free up clinical and care capacity, reduce administrative burden and support earlier recognition of deterioration. These technologies enable more consistent decision-making across teams and ensure that preventative, proactive working becomes the norm rather than the exception.

. Practical enablers of integration, agreed through the Health and Care Partnership and progressed through neighbourhood delivery arrangements, feature strongly in the BCF investment plan. Funding for the Care Coordination Hub, shared documentation, consistent ward practices, and operational leadership will ensure smoother transitions of care and reduce variation across neighbourhoods. Weekly PDSA cycles within each neighbourhood, backed by targeted project management and organisational development support, will drive continuous improvement and allow effective practice to be rapidly adopted across the system. These improvement structures are essential to ensuring that neighbourhood working becomes fully embedded by 2027/28.

Overall, BCF funding in 2026/27 is intentionally aligned to deliver measurable and sustained improvements in integrated and preventative care at neighbourhood level. By building on the achievements of 2025/26, addressing identified bottlenecks, scaling effective practice and investing in the digital and operational enablers required for system-wide consistency, the BCF provides the foundation for South Tyneside to deliver a mature, fully operational Neighbourhood Model that improves access, reduces fragmentation, strengthens flow and supports people to remain independent for longer.

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 goals for non-elective admissions for people aged 65 and over, and for delayed discharges, have been developed using a consistent and evidence-based methodology aligned with local performance trends and the approaches used in previous years. Trajectories for 2026/27 are based on historic trend analysis, seasonal profiling, and an assessment of expected system improvement as neighbourhood MDTs, proactive frailty pathways, Virtual Wards, and Urgent Community Response continue to scale. This provides a robust baseline while allowing for measured improvement as integrated neighbourhood working becomes further embedded.

For non-elective admissions, trajectories reflect the anticipated impact of strengthened anticipatory care, improved case finding for those at risk of deterioration and enhanced community alternatives to conveyance and hospital admission. Monitoring will include analysis by treatment function code, review of coding reliability and utilisation of Care Coordination Hub activity to understand the effect of call-before-convey arrangements and the use of urgent community responses. This will be supplemented by routine variance analysis to identify and reduce unwarranted variation across neighbourhoods, with learning from high-performing areas shared and adopted at pace.

For delayed discharges, goals focus on increasing the proportion of people discharged on their discharge-ready date (DRD) and reducing the average number of days between readiness and actual discharge. These targets reflect improvements expected from strengthened ward-based discharge planning, consistent application of Home First principles and the additional reablement capacity funded through the BCF. Performance in 2025/26 was impacted by a combination of system pressures, including capacity constraints within domiciliary care provision during part of

the year, alongside wider operational factors such as variability in referral quality and delays in confirming individuals as clinically ready for discharge. These issues are being addressed through strengthened pathway management and the full rollout of the Guiding You Home (GYH) model, which is expected to improve earlier decision-making, consistency in pathway application and overall system flow.

Delivery against DRD metrics in 2026/27 will be supported by strengthened in-year monitoring and clear system accountability across Adult Social Care and Trust operational leads. Oversight will be maintained through daily ward-level discharge huddles and surge and flow arrangements, alongside weekly multidisciplinary pathway reviews and enhanced system dashboards, including the development of the GYH dashboard to provide real-time system visibility of performance by ward, pathway and cause of delay. System leaders will take action in relation to the delays at an operational level as part of day to day service delivery . This will be monitored by GYH operational leadership group on a weekly basis as part of the system visibility system challenge, communicating what was observed, what action has been taken and any support from the system required, to bring performance back in line. The GYH Operational Leadership Group is accountable to the GYH Strategic Leadership Group (Senior Leaders across the partnership, including STSFT, ICB and Local Authority), where assurance around delivery and any barriers will be discussed with action taken accordingly. The DRD metric is owned by the Operational Leadership group with the SRO's taking responsibility and accountability for action. it will also be complemented by monthly review through BCF governance arrangements, with DRD performance included as a standing item within the BCF Operational Group, enabling robust variance analysis, escalation and timely corrective action where performance deviates from plan.

Reducing avoidable long-term admissions to residential and nursing care remains a key priority. Locally agreed goals anticipate a gradual, sustainable year-on-year reduction, supported by improved intermediate care flow, increased home-based reablement and earlier MDT-led intervention for those at risk of deterioration. Analytics will provide detailed insight into conversion rates from short-term to long-term care placements, identify cohorts most likely to maintain independence and measure the contribution of assistive technology, proactive outreach, and neighbourhood-level support. Regular case reviews across Borrowdale, Haven Court, and community reablement teams will ensure short-term placements remain focused on recovery and do not inadvertently drift into long-term care. Where long-term placements do occur, these will be reviewed to identify opportunities for upstream intervention within the Home First pathway.

Improving outcomes from reablement will be driven through increased capacity, strengthened Home First pathways and the use of continuous improvement techniques embedded within each neighbourhood. Weekly PDSA (Plan–Do–Study–Act) cycles will be used to test and refine

operational changes, providing a structured method for rapid learning and system-wide adoption of effective practice. Rather than implementing large-scale changes at once, neighbourhood teams will use PDSA cycles to trial small improvements, assess their impact and spread successful approaches across other teams. This ensures changes are evidence-based, sustainable and grounded in staff and patient experience.

Feedback from individuals receiving reablement—and from their carers—will play a significant role in informing service improvement. Feedback gathered at the end of reablement episodes will provide insight into the lived experience of the pathway, highlighting factors that support or hinder independence, such as visit timing, clarity of goals, communication, and confidence in daily living tasks. Themes emerging from this feedback will be considered alongside operational data and insights from PDSA cycles, guiding improvement priorities and ensuring changes are person-centred. This approach strengthens the alignment between therapy goals, daily routines and the practical support individuals require during their recovery at home. Feedback will also support reflective practice across teams, informing workforce development, MDT collaboration, and ongoing refinements to Home First pathways.

Progress across all BCF metrics—non-elective admissions, delayed discharges, avoidable long-term care admissions and reablement outcomes—will continue to be monitored through dashboards, monthly variance analysis, and regular operational forums with acute, community and social care partners. Additional reablement monitoring will track throughput, time to first visit, waiting times for therapy and conversion rates back to independence, ensuring capacity is targeted where it has the greatest impact. Governance through the BCF Operational Group and Alliance structures will provide the system-wide oversight needed to unblock challenges, maintain momentum, and ensure effective practice is embedded consistently across all neighbourhoods.

Together, this integrated approach—anchored in robust analytics, operational grip, feedback-driven improvement, and neighbourhood-level PDSA cycles—provides a strong and sustainable mechanism for achieving and maintaining improvement across admissions avoidance, reablement outcomes, discharge performance, and reductions in avoidable long-term care home admissions.

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

Please provide a concise statement of around one page (e.g. around 500 words). Please provide your response below:

BCF funding will play a critical enabling role in achieving the system's goals for admissions avoidance, improved discharge performance, strengthened intermediate care flow and reduced

conversion to long-term care. Investment is aligned to the delivery of neighbourhood-based models, community alternatives to admission and consistent Home First practice across health and social care.

Admissions Avoidance

Neighbourhood MDTs will use insights to maintain proactive oversight of people at rising risk, ensuring early intervention before deterioration leads to crisis. Urgent Community Response will continue to provide same-day assessment and intervention at home, stabilising people in the community and preventing unnecessary conveyance. Virtual Wards will expand step-up alternatives to hospital admission, including respiratory pathways and IV therapies. The Care Coordination Hub will operate as the single point of advice, coordination and referral, reducing duplication and avoidable conveyance.

BCF funding enhances this by supporting:

- Proactive identification of rising-risk individuals
- Same-day community interventions via UCR
- Step-up Virtual Ward capacity for respiratory and IV care.
- Streamlined access via the Care Coordination Hub
- Additional workforce and data capacity to underpin MDT working.

Improved Discharge and 'Guiding You Home' Disciplines

Throughout 2026/27, BCF investment will embed improved discharge processes across wards, community teams, and operational governance. Key components include earlier ward-based decisions, clear and standardised pathway criteria, consistent escalation processes, single accountable MDT leadership for each pathway and strengthened interfaces between the hospital discharge hub and community services. These measures aim to deliver timely, safe, and consistent decision-making that enables Home First as the default outcome.

BCF funding supports:

- Additional reablement, therapy and social care capacity
- Workforce continuity needed to convert discharge decisions into flow.
- Strengthened hospital discharge hub capacity.
- Joint training, supervision, and standardisation of discharge processes

Flow Through Intermediate Care

Borrowdale and Haven Court will be utilised as intentional step-up/step-down rehabilitation resources, with clear admission criteria and defined rehabilitation goals. Home First reablement will remain the default pathway for most people, supported by therapy and reablement teams aligned to neighbourhood caseloads. Regular case reviews will ensure people receiving short-term care do not drift unnecessarily into long-term placements.

This will be supported through:

- Defined admission criteria and rehabilitation goals

- Home First reablement as the expected pathway
- Routine MDT case reviews to prevent avoidable long-term placements.

Strengthening What Worked in 2025/26

The MDT culture established through the neighbourhood model will be reinforced through shared decision-making tools, neighbourhood huddles, and joint supervision. Evidence from 2025/26 shows that when neighbourhood MDTs met reliably and acted on shared information, escalation and admissions reduced. Therefore, 2026/27 plans mandate protected time, standard work, and consistent MDT participation to sustain and strengthen this way of working.

Addressing What Did Not Work as Well

Challenges identified in 2025/26—including reablement throughput, delayed starts to packages of care and variability in ward discharge practice—will be addressed through neighbourhood capacity planning, provider development programmes, and joint ward-based coaching. We will publish a monthly stability index to support neighbourhood teams in identifying whether improvements are sustained and where further support is required.

Actions include:

- Neighbourhood capacity planning
- Provider development
- Joint ward-based coaching
- Monthly stability index reporting

People and Carers

Carer support will be embedded within neighbourhood models, ensuring assessments, respite and support planning are fully aligned with reablement and discharge pathways. Communication with individuals and families will emphasise recovery, independence and supported self-management at home, reframing expectations away from automatic long-term placements.

Digital and Assistive Technology

Digital tools such as remote monitoring, sensors and speech-to-text technology will be deployed where they reduce risk or release staff time. They will support:

- Earlier identification of deterioration
- Reduced need for visits that are solely for observation.
- Real-time information to strengthen MDT decision-making.

Test and Learn Approach

Each neighbourhood will run PDSA cycles focusing on caseload thresholds, MDT composition, visit scheduling and alignment of therapy, social care, and voluntary sector capacity. Learning

will be shared through BCF Operational Group and Alliance governance structures to accelerate the spread of effective practice across the system.

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DFG and Housing Interface

The Disabled Facilities Grant (DFG) is a key enabler of the Home First approach, ensuring individuals can return home safely and maintain their independence. DFG-funded adaptations such as level-access showers, ramps, stairlifts and hoists help to reduce discharge delays and prevent avoidable admissions by ensuring the home environment can safely support recovery. Housing, Occupational Therapy and Neighbourhood MDTs work jointly to identify people who require adaptations at the earliest opportunity, streamlining referrals and fast-tracking urgent cases linked to hospital discharge. The Care Coordination Hub provides a single pathway for identifying, tracking, and prioritising adaptation needs, ensuring timely action and improved coordination. Monitoring arrangements include tracking referral-to-completion times, reviewing the number of adaptations linked to discharge, assessing the impact on reablement outcomes, and gathering qualitative feedback from individuals and carers to understand how well adaptations support independence and recovery.

Joint financial arrangements, including the full NHS minimum contribution, are pooled via the Section 75 agreement and used to maintain and improve adult social care capacity in 2026/27. Performance, finance, and governance structures jointly oversee the use of BCF funding to ensure it delivers value for money. Decisions are informed by unit-cost benchmarking across home care, reablement and bed-based care, the use of outcome-based commissioning where appropriate, and routine review of the impact per pound spent against the national BCF metrics. The overarching focus is on shifting from volume-based activity towards outcomes that sustain independence, improve flow, and reduce reliance on institutional care.

This includes:

- Unit-cost benchmarking across home care, reablement and bed-based services
- Use of outcome-based commissioning where appropriate
- Review of impact per pound spent against national metrics.
- A shift from activity volume to outcomes that promote independence.

Productivity will be strengthened through workforce redesign into single neighbourhood MDTs with clearer role boundaries and fewer hand-offs; digital tools that reduce duplication and streamline workflow; and flow improvements that reduce avoidable bed days. As neighbourhood teams mature, investment will be progressively rebalanced from bed-based provision towards home-based support, where outcomes are demonstrated to be superior. These changes will be supported by explicit trajectories agreed through BCF governance.

Key enablers will include:

- Neighbourhood MDT workforce models that minimise hand-offs
- Digital tools to streamline tasks and remove duplication.
- Flow improvements to reduce avoidable bed days.
- A planned shift from bed-based to home-based support as neighbourhood models strengthens.

Supply resilience will be enhanced through provider development in home care and reablement, expansion of trusted assessor approaches to speed up assessment and reduce delays, and shared training and development through the Care Academy. Commissioning approaches will continue to reward recovery and independence, minimise stranded capacity, and enable more flexible deployment of staff across neighbourhoods when demand pressure arises.

These improvements will be supported by:

- Provider development across home care and reablement services
- Expansion of trusted assessor roles
- Shared training and workforce development via the Care Academy
- Commissioning approaches that reward recovery and reduce stranded capacity.

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 Tyneside has a clear and comprehensive joint governance framework to ensure robust management of BCF expenditure, oversight of impact, value for money and continuous improvement. Governance operates across several layers, each with distinct roles, shared accountability, and strong links to the neighbourhood model. The 2026/27 BCF plan is jointly agreed by the ICB, Council and HWBB and is underpinned by the Section 75 agreement supporting integrated commissioning and delivery. Expenditure and success of schemes will be reviewed in-year to inform planning for 2027/28 and beyond.

Statutory Assurance and Strategic Oversight

The Health and Wellbeing Board (HWBB) provides statutory assurance for the Better Care Fund, ensuring alignment with the JSNAA, the Health and Wellbeing Strategy and wider system priorities. To support timely decision-making, the Board has delegated quarterly BCF approval responsibilities to the Directors of the ICB and Adult Social Care, operating within an agreed statutory framework.

Strategic oversight is provided through the South Tyneside Health and Care Partnership, which brings together leaders from the council, ICB, NHS providers, primary care, public health, and the VCSE. While not a formal BCF decision-making body, the Partnership provides the primary system forum for shaping, aligning and overseeing the neighbourhood model, ensuring Better Care Fund investment is fully joined up with wider health and care priorities, delivery commitments and place-based governance.

Operational Delivery, Risk and Financial Monitoring

Operational responsibility sits with the **BCF Operational Group**, a multi-agency group overseeing delivery of all BCF-funded schemes. Its remit includes performance monitoring, data quality, financial tracking, and risk management. The group assesses unit costs, evaluates impact per pound spent and identifies variance against national metrics. Continuous improvement is driven through neighbourhood-level PDSA cycles, pathway redesign, and targeted provider development where risks or delays are identified.

Daily operational resilience is supported through Surge and Flow arrangements, providing real-time oversight of discharge performance, bed capacity, and system flow across acute, community and social care pathways. This ensures BCF-funded resources—such as reablement, home care, therapy, and intermediate care—translate into improved operational flow and reduced delays.

Core Governance Elements

These structures together form a robust and coherent governance model:

- **Statutory assurance:** Health and Wellbeing Board
- **Formal delegated decision-making:** Directors of the ICB and Adult Social Care
- **System alignment and neighbourhood leadership:** South Tyneside Health and Care Partnership
- **Neighbourhood delivery and Better Care Fund implementation:** Aligned through the Health and Care Partnership, ensuring priorities agreed at system level translate into consistent operational practice across neighbourhood teams

- **Operational delivery, data, and risk**: BCF Operational Group
- **Real-time operational grip:** Surge and Flow arrangements

Value for Money and Assessment of Impact

A systematic set of mechanisms ensures that BCF investment delivers measurable benefit and strong value for money:

- Unit cost benchmarking across reablement, home care and bed-based pathways

- Outcome-based commissioning where appropriate
- Impact-per-pound assessment against national BCF metrics
- Shift from activity-based measures to outcomes that promote independence and reduce reliance on institutional care.

Continuous Improvement

Improvement is embedded throughout the governance system. Neighbourhood MDT models continue to reduce handoffs, increase role clarity, and strengthen integrated working. Digital tools support real-time decision-making and remove duplication, while flow improvements across reablement, intermediate care and home care reduce avoidable bed days and delays.
Improvement activity is driven through:

- Monthly performance reviews
- Quarterly deep dives
- Analytics, assessing outcomes, equity, and value for money.
- Learning from Guiding You Home, formalised into standard operating procedures, coaching and audit, with actions tracked to closure.

Governance documentation is being refreshed to reflect the strengthened neighbourhood emphasis, with clearer articulation of roles, responsibilities, and decision rights.

Public Involvement and Equality

Public and patient involvement remains central. Co-production, targeted engagement with carers and people with lived experience of frailty, and feedback at key points—such as discharge and reablement review—ensure services remain person-centred. Equality and health inequalities are assessed through neighbourhood-level analysis and Equality Impact Assessments to ensure improvements benefit all communities fairly.

The BCF plan provides targeted support for unpaid carers—timely carers' assessments, respite, advice, and contingency planning embedded within neighbourhood MDTs and aligned to Home First pathways. Carer needs are captured at discharge planning and reablement review, with information, advice and support coordinated through the Care Coordination Hub. Quality and safety are assured through commissioning standards, contract monitoring, and alignment with CQC regulatory requirements across home care, residential/nursing and intermediate care services. Safeguarding duties are embedded within MDT workflows, with incidents reviewed through established multi-agency processes and learning fed back into practice.

Reducing Health Inequalities: Analytics are used to identify priority cohorts at neighbourhood level (e.g. Core20PLUS5 and locally defined PLUS groups). Neighbourhood MDTs target proactive outreach, culturally appropriate support, and reasonable adjustments, with VCSE

partners engaged to improve access and trust. We will monitor access, timeliness and outcomes by deprivation, disability and ethnicity, and feed insights into monthly variance reviews and quarterly deep dives so commissioning and pathway changes address unwarranted variation.

Forward Trajectory

For delayed

- Scale what works from 2025/26
- Fix what has not worked well.
- Embed Guiding You Home learning so neighbourhood teams become the default model of integrated and preventative care.

BCF funding in 2026/27 acts as the bridge to full neighbourhood implementation in 2027/28, supporting measurable improvements in admissions avoidance, timely discharge, and sustained independence.