Choose an item.

Better Care Fund 2026-27
Narrative return

Introduction and guidance

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

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

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

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

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

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

Submission Requirements:

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

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

Submission details

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

Adapt as necessary	**HWB area 1**	**HWB area 2**
HWB	**Rotherham**	
ICB	**South Yorkshire (Rotherham Place)**	
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.**

Rotherham has a strong record of partnership working across Health, Social Care and the Voluntary and Community Sector (VCSE) to deliver positive outcomes for local people. Our Better Care Fund (BCF) objectives align with the NHS 10-year plan, the five-year commissioning intentions and the Council's Adult Social Care Strategy, all of which prioritise helping people live independently at home for longer. The shared ambition is to shift focus from sickness to prevention, from hospital to home and from analogue to digital. Current BCF investment is organised around six themes: prevention; community-based care (including intermediate care); integrated working; care management and coordination; support for carers; targeted support for high-need cohorts; and digital innovation.

Rotherham has a population of around 271,195, with rising demand driven by significant health inequalities and an ageing population. Thirty-six percent of residents live in the most deprived national quartile, with life expectancy gaps of up to 10 years. Healthy life expectancy is six years below the national average. There is a high prevalence of long-term conditions and disabilities. Currently, 25.8% of the population is over 65, with an expected increase of 8.2% by 2030. The number of people aged over 80 is projected to rise by 17.6% to 18,700. For those aged 65 and over with a primary need of learning disability, numbers are expected to increase by 8.5% to 1,291. Despite investment in alternative pathways to the Emergency Department (ED), attendances continue to rise and are being investigated. While admissions remain relatively stable, there has been a 5% increase in complex discharges between 2024–25 and 2025–26, indicating greater acuity and complexity, likely linked to reductions in avoidable admissions and earlier discharge.

We are approaching 2026–27 as a transition year. We will continue to progress development of integrated neighbourhood working, out-of-hospital pathways and system flow. This will incorporate activity and learning from national pilot programmes secured by Rotherham and SYICB, including the National Prevention Accelerator Site, the Integrated Neighbourhood Programme and Pathways to Work. We will strengthen neighbourhood capacity, in line with our five-year commissioning intentions, through redevelopment of our home-from-hospital model, expansion of clinical pathways and investment in enablement, including a new discharge-to-assess pathway. Neighbourhood teams will focus on reducing health inequalities through increased uptake of over-40s health checks, supporting young adults with emerging mental and physical health needs and building on our proactive care model for highly complex frail people, typically in their last year of life and at greatest risk of avoidable admission.

However, given projected growth in demand and cross-system financial pressures, we recognise these actions alone will not deliver the scale of left shift required. During 2026–27 we will review how urgent and emergency care is delivered, with a view to redesigning pathways, modernising ways of working and realigning resources. This will be a whole-system, diagnostic-led approach, underpinned by strong operational ownership and effective use of data. The work will be informed by:

i. A diagnostic to understand ED demand, with targeted activity to reduce attendances from high-intensity users, the top five referring GP practices, care homes, high-impact conditions (respiratory, CVD, diabetes) and 25–40-year-olds.
ii. A strategic review of community health services to identify operational and financial opportunities to reduce duplication and increase capacity.

iii. A review of intermediate care and the commissioned bed base to right-size pathways, grow support at home and reduce reliance on bedded care, including long-term care.
iv. Re-tendering of the Rotherham equipment service, with potential for a joint service with Sheffield and Doncaster to achieve efficiency savings.

Following a RAG review of BCF-funded schemes, we do not intend to make significant changes to BCF allocations in 2026–27 while these reviews are underway. We will continue to invest in services designed to prevent avoidable acute and community admissions and strengthen system flow:

i. Multi-disciplinary intermediate care: We will enhance the intermediate care pool, particularly Pathway 1 discharge to assess (D2A), by deepening integrated working between therapy and enablement teams. This will support faster, more accurate assessments, reduce discharge delays, reduce the size of care packages and minimise reliance on community beds. Resource will be redirected from a de-commissioned private bridging service into in-house capacity.

ii. Hospital at Home expansion: We will grow our Hospital at Home model as a core admission-avoidance and early-discharge pathway, increasing the number of clinical pathways to expand capacity and support more people safely at home.

iii. Support for carers, direct payments and the VCSE sector: Investment in carers, personalised support and VCSE partners will increase independence, resilience and the ability to manage at home, reducing escalation to urgent care and supporting smoother system flow.

iv. Specialist provision: To support those at high risk of admission or long lengths of stay including mental health, learning disabilities, stroke, neuro-rehabilitation and Breathing Space (respiratory). A review of high-intensity users will streamline identification and ensure proactive, targeted intervention.

v. Digitisation and technology-enabled care: We will expand shared care records, remote monitoring, online training and system-wide command information to improve visibility, early detection of deterioration and coordinated decision-making, reducing avoidable admissions.

Teams will be required to adopt more integrated ways of working, with enhanced care coordination and a stronger focus on productivity, value for money and impact. The future model will be funded through reallocation of existing resource, with additional targeted investment from the increased NHS contribution.

Oversight of the transition and delivery of in-year BCF goals and national metrics will continue through the Health and Wellbeing Board, supported by the Integrated Neighbourhood Programme, Urgent and Emergency Care and BCF governance frameworks.

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 BCF metrics and goal-setting process are aligned with wider health and care commissioning priorities, including model neighbourhoods, national urgent and emergency care (UEC) metrics, and plans to expand community capacity to support a left shift away from ED, acute care and community bedded provision. System-level population health modelling has projected increases

in demand, complexity and acuity if growth continues unchecked. These projections have informed targets to stabilise or reduce demand through preventative actions, including alternative pathways to ED, new models of working, increased integration and targeted investment.

Questions 4 and 5 outline Rotherham's three-tiered governance, assurance and performance management approach at system and service level. Key details for each BCF metrics are summarised below.

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

Planned figures are based on observed activity from locally held SUS data, providing timely intelligence consistent with South Yorkshire approaches. Rotherham is on track to meet the 2025/26 year-end goal. Analysis of 2024/25 and 2025/26 shows stable admissions with no significant growth. Planning aims are for 0% growth in ED attendances. As reducing avoidable attendances is expected to increase acuity, the 2026/27 planning target applies a 1% growth in average admissions across the previous two years to reflect underlying demand and seasonal variation. The figures used for number of admissions on the Numerical Template submission are taken from HES data. The HES data is several months behind and rounds to the nearest 5. We have applied the 1% growth to the number as reported in the SUS data. SUS data is timelier, enabling more accurate baseline and quarterly reporting. It also provides additional detail on admissions (allowing further drill-down analysis), is routinely used across our system, and is well understood by our providers. This approach has been taken following discussion with the BCF metrics advisors, however, it should be noted that it does result in the figures appearing to show a reduction when the narrative states a 1% growth.

Operational performance is monitored daily at pathway and Place level through system flow meetings. Whole-system oversight is provided by the Urgent and Emergency Care Group and the South Yorkshire Alliance Board, with performance meetings assuring home- and bed-based discharge pathways and community services.

Average length of discharge delay for all acute adult patients

Recent changes to measurement make year-on-year comparison difficult. Benchmarking across South Yorkshire shows wide variation in data. We note, further guidance is expected. We will use 2026/27 as a baseline to develop a time series and assess improvement activity. Local SUS data used to replicate the measure indicates that we are not on track to meet this target in 2025/26.

In 2024/25, 82.7% of adult patients were discharged on their DRD, with an anticipated rise to 84.7% by the end of 2025/26. The average delay was 4.9 days, with monthly variation. A deep dive into discharge performance will take place as part of the winter debrief, with an initial aim to reduce delays over 21 days in 2026/27. BCF-funded schemes and wider planning are expected to improve monthly DRD performance by 2 percentage points compared with the equivalent month in 2025/26 and reduce average delays by half a day. Metrics may need adjustment in Q1, subject to guidance.

Long-term support needs of older people met by admission to residential or nursing care

Fewer people than anticipated were admitted into formal care in 2025/26. All decisions for care home placements are reviewed by the Strength Based Eligibility Forum within Adult Social Care to ensure least-restrictive options are considered first, based around the principles of personalisation and a strengths-based approach. Around 70% of people receive home-based services before stepping up to bedded care, indicating that investment in home support is delaying admission. The 2026/27 target maintains current admission levels, derived through

regression modelling and service knowledge. Modelling extends the positive trend while accounting for rising demand, and service insight ensures caution regarding how long delays can be safely sustained, alongside inflationary and external pressures. Alignment with Client Level Data (CLD) has improved reporting stability.

Proportion of people aged 65+ discharged into reablement who remain in the community after 12 weeks

The Council re-designed the enablement service in 2025/26 with a change in leadership and management and increased investment including new roles to improve flow on and off pathways and regular reviews of progress to have timely changes to support interventions. Improvements also include proactive in-reach into the acute bed base to support earlier discharge.

Improvements to the OT provision in the service allow for greater OT intervention and oversight to improve access to equipment and Assistive Technology. Increased emphasis on timely assessment creates flexibility to provide support where it is needed, increasing longer term independence and reducing the need for formal on-going care. Further analysis of productivity, capacity and demand will take place during 2026/27 through the intermediate care review to release resource and inform future resourcing requirements. CLD data and the BCF dashboard will support monitoring and goal setting, although data lags remain a challenge. Benchmarking will inform future resource allocation and targets.

A core part of the 2026/27 system wide diagnostic work is to review what data, management information and insights currently exist within and across partner organisations, how they are used and who they can be accessed by to support urgent, emergency and community care. The outcome will be used to bring together a consistent data set, accessible by all partners, to inform evidence based whole system decision making for use in strategic decision-making forums such as the BCF /UEC governance and delivery groups, and operationally by services. The work will review consistency of data definitions and data quality to improve outputs. Data quality is also being addressed through the community service review and within individual services.

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

Population health and demographic trends (question 1) indicate rising demand that could negatively affect BCF metrics if left unchecked. Despite a 6% rise in ED attendances and a 10% increase in TOCH referrals between October and March 2025/26, performance largely improved: ED 4-hour performance rose, ambulance handover times fell from 39.60 to 16.77 minutes, category 2 response times improved from 28.73 to 21.82 minutes, and acute/community admission rates remained on target. Discharge delays remained challenging. BCF investment therefore focuses on admission avoidance, improved discharge pathways, and strengthened home-based community support, particularly enablement, to reduce reliance on acute and long-term residential care and improve system flow.

Prevention: Reducing Avoidable Hospital Admissions

Integrated neighbourhood objectives aim to increase self-care, improve quality of life and reduce demand on primary, community and urgent care including acute admissions. Funded services will target:

i. Adults over 40 who have not accessed health checks and are at risk of developing LTCs. People in deprived communities develop conditions earlier and remain undiagnosed for longer; Rotherham is currently an outlier for ‘healthy’ people presenting to unscheduled care, suggesting unmet need.
ii. Adults aged 18–39 with one physical LTC and depression, who are more likely to deteriorate quickly, develop additional LTCs earlier and experience prolonged ill health.
iii. Frail people with four or more LTCs and multiple admissions. Building on a pilot of 105 patients which showed reductions in medications, ambulance visits, admissions, out-of-hours GP calls and deaths. Those receiving a comprehensive geriatric assessment had 37% fewer admissions.

We will expand out-of-hospital pathways to deflect conveyances from ED and reduce avoidable admissions, including:

- New virtual ward pathways and an integrated Hospital at Home model with urgent community response services for flexible resource allocation.
- A new ‘PULL’ model for lower-level ambulance referrals, complementing the existing ‘PUSH’ model that reduces ED conveyances by c.39 per month.
- Continuing the community X-ray pilot, which delivered c.73 care-home X-rays, improving outcomes and reducing ambulance/ED demand.
- Digital innovation such as remote monitoring and self-care tools for early deterioration detection.

Reduced Hospital Discharge Delays

We will continue investing in integrated physical and mental health, therapy, enablement and social care to support timely assessment and coordinated discharge. Resource will be re-distributed to develop:

- The multi-disciplinary TOCH to improve referral quality, decision making and reduce delays.
- Home-from-hospital and enablement in-reach to identify early discharge opportunities and reduce length of stay.
- A discharge-to-assess therapy and enablement model to reduce long-term care needs through targeted short-term intervention.
- Digital tools including shared care records, an IMC bed dashboard and system flow command centre.
- Ring-fenced winter-pressure support including social care capacity, extended discharge hours, pharmacy, transport and increased enablement capacity.

Reduced Admissions to Long-Term Residential Care

c.70% of people receive care at home indicating progress in delaying admission. Alongside the above, we are investing in lower-level support through the All-Age Carers Strategy 2026–2031,

including a new Carer Connect app. Joint VCSE commissioning provides lifestyle and wellbeing support that reduces isolation and prevents decline.

A review of community OT services found 30% of users received more care than potentially required. Resource is being redirected to equipment provision, triage, trusted assessors, digital solutions, housing OTs and discretionary discharge funds to support independence for longer. We are exploring a joint equipment service with Sheffield and Doncaster. DFG funding will continue to support rapid home adaptations and time-critical interventions.

Increased Independence at Home Following Enablement

We are decommissioning an independent Home from Hospital service to expand in-house enablement capacity for both admission avoidance and discharge, enabling more timely support. This helps people reach and maintain a baseline at home, reducing admission/readmissions. Service improvements will focus on productivity to increase capacity including digitised record keeping and new roles to assess on and off service releasing care hours.

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.**

Rotherham uses a three-tiered approach to evaluating productivity, impact and value for money, enabling effective information sharing without duplication. Service specifications set out required qualitative and quantitative metrics, which are monitored within organisations and through ICB performance meetings. Service improvement, innovation and national performance measures are overseen through programme boards and cross-system assurance groups. The BCF Operational and Executive Group specifically monitors BCF-funded inputs, outcomes and metric goals, reporting to the Health and Wellbeing Board and wider governance structures. (See question 5).

Commissioning intentions align with the Health and Wellbeing Strategy and the Rotherham Place Partnership Health and Care Plan, which outline how health and care partners will deliver shared priorities. All commissioning plans, including the BCF Plan, are designed to maximise value for the “Rotherham pound”. Rotherham’s strategic commissioning approach is evidence-based, drawing on population health needs identified through the annual Joint Strategic Needs Assessment (JSNA) and capacity and demand modelling.

National datasets are used to benchmark performance, particularly for four-hour performance, bed occupancy and discharge delays. These include ECIST North Dashboards, the Rotherham A&E Flow Pack, the NEY Discharge Ready Date Report and the Weekly Discharge Report. The ICB has developed InSYghts dashboards, including an Integrated Performance Report, Urgent Care Board Report, Benefits Bank (measuring the impact of change) and population health data. Intelligence from national and local equipment service communities of practice and ADASS has informed plans for re-commissioning of the equipment service particularly in relation to key decisions around lead commissioner, credit or block model and financial baselining. We have aligned our standard and specials stock list with Sheffield for efficiencies and developed a joint specification informed by specs from Leicester and Kirklees.

Population health analysis and risk stratification tools, including Eclipse, have shaped the proactive care and neighbourhood model. The BCF-funded Population Health Lead has contributed to a new insights’ dashboard analysing ED attendances, which has informed five workstreams to reduce avoidable attendances and admissions and guide future investment.

Rotherham is an active member of local and national communities of practice, using good practice to inform local developments such as the establishment of a co-located, integrated, multi-disciplinary Transfer of Care Hub following visits to Barnsley and Oldham and Bradford's discharge-to-assess pathway, with bookable slots and ring-fenced resource. Following a presentation at the NEY Regional Networking Event in Leeds, Rotherham has hosted visits and webinars for areas interested in the nurse consultant-led hospital-at-home model and the integration of unplanned care services.

A joint health and social care mapping exercise has been completed for 2026/27, reviewing all BCF-funded schemes, applying a RAG rating and assessing current spend, future needs and objectives. This provides assurance that investment is targeted appropriately (see question 3). However, future funding will be conditional on transitioning to new delivery models, increasing integration and improving productivity to support the left shift, and neighbourhood agenda.

To support this, strategic reviews of community health services; intermediate care and the commissioned bed base and re-procurement of our equipment service are underway. These reviews will assess productivity, capacity and demand and ensure that future investment is aligned to need, supports system flow and maximises the impact of BCF resources. Work is informed by a new Theograph digital tool developed to provide a visual display of which services an individual is accessing and when. Information can be accessed as a summary or at an individual level to identify areas of duplication and opportunities to improve signposting and streamline care.

A key driver of service re-design and pathway development is to increase productivity. For example, the development of the Home from Hospital enables a larger pool of staff with a greater skills mix which is deployed according to the level of acuity. The advanced nurse practitioner service which previously only supported care homes is now part of this service, supporting complex triage, clinical telephone advice and home visits to those who would otherwise be in hospital. Lower level cases are seen by the urgent community response avoiding a potential admission. The introduction of remote technology has enabled patients to be monitored remotely, where safe to do so, further releasing capacity. The multi-disciplinary TOCH team enables rapid triage, bridging to support earlier discharge and an expanded discharge to assess approach which is reducing over prescription of care. Our home first measures have reduced the reliance on bedded care, including a reduction in winter spot beds from over £100k to c.£30k this winter. Productivity has been increased by digitising paper-based processes including SDEC and enablement services and the introduction of a single referral form to TOCH, now used across all discharge pathways, with a focus on improving the quality of information and a process review. We have reduced the burden of reporting, using national data sets wherever possible and automating reports, with monthly desk top monitoring and a reduced number of review meetings.

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.**

Rotherham has a strong record of joint commissioning between health and social care, supported by a joint commissioning framework and governance structure. This includes joint needs assessment, supply mapping, market analysis, pooled budgets and performance management. These arrangements have enabled the development of a community offer built on a shared commitment to supporting people with complex needs to remain independent at home for longer.

The BCF Section 75 Agreement for 2026/27 is approved by the Health and Wellbeing Board, whose membership includes the Cabinet Member for Adult Social Care and Health, Elected

Members, Chief Executives, senior officers from the Council, South Yorkshire ICB and TRFT, GP leads, Voluntary Action Rotherham and Healthwatch. The Board holds overall accountability for delivery of the BCF Plan and the Section 75 Partnership Framework Agreement.

Key responsibilities of the Health and Wellbeing Board include monitoring performance against national and local BCF metrics, receiving exception reports, agreeing the BCF Commissioning Plan and approving commissioning or decommissioning decisions relating to BCF-funded services.

The BCF Executive Group is chaired by the Cabinet Member for Adult Social Care and Health and includes SY ICB Executive Place Director, Director of Partnerships/Deputy Place Director, Director of Financial Transformation, Health and Care Portfolio Lead and Strategic Commissioning Manager. From the Council, the Executive Director of Adult Care, Housing and Public Health, Director of Public Health, Service Director, Strategic Commissioning, Service Director, Adult Care and Integration and Head of Finance (Adult Care, Housing and Public Health).

Key responsibilities of the BCF Executive Group include:

- Making recommendations on the strategic direction and management of the BCF to the Health and Wellbeing Board.
- Overseeing delivery of the 2026/27 BCF Plan.
- Reviewing performance against objectives and metric goals, adjusting focus and/or resources where required.
- Managing the strategic operation of the BCF Partnership Agreement.
- Setting the strategy, framework, priorities and criteria for the BCF.
- Assuring feasibility, business planning, achievement of outcomes and budget strategy.
- Monitoring delivery through quarterly meetings and ensuring timely, high-quality reporting to NHS England, and
- Ensuring schemes are delivered effectively and mitigating unintended consequences.

A BCF operational group is co-chaired by the ICB Director of Finance (Rotherham) and the Service Director, Strategic Commissioning. Membership includes SY ICB Health and Care Portfolio Lead, Senior Data Analyst, Strategic Commissioning Manager and the Council Head of Service for Access, Performance and Business Intelligence Manager and Consultant in Public Health.

Its function is:

- To co-ordinate the delivery of the BCF Performance Measures, metrics and Action Plan.
- To create the funding plan to be signed off by the Executive Group.
- To ensure that effective performance management of the BCF Performance Measures takes place and where performance is not meeting targets, appropriate and timely action is taken, providing assurance and escalation to the Executive Group where required.
- To ensure the BCF conditions are met.
- To co-ordinate partner activity within the BCF Plan, ensuring that all elements of the plan are linked together to deliver positive outcomes and assess impact.
- To monitor and ensure the Rotherham BCF Scorecard is updated on a quarterly basis and to circulate to the Executive Group.
- To review risk and to oversee the implementation of mitigating actions.
- To ensure the customer journeys/experience are delivering increased customer satisfaction as shown by the delivery of the measures and the plan.

Development of the BCF Plan has involved senior leadership from the Council and ICB, commissioning, adult care and integration, public health, strategic housing, Disabled Facilities Grant leads, finance, performance and intelligence teams. The Plan has been agreed by the Council and ICB Chief Executives and the Chair of the Health and Wellbeing Board.

The BCF monitoring framework will be strengthened in 2026/27 to align more closely with neighbourhood ambitions and place greater emphasis on impact and value for money - to inform future decision-making. Both the Neighbourhood and BCF governance structures report into the Place Board and Health and Wellbeing Board.

As the BCF underpins Place plans, activity is also reviewed through wider Place governance arrangements. The Place Board provides the strategic and collective leadership for the Place Partnership to deliver the ambitions of the Place Partnership and the Rotherham Place Plan. It is the forum where all partners come together to formulate, agree and implement strategies to deliver the Place Plan. The Board works across boundaries to improve person centred experience and outcomes. Sub-groups include the Mental Health, Learning Disability and Autism Group and the Urgent and Emergency Care Group, which reports into the South Yorkshire Alliance Board. These arrangements will be adapted in 2026/27 to reflect changes to ICB roles and responsibilities, while maintaining a strong Place focus and exploring opportunities for economies of scale across South Yorkshire.

A monthly meeting between the Council, ICB and TRFT Executive teams supports strategic development and addresses in-year pressures, particularly in urgent and emergency care. BCF metric goals are aligned to this work, ensuring a clear line of sight between governance, operational activity, improvement work and whole-system flow.

BCF finance and commissioning functions are embedded within the new SY ICB Target Operating Model. The Rotherham BCF will continue to support two joint ICB–Council roles that provide strategic and operational leadership for the BCF.