Choose an item.

Department of Health & Social Care

Ministry of Housing, Communities & Local Government

NHS England

MAY 1, 2026

BCF NARRATIVE 26/27 PLANNING DRAFT V.2

INTEGRATION TEAM

Choose an item.

Department of Health & Social Care | Ministry of Housing, Communities & Local Government | NHS England

Better Care Fund 2026-27
Narrative return

Introduction and guidance

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

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

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

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

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

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

Submission Requirements:

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

Submission details

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

Adapt as necessary	**HWB area 1**	**HWB area 2**
HWB	**Leicestershire**	
ICB	**Leicestershire, Northamptonshire & Rutland (LNR) ICB**	
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.**

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

Our 2026–27 Better Care Fund (BCF) plan directs investment towards strengthening integrated and preventative services across neighbourhood health and social care, ensuring resources are aligned to shared system priorities and the needs of our local population. The focus of BCF funding continues to be enabling people—particularly those with more complex health and social care needs—to remain independent for longer, receive timely intermediate care, and experience more coordinated support across organisational boundaries.

Approximately 66% of BCF spend in Leicestershire is aligned to prevention services that improve and maintain independence in the community. A further circa 18% is aligned to community crisis response and intermediate care (step-up and step-down). This approach supports the strategic transformation priorities set out in the ICB's 5-year strategic commissioning plan around frailty and preventable mortality, ensuring that local and system-wide strategies remain connected.

The Health and Wellbeing Board's (HWB) assessment of demand and capacity for intermediate care and community care has directly informed the 2026–27 plan, highlighting areas where additional investment is required to meet rising levels of frailty, support timely discharge and the home first ethos and maintain flow through community services. Table 1 below, shows the change in demand for services and the investment opportunities to either increase capacity, reduce demand or provide more effective and efficient services.

Table 1:

Area	**24-25 Activity**	**25-26 Activity**	**26-27 Planned Activity**	**Comments**
HART Reablement (community)	2840	2188	2888	Increase in staffing see section 4 to reverse decline in capacity and increase starts
Community Dom Care	5702	6470	5702	Increased reablement capacity will reduce the number of domiciliary care starts to 24-25 numbers approx
HART capacity rejections (community)	229	166	120	Reduced by 30% in 25-26 and aiming for a further 30% reduction in 26-27
Community therapy / rehab (step up and down)	6617	6746	6881	Capacity in community therapy and rehab has increased by 2% in 25-26 and this increase has been reflected in further capacity for 26-27.
Community short stay beds (step up)	1656	1793	1656	We want to reduce the 8% rise seen in 25-26 to the usage for 24-25 by

				ensuring earlier intervention and increased reablement capacity
Intermediate care HART reablement step down (hospitals)	3062	3235	3655	Increased capacity in reablement ensures the increase in step-down reablement is maintained
Intermediate Care HART Urgents step up and down	550	424	424	We want urgent response service activity to remain stable
Intermediate care dom care step down	778	998	778	We want to further increase step-down activity into reablement prior to dom care so expect levels to return to 24-25 figures
HART capacity rejections (hospitals)	1527	1117	782	Increased reablement capacity is aiming to further reduce the amount of capacity rejections into dom care
Intermediate care bedded step down	840	934	840	We will be working in year to reduce the amount of P2 bed usage back to 24-25 levels
Total activity	**26644**	**27258**	**28508**	**Overall activity is projected to increase by 4.5%**

Overall, the intermediate care services that form part of the demand and capacity modelling have seen a 2% increase in activity during 25-26. For 26-27 this is projected to increase further by 4.5% representing a further 2.5% capacity on the predicted growth. This supports left-shift of demand and capacity into community and intermediate care from acute care services in line with national requirements for increased productivity in acute services. Additional BCF investment is aligned with increasing capacity in these areas. This is outlined in table 3 below.

Each year the Health and Wellbeing Board hold a BCF development session. This is attended by all partners and elected members. We discussed in each of the spend areas (table 2) how we could make improvements utilising changes in BCF funding. This focused particularly on preventing the need for statutory services, increasing reablement, reducing the utilisation of step-down short-stay residential care beds and reducing domiciliary care where reablement has not been considered first.

- We will be investing in Project Management resource to produce and take forward options for reducing the use of spot purchase beds and overall system bed utilisation. How this is expected to impact is covered in more detail in question 3.
- West Leicestershire has been part of the national implementer site programme for neighbourhood Health. The focus has been on the delivery of MDT's for people who have COPD and are housebound. BCF funded Care Co-ordinators have worked with other professionals to attend MDT's and to work with people in their own homes to offer a range of preventative and supportive services. The MDT's have worked with approximately a quarter of the cohort, defined using population health management data, linking 100 people out of 450 so far, with social care, carers support services, voluntary sector and housing. This has also allowed us to focus on person-centred outcomes in (PROMS and PREMS) and the collation of case-studies to show the difference this is making to people in their communities. As part of the 26/27 plan, the BCF is going to support the expansion of neighbourhood models of care through additional investment which has been scaled up based on the lessons learned in the implementer site pilot. Initially, this will be aligned to support the 24,439 people

in Leicestershire who are in Patient Need Groups (PNG's) 10 and 11 (Muti-morbid high complexity and frail populations – the populations with highest health care needs). Initiatives will also include support to those at end of life care including targeted conversations at neighbourhood level around end of life care including RESPECT planning and support to carers. This will support the urgent end of life medication service which provides earlier treatment to avoid escalation of acute needs. This is funded through capacity funding.

- To support delivery, investment to commission the VCSE sector in a hub and spoke model has been included in the BCF plan for 26-27. This will utilise a centrally contracted/funded hub to engage and commission services with VCSE sector organisations locally who can provide health and wellbeing support to residents referred via Integrated Neighbourhood Teams. This has the potential to target local resources to support identified local needs in a more time-responsive manner. Part of this will be to support INT's to develop in order to deliver preventative MDT's.
- We will be extending our VCSE 'Hospital to Home' contract with the Royal Voluntary Service (RVS) to March 2027. This will allow us sufficient time to conduct an effective procurement exercise as per contract and procurement rules and gives us an opportunity to ensure we are receiving value for money within the current market provision. This service supports safe discharges of people who are leaving hospital with either no formal support (pathway 0) or support provided in their own home (pathway 1). During 2025-2026, 604 patients were supported with assisted discharges which is an 18% increase from the previous year. This service also provides hospital to home provision providing 6-12 weeks of support once back at home. For example, helping people with a weekly shop, transport to any medical appointments and more. Demand for this service has increased over the last year with a 0.5% or below readmittance rate after 28 days being at home.
- We are continuing to work with one of our community health partners DHU Health care who provide a clinical falls response for low level fallers within the community. Between 2024/25 and 2025/26, referrals increased by 33.8%, with a corresponding 31.5% increase in the number of individuals supported to remain at home. Even with the increased demand, over 93% of referrals in 2025/26 remained at home. Based on current trends and with no planned service expansion, we anticipate a more moderate referrals increase of approximately 8–12% in the next year.

Governance arrangements for Health and Wellbeing Board (HWB) delivery against national Neighbourhood Health priorities have been put in place. A new sub-group will shape and deliver the models across Leicestershire and develop the place based strategy. This will form an addendum to the Leicestershire Joint Health and Wellbeing Strategy which has a life course approach and was refreshed in 25-26.

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:

Our goals for reducing non-elective admissions for people aged 65+ and delayed discharges have been developed using a combination of recent performance trends, benchmarking against comparable systems, and assessment of planned service changes. We have based goals on previous-year experience, peer comparison, and anticipated impact of operational changes.

To establish our targets and goals for next year we have utilised our own published performance via SUS data and the England average and East Midlands peer comparator data on the DHSC website.

It is important for Leicestershire to compare to East Midlands peers as 30% of residents utilise acute services out of area in neighbouring east midlands authorities including Derbyshire, Nottinghamshire and Northamptonshire. Main utilisation outside of UHL is George Elliot, Burton Hospital, Queens Med, Ketttering and Derby Hospital. We also share usage of many services including the ambulance trust, 111 and Derbyshire Health United. It also shows us ICB cluster partner performance across Leicestershire, Northamptonshire and Rutland (LNR).

Health and Wellbeing Board (HWB) goals for non-elective admissions and discharge delays have also been aligned with NHS provider and ICB medium-term planning trajectories, with any variances highlighted where local expectations depart from NHS planning assumptions.

For non-elective admissions (over 65) in 25-26, the data so far (until Dec 25) shows a rate of 1469 admissions on average per month against an average target rate of 1,661 per month (20,810 actual admissions year to date against a target of 23,520). Using this data we have proposed a target for 26-27 of a further reduction of 2% on the actuals for 25-26. This equates to an approximate average reduction of 48 patient admissions per month throughout the year to an average rate per month of 1626. This has been aligned to the UHL (and wider NHS acute targets) supporting an overall requirements to increase productivity in elective activity. We aim to support this by increasing capacity in community and intermediate care and proactive care in neighbourhood health teams. The target has also been mirrored across other HWBB's within the wider ICB cluster. How BCF funding will aim to achieve this reduction is detailed in question 3. The Urgent and Emergency Care (UEC) strategic group will be aligned to the monitoring of this metric to ensure there is adequate read across from BCF to acute provider strategy and performance.

Throughout 25-26, Leicestershire performance has been off target for the 'Proportion of adult patients discharged from acute hospitals on their discharge ready date' indicator requirements. The target was to achieve 89% by the end of the financial year. This has not been achieved, with the best individual monthly performance in June of 86.2%. Improvements have also not increased as the year has progressed. Looking at the current performance levels, it has been agreed to apply a target of a 1.5% improvement on the best performing month of 25-26. Therefore, the target for 26-27 overall will be 87.7%. This represents a stretch target on current performance and if met, would be better than the England average. In 25-26, Leicestershire consistently performed better than the East Midlands average.

For the average number of days from discharge ready date to discharge, a target of 3.9 days has been set as an average for all months. This was the best achieved performance recorded in June 25, with an overall average performance throughout 25-26 of 4.4 days. This target is therefore a 0.5 day improvement on last year. Currently Leicestershire is in the top quartile nationally for this indicator and 3.9 days represents an ambitious stretch target to achieve across all months. Collectively, all partners have been involved in workshops to look at managing the discharge processes more effectively to help to meet this target. This includes community health services and community hospitals along with acute providers and local authorities and EMAS. The development and adherence to Standard Operating Procedures (SOP's) for discharges will focus on how and where timescales in discharges and discharge planning can be reduced to create the 0.5% improvement.

For long-term admissions to residential or nursing care, the target for 25-26 was a rate of 563.1 per 100,000 population. To date this has been exceeded in 25-26. For 26-27 the target will be set at the current 25-26 projected rate of 552 per 100,000 population, a reduction of 2% on the 25-26 target. This is against a projected notable increase in demand over the next quarter and the following twelve months based on demographics and the impact this has had on current upward trends since 2024. Currently, Leicestershire performs better than the England average and is equal to the East Midlands average. We are investing funds into a Discharge Project to underpin the reasons for use of temporary bedded care (which leads to permanent admission 12 weeks later for 45% of people) and look at ways of improving the way we commission. With our planned improvements within HART Reablement and Intermediate care pathways and preventing need through Neighbourhood care programmes focusing on frailty, we aim to keep up with the demand if not to further reduce the long term admissions to residential or nursing care where possible.

Reablement performance, particularly the proportion of older people who remain at home 12 weeks after discharge, is expected to improve through enhanced capacity in reablement and intermediate care pathways. Based on our own data on reablement outcomes at 12 weeks, we are broadly stable compared with the previous year. The proportion of discharges to ASC who were in reablement at one week increased from 29% (Apr 2024–Mar 2025) to 33% (Apr 2025–18 Jan 2026). At 12 weeks, the majority in both periods had 'no onward services' (69%), with HC maintenance remaining similar (19% in 2024/25; 18% in 2025/26 YTD). The later period shows a higher proportion recorded as deceased (9% vs 7%) and a lower proportion in other services (3% vs 5%). It is worth noting that the proportions are comparable, but the counts are not directly comparable as the earlier figures and the later period are not both full-year '12 weeks later' views. Our target for 26/27 is based on the numerator from the metric. Current performance indicates that we will maintain a performance in line with the national average.

The HWB will continue to review the accuracy and completeness of data relating to the metrics on a quarterly basis with bi-monthly performance reported to the Integration Executive where any changes in performance are monitored and actioned.

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:

As part of the Health and Wellbeing Board development session, all areas of spend were discussed in relation to outcomes, performance and value for money. Looking at performance in 25-26, the large majority of BCF funding has maintained the current position in terms of performance goals. Taking into account the increase in demand from the projected population increase, we feel the majority of the current investment is working well to sustain performance levels against rising ageing population needs. However, as part of contractual arrangements, the domiciliary care contracts will be re-let in 26-27 and part of this exercise aims to increase value for money (VFM). The new framework will commence in October 2026 with VFM and performance improvements projected from quarter 4 onwards. A review of current contracts for community health services is also taking place led by the ICB. There will be a review of the Key Lines of Enquiry (KLOE) document with regard to community health care services in quarter 2 expecting an increase in performance from quarter 4 onwards. This will help to drive the additional 2% productivity and capacity in community services detailed in the demand and capacity table 1. This will include reviewing commissioning for value principles that will include quality, performance and any variation or duplication in service delivery. These two areas account for approximately 50% of the overall BCF funding.

Table 2 below shows the current approximate split of the total BCF allocation against areas of spend and the overall percentage that this represents.

Table2:

Area	**Total Spend for each area (M)**	**% of spend for each area**
Prevention, Neighbourhood and Community care	£56.3	65%
Crisis & Intermediate Care	£15.4	17%
Discharge & acute	£4.2	6%
End of Life	£6.8	7.5%
Other	£4.0	4.5%
Total Spend	**£86.5**	**100%**

Recognising that a large proportion of the investment is committed to staffing and contracted spend, we have identified approximately £1m of funds that are available to focus on achieving goals related to national priorities and local areas of performance improvement in 26-27.

Table 3 below shows all new or enhanced areas of funding designed and allocated to meet the emerging goals for 26-27. It shows which spend area and a rationale and timescales for delivery.

Table 3:

Scheme/Area	Value	Metric, rationale and timescale
DHU falls car Prevention, Neighbourhoods and Community Care	£550,000	Avoidable admissions: Supporting people to remain at home after a fall and reducing need for A and E attendance or EMAS. Prevents long-lies and deterioration 34% Increase in referrals in 25-26 from 24-25. Aiming to increase capacity further during 26-27. Circa 95% people remain at home after referral. Circa 50% referrals are from care homes.

		Contract in place for 26-27 full year.
Steady steps / Fame / Active together Prevention, Neighbourhoods and Community Care	£152,000	Reducing admissions due to falls / reduced long-term care admissions – This agreement expects a minimum of 516 participants across a minimum of 37 courses across Leicestershire and Rutland to prevent falls. Contract in place for full 26-27 year
Therapy support for step up Discharge and acute	£100,000	Avoidable admissions: 1 x FTE Therapist for proof of concept to avoid admissions in frail elderly cohort from the Emergency Department by 48 per month as per target reduction in metric performance (this aligns to the unmet need study). UHL Therapy currently discharge 77% of patients assessed on the day of admission but have an 'unmet need' of up to 72 patients per month who could be assessed but can's due to staffing levels and capacity. Reduce usage of spot purchased residential care D2A: 1 x FTE Therapist for proof of concept – earlier Therapy intervention at the 'front door' for patients who require medical admission, in order to reduce overall LOS and support improved outcomes, leading to less usage of residential care step-down. Patients seen by Therapy within 48 hours of admission have a shorter LOS (average 4.8 days) and have a much higher chance of returning home (P0 or P1) or transferring to a Rehabilitation facility, than those seen after 48 hours who are at significantly higher risk of requiring D2A placement. Fixed term contracts can be in place Q1
Project management support to P2 system solution Intermediate Care	£35,000	Reduction in P2 D2A bed usage and business case development for overall bed requirements in Leicester Leicestershire and Rutland (LLR). Can be in place Q1
VCSE hub and spoke contract Prevention, Neighbourhoods and Community Care	£58,333	Avoidable admissions / Reduced admissions to long term care: This aims to support Multi-disciplinary Teams (MDT's) to utilise local voluntary sector groups to support people at home and reduce emergency care usage and long term care home admissions as part of neighbourhood care. Contract will commence Q4 due to procurement timescales
NMC support to INT's and MDT's Prevention, Neighbourhoods and Community Care	£100,000	As above but for Integrated Neighbourhood Teams (INT's) to support MDT's. Ad hoc dependent on INT needs and national guidelines on deliverables.
Partnership wide Discharge and flow training event Acute and discharge	£5000	A system-wide training and information event for frontline staff to increase awareness of community-based services and referral pathways to support timely discharges and improved performance on discharge timescales. Est June 26

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:

ICBs, local authorities and the HWB have taken a structured, evidence led approach to ensuring BCF funded services represent value for money. This includes assessment of inputs (costs and workforce capacity), outputs (activity and throughput), and impact (outcomes and avoided demand). This aligns with the guidance recommending optimal use of resources and transparent assessment of impact.

Annual KLOE documents are completed for each scheme line which outlines (where applicable) the outputs of services, staffing levels and how they each meet the metrics and provide value for money. Benchmarking, both actual and planned, informs the review of cost and performance across key BCF funded services. Insights from benchmarking exercises are used to guide future service improvement and commissioning decisions.

The partnership has identified clear opportunities to enhance productivity, including:
Reviewing longer term and larger contracting arrangements – see above Dom care and Community services contracts. This supports the overall aim of a left-shift into community and prevention services that aims to contribute to increased acute productivity including completion of elective admissions. This is aligned to increases in reablement and care co-ordination productivity that both prevent or delay need for formal or acute services.

Optimisation of reablement workforce skill mix – We are aiming to recruit a net increase of at least 30 FTE direct support staff by May 2027, enabling delivery of around 700 additional HART reablement service starts per year. This will be achieved through a combination of improved recruitment practices, enhanced pay for direct care staff, permanent job advertising, and data-driven targeting of candidates. Further measures include offering full-time contracts, streamlining recruitment processes, increasing administrative support to reduce delays, and implementing a new roster system to improve capacity utilisation. Together, these actions are expected to increase recruitment by an average of 3.2 FTE per month between July 2026 and April 2027.

Improved deployment models in key community services – Care Co-ordinators have been deployed to accommodate delivery changes in the national neighbourhood health programme. This includes additional BCF support to INT's and MDT delivery alongside investment from health partners of 1.8 million into neighbourhood health to support the left shift from acute care and increase their productivity by supporting providers to meet elective care targets as a result. This reflects the national expectation for NHS providers to deliver 2% year-on-year productivity improvement over the next four years and recognises how BCF funded services contributes to this ambition. For Leicestershire, the focus on the frail cohort equates to a population size of approximately 24,439 who attend or are admitted to acute care approx. 1.65 times annually at an indicative cost of £3787 per person per year. Based on the current levels of MDT productivity in the implementer site, there is scope to work with approx.400 people annually which has the maximum benefit of reducing 600 admittances or attendances to acute care at a cost of approx. £1.5 million.

Table 4 below, shows increased or new BCF funding that will contribute to improved productivity during 26-27.

Table 4:

Scheme	Value	Increased productivity rationale
Shared care tasks	£150,000	Increases productivity in community health services. Dom care providers trained on low level health care tasks to

		reduce duplication of daily visits by professionals and releases capacity back to community health
RVS contract	£16,000	Increased demand to support pathway 0 discharges and reduce delays also increased capacity to take P0 work from Care Co-ordinators to release capacity for them to only work on proactive and preventative neighbourhood health case management
Home First additional management	£120,000	Supporting increase in workforce capacity in Home First teams (mainstreamed as previously funded through discharge grant)
Housing Enablement Team	£14,280	This represents a 13% uplift in contract value with an overall increase in productivity of 38% across the service. The four self-contained temp discharge housing units freed up 12 hospital beds, releasing over 317 acute and community bed-days back to clinical use in 25-26 this has been extended to continue in 26-27
Armed Forces	£25,000	Increased funding to ensure the area is well positioned for emerging regional and national opportunities, including VALOUR Centres. This will shift support towards earlier, preventative engagement and strengthening connectivity between statutory services, the VCSE sector and the Armed Forces community
S1 unit for CC's	£45,000	This unit will allow the Care Co-ordinators to access S1 patient records across INT areas allowing better case management and improved productivity. With the implementation of the NMC it is anticipated that this will generate an extra 96 referrals per month. Having a combined unit rather than 72 separate ones will increase productivity across the team and give the ability to keep up with the increased demand providing better value for money whilst still providing good outcomes contributing to the effectiveness of avoidable admissions and Neighbourhood Models of Care.

Existing, new and increased investment and productivity is monitored in year by the governance set out in question 5 below. The KLOE documents for each scheme are reviewed annually as part of the HWB BCF development session and are refreshed to include any new or additional information in regards to staffing, re-contracting and added VfM. The Integration Executive meets bi-monthly and includes both general and focused performance reviews on schemes that impact on VfM. It also receives the quarterly BCF returns on income, expenditure and performance.

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:

Our governance arrangements are well established with relationships across partners embedded into our service delivery. We continually evolve and adapt to meet requirements and always look for new ways to assess value for money.

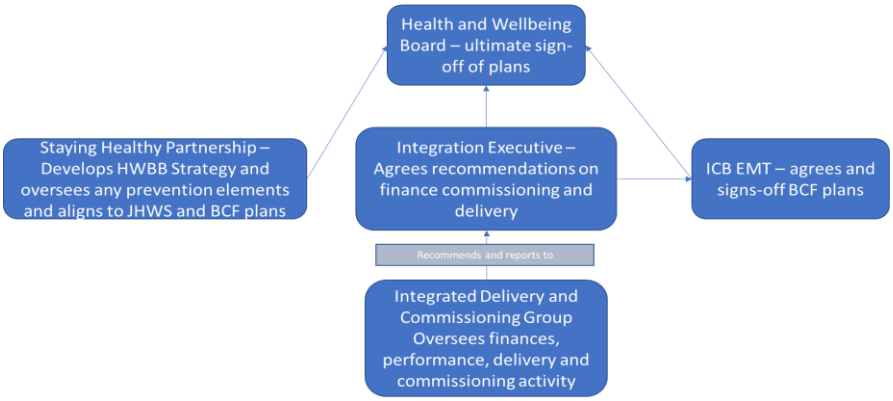
Bodies involved strategically and operationally in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils):

Leicestershire County Council
Leicestershire, Northamptonshire and Rutland ICB
University Hospitals Leicester Trust
Leicestershire Partnership Trust
Blaby District Council
Charnwood Borough Council
Harborough District Council
Hinckley and Bosworth Borough Council
Melton Borough Council
Northwest Leicestershire District Council
Oadby and Wigston Borough Council
Rutland County Council
Healthwatch
Royal Voluntary Service
Voluntary Action Leicestershire
Homecare Alliance

For the 26-27 BCF plans, a workshop with Health and Wellbeing Board members was held in January to look at the progress of schemes during 25-26. This was attended by elected members, NHS partners, LA's, Healthwatch and VCSE representatives with an introduction from the Midlands BCF team within NHSE to discuss the changes for the forthcoming year. Schemes were grouped into the BCF themes of Prevention, Preventative care and neighbourhoods, Crisis response and Intermediate care, Acute and Discharge and End of Life and nursing care. Each scheme has a KLOE document that details the spend, staffing, contracts and outputs for partners to gain a full understanding of the vfm and the workshop offers an opportunity to discuss any improvements required against the activity. The KLOE document has been shared both regionally and nationally as an example of good practice. These are updated annually.

Below is a diagram of the governance arrangements for reporting of the BCF showing the HWBB with the statutory responsibility and the supporting executive and operational group. This responsibility includes receiving annual and quarterly reports including quarterly expenditure which measures the current spend and any changes, additional spend or areas of slippage. This enables joint decision making across partners to any in year changes or areas and ideas for improvements. The board also receives and agrees the section 75 agreement and agreement for the DFG amounts to be transported to each District Council within Leicestershire. This is passed on in its entirety with top slicing agreed by partners for wider housing related schemes. Where a HWBB is not meeting prior to submission the Integration Executive signs off the documentation with the Chief Executive of the County Council using powers of delegation to sign off on behalf of the HWBB.

Governance diagram



Demand and capacity modelling is undertaken to look at the impacts of schemes and their effectiveness both as part of contractual arrangements or annually to establish VFM and if there are any improvements required as part of the ongoing performance management of the BCF.

The administration of this process is conducted by the local authorities Integration team who are supported by finance colleagues and commissioning support colleagues. This resource is financed through the BCF fund. This includes working with other local authority areas on their plans to ensure that this aligns to the ICB and wider system plans for integrated services across LLR.

The BCF is also aligned with the Joint Health and Wellbeing Strategy (JHWS) priorities (Living and Supported Well and Dying Well) of the HWBB and the ICB and NHS respective 5/10 year strategy delivery. An additional sub-group of the HWB has been formalised to support the delivery of Neighbourhood Health priorities. This will include the development of the Leicestershire strategy on Neighbourhood Health which will form an addendum to the JHWS. This group will also be responsible for BCF funding elements and contractual arrangements for Leicestershire aligned to this area of work.

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