ALL PARTY PARLIAMENTARY GROUP ON ADULT SOCIAL CARE

MAXIMISING THE IMPACT OF THE BETTER CARE FUND (ESSEX)

A roundtable discussion with Jen Craft MP, Member of the Health and Social Care Committee, and key decision-makers presiding over the Better Care Fund in Essex.

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Jen Craft MP, Member of the Health and Social Care Committee

Foreword

As a Member of the Health and Social Care Committee, it was a privilege to convene this roundtable bringing together local leaders from across Essex to discuss how the Better Care Fund is working in practice and how it could be strengthened to deliver better outcomes for people and communities.

This discussion took place at a time of intense pressure across health and social care, but also one of real opportunity. Through our recent inquiry into adult social care reform, the Committee heard compelling evidence of the impact that a failing social care system has not only on individuals and families, but on the NHS, local government and the wider economy. Poorly functioning social care drives delayed discharges, worsens patient outcomes and places unsustainable strain on acute and primary care services.

It is in this context that the Better Care Fund is so important. While it cannot resolve every challenge facing the system, it plays a crucial role in bridging acute care, primary care and social care. When used effectively, it can support people to live independently and avoid unnecessary deterioration in their health. Preventing avoidable hospital admissions and improving outcomes for those who need care must remain a shared priority.

Participants spoke candidly about what is working well and where the current operation of the Better Care Fund risks falling short of its original ambition. There was strong support for the Fund's principles but a consistent message was the need to trust local partnerships.

Those closest to communities are best placed to understand what will keep people well and independent, whether through better integration of services or addressing wider determinants of health, such as transport and social connection. With both NHS reorganisation and local government reform underway, there is a real opportunity to take a more joined-up, place-based approach.

This report reflects the expertise and commitment of partners across Essex and a shared determination to ensure the Better Care Fund fulfils its potential as an enabling force within the system. I hope it contributes constructively to the ongoing debate about how it can be strengthened, so that it continues to support integration and help address the very real costs of inaction in our health and care system.

Jen Craft MP
Member of the Health and Social Care Committee

Attendees

Jen Craft MP
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Introduction

About the Better Care Fund

The Better Care Fund (BCF) is the Government's primary vehicle for driving integration across health, social care and housing. Its purpose is to shift the focus from reactive, hospital-based treatment towards prevention, independence, and improved continuity of care for people with complex needs.

Its core objectives are:

- To **support the shift from sickness to prevention,** including proactive and co-ordinated support for people with complex needs, better use of technology and home adaptations, and support for unpaid carers.
- To **enable people to live independently and support the shift from hospital to home,** preventing avoidable admissions, improving timely discharge, supporting recovery at home, and reducing long-term reliance on residential care.

The BCF combines mandatory contributions from Integrated Care Boards, the Local Authority Better Care Grant, and the Disabled Facilities Grant. In 2025-26, its minimum income stands at £8.97 billion. Additional contributions from ICBs and local authorities increases the budget by a significant percentage each year. In 2024/25, additional income totaled £2.7 billion.

This year, the government's NHS 10 Year Health Plan pledged reform to the Better Care Fund, focused on "providing consistent, joint funding to those services which are essential to deliver in a fully integrated way, such as discharge, intermediate care, rehabilitation and reablement." The reformed Fund is set for implementation in the 2026-27 financial year.

Roundtable: Perspectives from Essex

In January 2026, Jen Craft MP, a member of the Health and Social Care Committee, brought together leaders from local authorities, Integrated Care Boards, NHS organisations and the independent care sector in Essex to discuss how the Better Care Fund is working locally, and how it could better support integration and community-based care.

The roundtable was designed to be a working discussion, focused on what is happening on the ground. Participants shared experience of delivering services under pressure, reflected on where the Better Care Fund has helped, and debated how it could be used more effectively at a time of financial constraint and sweeping organisational change.

There was strong support around the table for the principles behind the Better Care Fund. Attendees spoke positively about its role in bringing partners together, creating space for joint decision-making, and encouraging services to think beyond organisational boundaries.

Many felt it has helped to normalise collaboration and made integrated working feel more routine rather than exceptional.

However, there was also a clear sense that the way the Fund now operates does not always match those ambitions. Participants repeatedly returned to the pressure created by short-term funding cycles and the way performance measures often prioritise system flow over long-term outcomes.

Even so, the discussion was not pessimistic. There was a shared view that the original purpose of the Better Care Fund still matters, and that with the right changes – particularly around greater flexibility, clearer priorities, better data and stronger neighbourhood working - it can play a much bigger role in supporting genuinely joined-up care.

1. Rethinking discharge

Discharge dominated much of the discussion, with many participants describing it as the main pressure shaping how services are organised and funded. Several felt that the system has become so focused on hospital flow that other objectives, such as prevention, can be pushed into the background.

One senior ICS representative explained that bringing discharge funding into a single pot had helped remove arguments about “whose responsibility” a patient was, saying that "we stopped asking whether it was health or social care, it became about getting the person into the right place”. This shift was seen as central to the success of complex and intermediate care pathways.

Participants repeatedly pointed to multi-disciplinary team (MDT) working as the real driver of better outcomes. An operational lead said that what made the biggest difference was not the funding itself, but the fact that teams came together around shared information; “what we already know about the person”, rather than starting again at each stage of the pathway.

Several shared evidence of the impact this approach has had. One system leader at the local authority level described how, within the first three months, readmissions were reduced by around 20 per cent, while the average length of stay for people with the most complex needs fell from around 57 days to just 28. They also noted that even among people expected to need long-term care, “16 per cent still went home”, challenging assumptions about what is possible.

Participants felt this success came from allowing people time to recover outside acute settings and to be assessed properly. Some reflected that under earlier models, people were often assessed too late, by which point they had become “so institutionalised” that the chance of returning home was much smaller. Now, intermediate and complex care beds are used to create space for recovery and better decision-making pathways with families and professionals.

Another theme running through the discussion was how decisions are made about who is referred into complex or intermediate care, and how risk is judged at the point of discharge. Several participants felt that people are sometimes moved too quickly into long-term placements because professionals are anxious about risk.

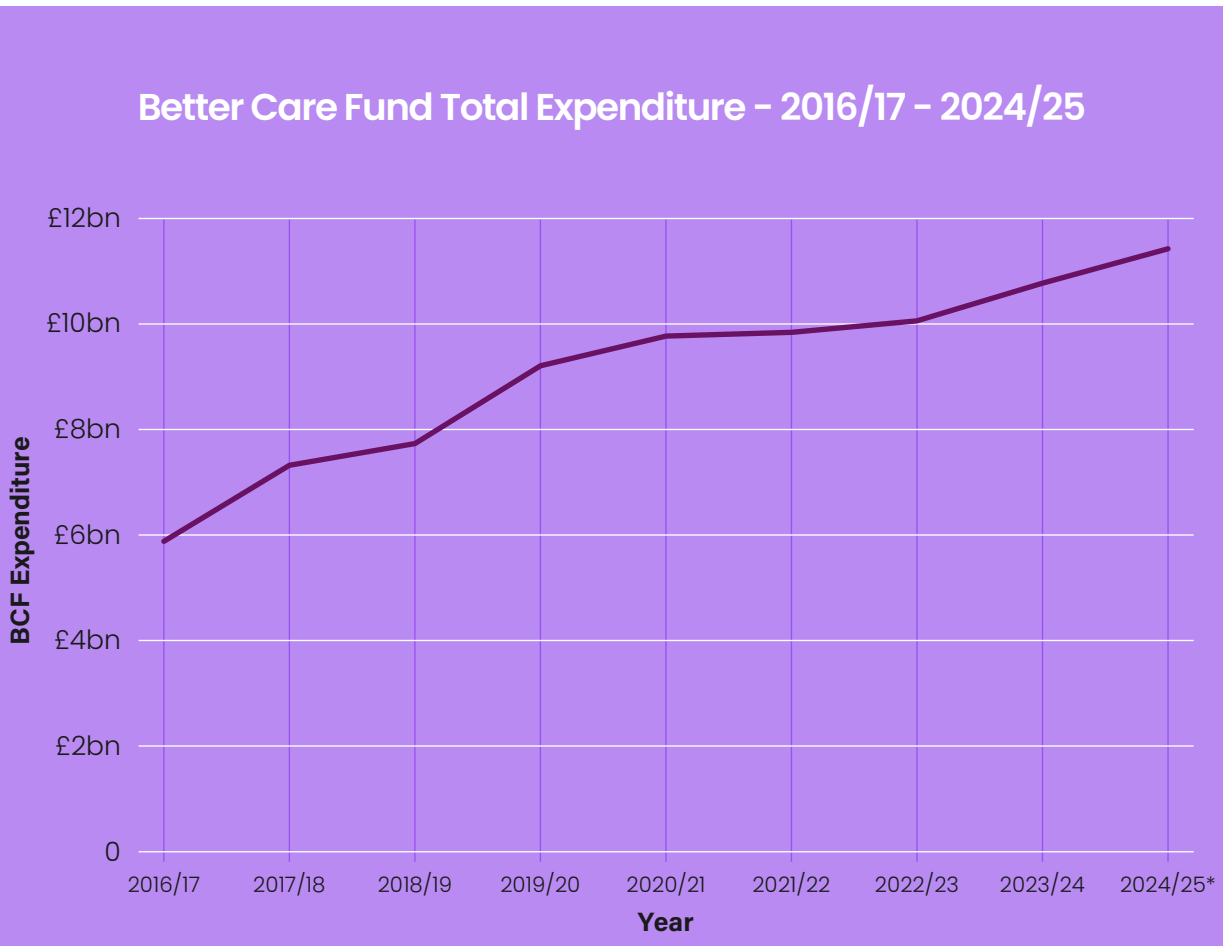
> **“We stopped asking whether it was health or social care, it became about getting the person into the right place”**
>
> **- Senior ICS representative**

A senior ICB representative explained that for them, the starting point is always “what does the person want”, and that someone being worried about going straight home can, on its own, be “a good enough reason” to explore other options. Others noted that stronger use of Mental Capacity Act and best-interest processes has helped bring more scrutiny and balance into these decisions, reducing the tendency to default to the “safest” option.

The practical impact of more integrated discharge pathways was also clear. Officials from one local authority said that the number of people in intermediate care beds at any one time had fallen from around 70 to closer to 20, simply by getting people into the right place more quickly and having clearer shared processes.

However, there was concern that discharge has become too dominant as a system lens. Several felt that when everything is judged through hospital flow, community services and prevention are seen as secondary. A local authority representative argued that the system needs to “change the lens” away from the acute hospital and toward the community.

Participants agreed that discharge-focused funding has shown what is possible when systems remove artificial boundaries. The challenge now, many felt, is to apply the same joined-up approach earlier, so that people are supported before crisis, rather than only once they reach hospital.



2. Planning without certainty

While there was widespread support for the principles behind the Fund, many felt that it has gradually shifted away from being a flexible vehicle for integration and towards something closer to a holding mechanism for existing services. One system leader captured this early in the discussion, saying that the BCF often becomes "an envelope we continue to do the same things within", rather than an environment that enables genuinely new or locally tailored approaches.

Several participants echoed the sense that the Fund's purpose has become harder to articulate over time. An attendee working across local authority and ICB reflected that they could not say, "hand on heart", what the Better Care Fund is currently meant to achieve. When it was first introduced, they said, it had a clearer focus, whereas now it risks trying to be "too many things at once".

This lack of clarity was seen as having practical consequences. A local authority BCF lead argued that because the Fund is large and used for multiple purposes, it needs firmer definition. They questioned how systems are meant to move money into the "right places" if it is not clear what the BCF should, and should not, be used for, and where alternative funding would come from if certain activities were excluded.

At the same time, participants were clear that clarity should not mean over-centralisation. Several stressed that while national priorities and guardrails are necessary, decisions about how the Fund is used on the ground must remain with local leaders who understand their populations. One commissioning lead said that national teams can set direction, but delivery needs to sit with "the people who actually know what works locally".

Funding timescales were repeatedly raised as a major barrier to improvement. The reliance on one-year funding cycles was described as making it "very difficult to plan effectively", particularly for services that need time to embed. Although the two-year cycle used between 2023 and 2025 was described as a "welcome step in the right direction", the return to a one-year settlement for 2025/26 was seen as reintroducing uncertainty.

One attendee said this reflected a wider tendency across the health system to plan annually, but argued that the challenge is compounded in the Better Care Fund by the late publication of national policy and planning guidance. Another local authority director added that uncertainty around funding longevity and delayed guidance actively "undermines" the opportunity of the Fund, particularly because its current operating model does not align well with either NHS or local authority planning processes.

> **"Funding arrives so close to delivery that you're just keeping a lid on service provision"**
>
> **- ICB representative**

The impact of such delays were described as being felt most acutely during winter, when demand increases rapidly. One attendee explained that because funding and guidance arrive late, a significant proportion of BCF money ends up being spent temporarily to manage winter pressures. While this helps meet immediate need, they warned that it does little to support long-term sustainability.

An ICB representative described the practical reality of this approach, saying that “funding arrives so close to delivery that you’re just keeping a lid on service provision”. A local authority official warned that in these conditions, "you just maintain the status quo and begin to lose capacity and innovation”.

Several local authority representatives agreed that when budgets tighten, investment in prevention is often the first casualty. One local authority offical said this pushes systems into a reactive cycle, paying a premium for short-term responses while failing to address the underlying drivers of demand.

This tension between immediate operational pressures and longer-term transformation was reflected in views on what the Better Care Fund has achieved so far. An ICB representative said that while the Fund has provided valuable capacity to support discharge and help people move out of hospital, it has been less successful in “driving real transformation”, in part because the annual funding cycle restricts future-focused investment.

The discussion also highlighted how uncertainty affects independent providers. A local authority attendee explained that when funding horizons are short, providers can only commit in short bursts, which limits their ability to recruit, invest and scale services. They argued that longer-term, better-planned collaboration between the public and independent sectors could deliver better value for money, but that current uncertainty makes this difficult to achieve.

Despite these frustrations, there was no appetite to abandon the Better Care Fund. Participants broadly agreed that its founding principle, creating a shared space for health and social care funding, remains important, and in some cases protective. But without clearer purpose and better alignment with planning processes, attendees warned that this tension will continue to limit its impact.

> **“You just maintain the status quo and begin to lose capacity and innovation”**
>
> **- Local authority representative**

3. Integration in practice

Participants were clear that integration is no longer an abstract ambition. Where it works well, it was described as being driven less by formal structures and more by shared purpose and trust between organisations.

Several attendees emphasised that effective integration depends on people working together around individuals, rather than organisations working alongside one another. One local authority representative reflected that progress has come from "bringing people together who actually deliver care", rather than relying solely on governance arrangements or pooled budgets. In their experience, "integration works best when you bring together the people who actually deliver care", those professionals that have a good understanding of each other's roles.

Neighbourhood working was repeatedly highlighted as a practical way of making integration real. Participants described how working at a smaller, place-based level makes it easier to coordinate support, identify issues early and respond flexibly. Most attendees noted that neighbourhood teams are better placed to understand local context, including transport, housing and access to services - factors that often determine whether care plans succeed or fail.

Prevention and early intervention were seen as central to this approach, but also as areas under growing pressure. Several participants felt that while everyone agrees prevention matters, it is often the first thing to be scaled back when resources tighten. One system representative said that this creates a cycle in which services are constantly responding to crisis rather than addressing the underlying drivers of demand.

This was linked to wider determinants of health. Participants discussed how issues such as poor transport links, limited access to local services and housing challenges can undermine even well-designed care pathways. An ICB representative explained that without addressing these wider factors, "we're asking health and care services to compensate for problems they didn't create".

> **"Integration works best when you bring together the people who actually deliver care"**
>
> **- Local authority representative**

Jen Craft MP drew attention to the importance of seeing integration in this broader context, asking whether such infrastructure fully considers how people engage with public services on a day-to-day basis. She highlighted that for many constituents, the challenge may be less in navigating individual services but navigating between them.

Attendees were clear that integration remains fragile. It relies heavily on individual relationships and local leadership, rather than being consistently embedded in systems. Several warned that without more stable funding and clearer alignment between organisations, integrated ways of working risk being eroded under pressure.

Overall, participants agreed that integration in practice looks very different from integration on paper. The challenge for the Better Care Fund, they felt, is to protect and strengthen these ways of working, rather than allowing them to be squeezed out by short-term pressures.

> **"We're asking health and care services to compensate for problems they didn't create"**
>
> **- ICB representative**

4. Measuring outcomes

Participants spent time reflecting on how success is currently measured across health and social care, and whether existing metrics genuinely reflect what the system is trying to achieve. There was broad agreement that while performance measures are necessary, the current balance places too much emphasis on activity and flow, and not enough on outcomes that matter to people.

Several attendees felt that discharge-focused metrics, while understandable given system pressures, have come to dominate decision-making. One local authority official said that when performance frameworks prioritise speed and throughput, they inevitably shape behaviour, even if they do not align with longer-term goals. In their words, "the system ends up doing what gets measured, not necessarily what delivers the best outcomes".

This was seen as particularly problematic for prevention and early intervention. Multiple participants noted that preventative work rarely shows up in short-term metrics, despite being central to reducing demand in the long run. A senior local authority representative said that because "prevention is harder to evidence quickly, even though everyone recognises its importance, it's the first thing to be deprioritised" when systems are under pressure.

Jen Craft MP challenged the group to consider whether current measures genuinely capture success from a user's perspective. She asked whether metrics focused on system performance adequately reflect people's experience of care, their independence, or their quality of life after an intervention. This prompted discussion about the gap between what is easy to count and what is meaningful to individuals and communities.

Participants also highlighted how fragmented digital systems reinforce these issues. Several described how the lack of shared records and interoperable systems makes it harder to track outcomes across pathways. A local authority leader noted that when information is held in separate systems, professionals are forced to rely on proxy measures rather than a rounded understanding of a person's journey, while residents are left repeating their story at each point of contact.

> **"The system ends up doing what gets measured, not necessarily what delivers the best outcomes"**
>
> **- Local authority official**

Several attendees added that this fragmentation shapes what can realistically be measured. If systems cannot easily see what happens to someone once they leave hospital, for example, then success is more likely to be defined by discharge itself rather than by recovery, independence or avoidance of readmission.

There was also concern that the way outcomes are measured does not always align across organisations. Participants described situations where local authorities, ICBs and providers are working to different definitions of success, creating tension and duplication. One attendee said that without shared outcomes, "we end up optimising one part of the system at the expense of another".

Despite these challenges, attendees were not arguing for fewer measures, but for better ones. Several suggested that a smaller set of shared outcomes, focused on people rather than processes, would help align behaviour across the system. One ICB representative said that if partners were held collectively accountable for outcomes such as sustained independence or reduced need for ongoing care, it would change how resources are used and where effort is directed.

> **"Prevention is harder to evidence quickly... it's the first thing to be deprioritised"**
>
> **- Senior local authority representative**

Conclusion

Across the discussion, participants were clear that the Better Care Fund continues to play an important role in bringing health and social care together. In several areas, it has enabled more joined-up, person-centred ways of working, particularly in discharge and intermediate care, where removing organisational boundaries has allowed professionals to focus on outcomes rather than responsibility.

However, there was also a strong sense that using the Fund to drive longer-term change is becoming increasingly difficult. Short-term funding cycles and misaligned planning processes were repeatedly identified as barriers to improvement, limiting the ability of systems to plan ahead, invest with confidence and develop new models of care. As a result, the Better Care Fund is often drawn into sustaining core services and responding to immediate pressures, rather than supporting prevention and transformation.

Participants reflected that integration, where it works well, remains fragile. Progress on the ground was described as depending less on formal structures and more on trust and shared purpose. Without greater stability and alignment across organisations, attendees warned that these ways of working risk being eroded as day-to-day operational pressures take precedence.

There was also considerable discussion about how success is measured, and the influence this has on system behaviour. A strong emphasis on activity and flow, particularly around discharge, was seen as obscuring longer-term outcomes such as independence and recovery. Participants felt that without measures that reflect what matters to people and communities, short-term objectives will continue to dominate decision-making.

Despite these challenges, the overall tone of the roundtable was not pessimistic. There was a shared conviction that the founding purpose of the Better Care Fund remains relevant, and that with clearer priorities, longer-term certainty and more meaningful measures of success, it could play a stronger role in supporting integration and prevention.

Taken together, the discussion pointed to the need for a rebalancing of the Fund to improve outcomes for people and communities across Essex. Moving away from a focus on short-term crisis management alone, and towards supporting integrated and preventative approaches, will require closer alignment across organisations.

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