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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	**Brent**	
ICB	**West & North London (W&NL)**	
ICB	**N/A**	
ICB	**N/A**	

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 plan for 2026/27 positions the Better Care Fund (BCF) as a key enabler of integrated, preventative care delivered through a neighbourhood-based model. Funding is used to bring together multidisciplinary partners across health, social care and the voluntary sector to deliver coordinated, person-centred support aligned to the needs of local populations. This approach enables earlier intervention, prevents escalation of need, and supports seamless transitions between services, underpinning a sustainable shift from hospital-based care to community resilience and independence.

As a transition year, the focus in Brent is on maintaining service stability and high-quality operational delivery, while strengthening the foundations required for further integration and reform. As a result the majority of schemes roll over from the 2025/26 plan including all schemes commissioned by W&NL ICB. Schemes 41 and 42 are new (highlighted in naming convention on the plan).

This includes continued investment in core community, social care, and intermediate care services that are critical to supporting people at home and enabling timely discharge from hospital. These services are under increasing pressure due to rising demand, increasing complexity of residents needs, and wider system challenges, making it essential to sustain capacity and effectiveness across all pathway.

Capacity and demand are managed through a predominantly spot-purchasing model, which provides the Local Authority with flexibility to respond to fluctuations in demand. This ensures access to a diverse provider market and sourcing of care packages and placements that meet assessed need. Pro-active monitoring of providers, market wide capacity and demand confirms that there is sufficient capacity within the local system to meet current and anticipated demand. Where fixed capacity exists in both health and ASC step down beds a focus on appropriate referrals and throughput is designed to ensure capacity and demand are balanced.

Alongside this, a detailed review of local authority-commissioned services has been undertaken to ensure funding reflects current demand, inflationary pressures and value for money. Funding and activity assumptions for 2025/26 were refreshed using scheme-level performance data including service utilisation, delivery against key performance indicators, assessed levels of need and analysis of growth or change patterns over the previous years. Plans were also adjusted to reflect growth or reductions in demand across different cohorts and pathways. This has informed revised investment

priorities, ensured that funding matches need and supported the adaptation of existing service models to respond to changing pressures across health and adult social care.

Key schemes such as Bridging to Home (P1), Reablement, and Complex Care (P3) remain central to delivery. These services provide targeted, short-term support to residents with higher levels of need, enabling safe and timely discharge from hospital, reducing readmissions, and supporting recovery and independence. Their continuation reflects the importance of maintaining effective, trusted pathways while the wider system evolves.

During 2026/27, BCF funding will also support the further development of neighbourhood working in Brent. This includes strengthening multidisciplinary teams aligned to Primary Care Networks and improving coordination across services to ensure care is organised around the individual. There will be a particular focus on proactive and preventative care, including for groups experiencing poorer outcomes, such as people experiencing homelessness.

Brent has a diverse and growing population, with a high overall population density and a high proportion of residents from ethnic minority backgrounds, significant levels of deprivation and a younger population profile. This is now existing alongside a rising number of older people with complex needs. These characteristics align with the priorities set out in Core20PLUS5, with particular relevance to communities experiencing poorer health outcomes, multimorbidity, and barriers to accessing services.

The development of neighbourhood working supported by neighbourhood-level coordination functions, including Integrators enabling improved local alignment, responsiveness to emerging need, and more joined-up delivery across partners. BCF-funded services therefore play a critical role in addressing health and socioeconomic inequalities through targeted, preventative, and community-based interventions that reduce demand on acute services and improve outcomes for Brent's most vulnerable residents.

A key priority remains reducing avoidable hospital admissions through early intervention and rapid response. Schemes delivering timely, multidisciplinary support in community settings include the Integrated First Response Service, Community Rapid Response and Falls Service, and Enhanced Care Home Support. These are complemented by targeted initiatives such as the deployment of occupational therapy and social work capacity within A&E to support admission avoidance, the use of assistive technology to proactively manage risk and maintain independence at home and the establishment of the Brent Admiral Nurse program supporting Carers for, and residents with Dementia.

A key priority remains reducing avoidable hospital admissions through early intervention and rapid response services, particularly in response to Brent's growing population of older residents and rising levels of frailty, dementia, long-term conditions, and complex care needs. High levels of deprivation,

housing pressures, and persistent health inequalities across the borough further contribute to increased demand for urgent and acute care services. The complexity of healthcare need in Brent is driven by the interaction of chronic illness, socioeconomic disadvantage, language barriers, and unequal access to primary care, all of which can delay treatment and increase the likelihood of hospital admission.

Schemes delivering timely, multidisciplinary support in community settings include;

- Integrated First Response Service - The service helps residents receive coordinated support earlier and in community, reducing urgent care usage. This is particularly where issues relate to frailty, mental health, social isolation or difficulty coping at home. Ultimately supporting and integrating with services to support both complex health and social care needs.
- Community Rapid Response and Falls Service - Falls and frailty are major drivers of hospital admission for older residents. Brent's growing older population and increasing prevalence of long-term conditions mean demand for rapid community intervention is increasing. The service supports residents to recover safely at home and reduces pressure on acute hospitals.
- Enhanced Care Home Support - Care home residents are among the most clinically vulnerable residents, with high levels of frailty, dementia and multiple long-term conditions. Enhanced support helps avoid unnecessary hospital admissions, improves continuity of care, supports more coordinated management of complex residents within care home settings and supports Care Home providers effectively so they accept the more complex placements.

These are complemented by targeted initiatives such as;

- A new scheme to place a ASC occupational therapist and social worker within A&E to support admission avoidance - an identified gap in the existing provision of services.
- Developing the use of assistive technology to proactively manage risk and maintain independence at home - supporting the home first agenda, reducing reliance on paid and unpaid carers, and delaying or preventing the need for placements.
- The Brent Admiral Nurse programme supporting residents with dementia and their carers - meeting an identified need in community, to reduce carer burden, ensure appropriate wrap around services in place, reduce the need for paid care and keep residents at home for longer.

Collectively, these schemes enable a shift from reactive to preventative care, reducing system pressure while improving outcomes for residents. This approach reflects a shared commitment across Brent and the wider system to balance immediate operational pressures with longer-term

transformation, supporting the delivery of more integrated, preventative, and locally coordinated care, and ensuring the best use of available resources.

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:

Goals for non-elective admissions (65+) and delayed discharges have been developed using the national Better Care Fund dataset, ensuring alignment with national definitions, reporting requirements and the methodology set out in the BCF Metrics Handbook. A localised version of this dataset has been used to support modelling and trajectory setting, enabling the incorporation of local intelligence on demand (increasing population, operational pressures and service capacity. This approach ensures that targets are both evidence-based and realistic, while maintaining appropriate levels of ambition in the context of system pressures. Financial constraints across budgets exacerbated by budgets not rising in line with cost inflation, make balancing need and service capacity difficult. BCF funded schemes, and the wider allocation of resources have been designed to provide best value aligned to key metrics.

Emergency Admission Targets

In setting targets for non-elective admissions for those aged 65 and over, analysis has considered multi-year trends, demographic growth and service impact. Brent has experienced significant population increases, with predicted 14.35% growth in the 65+ population and 6.05% growth in the 80+ population between 2022 and 2027. Despite this, growth in emergency admissions has remained comparatively modest, indicating a positive trajectory when adjusted for population change.

Based on this analysis, the 2026/27 target aims to maintain admission rates at 2025/26 levels. In the context of continued demographic pressure, this represents a continued improvement in performance and reflects the impact of system-wide interventions to manage demand more effectively and support care closer to home.

Delivery against this metric will be supported by both BCF and wider system initiatives. BCF-funded schemes, including rapid response services, reablement, and integrated neighbourhood working, play a key role in preventing escalation of need and avoiding admission. These are complemented by

wider system developments such as urgent community response, virtual wards, and integrated care coordination, which collectively support a reduction in avoidable admissions.

Key to delivery is Brent's Community Frailty Service which will be the first to implement the NWL Community Frailty Specification, developed collaboratively with key partners across the sector. The service will be delivered at neighbourhood level and act as a key pillar to development of the neighbourhood health model.

The service will introduce a Single Point of Access, with streamlined referrals and improving equity by ensuring consistent access and provision across Brent. The model is underpinned by a core multidisciplinary team (MDT), which will manage patients initially and coordinate input from a wider network of professionals including GPs, mental health specialists, pharmacists, geriatricians and social workers based on individual needs.

Discharge Delay Days Target

The delayed discharge target has been set using 22 months of detailed performance data from the DHSC Better Care Fund & Discharge Dashboard, reflecting the position across all Health Trusts, alongside analysis of key drivers of delays. The plan reflects the challenges experienced in 2025/26 while incorporating the expected impact of service improvements being put in place. These include;

- Reduced capacity in Acute (HDT) and Mental Health (MH) Hospital Discharge Teams

HDT - add additional capacity, re-structure of roles, new recruitment practices and improved capacity for supervision. Combined changes will address difficulties in recruiting suitably qualified personnel, reduce staff turnover and effectively support the Hospital Discharge team at all levels.

MH Team is also being re-structured to create a focused Hospital Discharge team to match physical health, and once team fully recruited allocating staff to key locations to increase integration and relationships.

- Expanded bridging services - to accept non-complex double handed care packages, reducing time from referral to discharge.
- Strengthened pathways for patients with 'Gap' and complex needs who sat between existing ASC criteria, but not sufficiently complex to meet CC criteria.

This includes more targeted support and pathways for patients with dementia and behavioural needs and reduces time identifying pathways and negotiating between health and social care partners.

- Equipment delays and additional costs after supplier collapse August '25, new network of suppliers now in place.

Progress against both metrics will be monitored through Discharge Ready Date data (with quality improvements in data collected as system wide consistency of reporting has improved), established system governance arrangements, including regular performance reporting at scheme level, data review and operational oversight across health and social care partners. Combined this enables early identification and resolution of delays, as well as the use of system-wide data and analytics to track trends, undertake deep dives and inform service improvement.

The 2026/27 plan has been developed jointly with Brent ASC and ICB borough colleagues, informed by data to January 2026 and wider system intelligence.

Q1 is expected to show a higher position than the equivalent period in 2025/26, reflecting continued system pressures from the end of 2025/26, including ASC capacity constraints and the challenges in setting up the 'Gap' pathways for patients with health needs who do not meet CHC criteria.. From Q2 onwards, performance is expected to improve progressively over the remainder of the year, reversing the 2025/26 trend of a strong start followed by deterioration.

This table shows DRD data and changes since 2024/25. However acknowledged data quality issues - particularly in earlier periods - mean these should be interpreted as indicative of trends rather than directly comparable measures.

Value	Average days from Discharge Ready Date to date of discharge (exc 0 day delays)	Proportion of adult Patients Discharged on their Discharge Ready Date
Average for 2024/25	5.47	89.91%
Average for 2025/26	6.20	87.58%
Average for 2026/27	5.95	88.29%
	Lower = better performance	Higher = better performance
Change from 24/25 to 25/26	0.73	-2.33%
Change from 25/26 to 26/27	-0.25	0.71%
	Minus = Improvement	Positive = Improvement

Residential Admissions Target

For 2026/27, the care home admission metric has been set in line with 2025/26 actual performance. While this represents a flat trajectory, it should be viewed in the context of a projected 2.8% increase in the population aged 65 and over, meaning the target constitutes a positive and proportionate

stretch. Maintaining current admission levels despite demographic growth reflects the anticipated rise in complex health needs and the borough's comparatively high levels of health deprivation. As such, the target is considered both realistic and appropriately ambitious within the local context

Brent has historically maintained one of the lowest rates across London, reflecting a strong strategic focus on prevention and independence. Services to prevent admission include reablement services, extra care housing (additional capacity launching in Summer '26) and flexible support such as one-to-one care and night-time provision. These services enable residents to remain at home for longer, reduce reliance on residential care, and improve outcomes following discharge.

Overall, this approach ensures that targets are grounded in robust analysis while being supported by a clear delivery plan and strong system oversight, enabling Brent to continue improving outcomes despite increasing demand and complexity.

Monitoring and goals set are completed in line with the process and principles defined in the ASCOF measures.

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

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

BCF-funded services will deliver improved outcomes by addressing increasing demand, supporting an ageing population, and responding to rising complexity of need as outlined on page 4-5. A key priority remains reducing avoidable hospital admissions through early intervention and rapid response services, particularly in response to Brent's growing population of older residents and rising levels of frailty, dementia, long-term conditions, and complex care needs. High levels of deprivation, housing pressures, and persistent health inequalities across the borough further contribute to increased demand for urgent and acute care services. The complexity of healthcare need in London Borough of Brent is driven by the interaction of chronic illness, socioeconomic disadvantage, language barriers, and unequal access to primary care, all of which can delay treatment and increase the likelihood of hospital admission.

. Funding is strategically deployed to strengthen community-based, preventative services that reduce avoidable hospital admissions, improve discharge performance, and support residents to remain independent for longer.

The planned impact of this investment is a continued shift from reactive, hospital-based care to proactive, community-led support. This includes enhancing early intervention, reducing escalation of need, and improving recovery following illness or hospital stay. As a result, BCF-funded schemes are

expected to contribute directly to stabilising non-elective admissions, reducing delayed discharges, and avoiding residential placements where care in the community can be provided.

2026-27 will see the role of Central North West London NHS Foundation Trust (CNWL) as the system integrator in Brent developing significantly alongside the wider ICB and NHS England structural changes. Their role as a coordination and leadership function brings together all members of the borough integrator partnership including NHS providers, Local Authority, and voluntary and community sector partners to co-ordinate the delivery of services to residents. The role of CNWL as integrator operationalises the BCF ambitions by aligning organisations around shared outcomes, accelerating the shift to neighbourhood and preventative care and support maximising BCF funding to deliver co-ordinated services. This is achieved through ensuring services are joined-up, proactive, and person-centred and supports the removal of barriers between organisations (e.g. pathways, funding silos).

For 2026–27, funding is prioritised to support the development of an integrated neighbourhood model, with a focus on delivering measurable improvements across key pathways. Services specification ensure coverage across the borough so delivery based on need and not geography, with multi agency working seeking to close the gaps in provision which can disproportionately affect populations who find access to services harder for example due to language barriers. Funding includes:

- Enhancing intermediate care capacity (step-up and step-down), which will improve patient flow, reduce length of stay, and support timely discharge – schemes 6, 7, 8, 103 and technology from scheme 26.

- Strengthening admission avoidance pathways through rapid response and multidisciplinary community teams, reducing unnecessary hospital attendance and admissions – scheme 13, 27, 38, 41, 101, 102, 105, 109, 110, 111

- Expanding community rehabilitation and recovery services, improving functional outcomes and increasing the proportion of residents remaining at home following reablement - scheme 4, 5, 6

- Improving discharge processes, including for mental health pathways, to reduce delays and ensure smoother transitions of care – scheme 20, 23, 42

- Maintaining and optimising core discharge schemes such as Bridging to Home (P1) and Complex Support (P3), enabling safe discharge for higher-need patients and reducing readmissions – schemes 2, 4, 5, 9, 10, 18, 22, 24, 31, 32, 33, 34, 35

A key area of impact for 2026/27 is the introduction of the Homeless Health NWL Enhanced Model - scheme 115, delivered through reprioritisation of existing BCF resources. This model targets a high-risk and underserved population by providing dedicated support within emergency departments to

prevent unnecessary admissions and improve access to appropriate community-based care. This will contribute to reducing health inequalities while supporting admission avoidance and improved system flow. The new integrated model addresses previously unmet needs in Brent within service provision, which reduced options for early intervention, driving up need and costs which put pressure on other parts of system in particular acute services. It has been designed to ensure care is delivered across borough boundaries, recognising the transient nature of this population.

Overall, BCF investment will strengthen integrated neighbourhood services, enabling more coordinated, proactive care delivery. This is expected to reduce pressure on acute services, improve independence and recovery outcomes, and support a continued reduction in long-term care needs. Progress will be monitored through established performance frameworks, ensuring that funding delivers measurable impact against key BCF metrics and local priorities.

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:

The joint approach between Brent Council and the West & North London Integrated Care Board (ICB) ensures that BCF-funded services deliver value for money through robust governance, shared decision-making, and ongoing performance review. The 2026–27 financial plan maintains delivery within the existing funding envelope, with all changes jointly agreed and subject to system-wide oversight and challenge.

Confidence in value for money is achieved through regular monitoring of service performance, activity, and outcomes, alongside financial oversight. Schemes are reviewed to ensure that investment is aligned to demand, delivers measurable impact against BCF metrics, and supports system priorities such as reducing admissions, improving discharge, and increasing independence. Where services are not delivering expected outcomes, these are subject to review and redesign.

In addition to routine performance and financial monitoring, Brent Council and the ICB undertake benchmarking and comparative analysis to assess value for money.

Benchmarking is used not only to compare performance but also to inform commissioning decisions, service redesign and the reallocation of resources towards interventions demonstrating the greatest impact and value.

Benchmarking considers service costs, activity levels, throughput and outcomes to ensure that investment is delivering both improved resident outcomes and efficient use of public resources. Comparative review includes performance against national BCF metrics, discharge performance, admission avoidance measures and Adult Social Care Outcomes Framework (ASCOF) indicators. Findings are used to identify areas of variation, challenge existing models of delivery, and in-year inform service redesign where flexibility exists. Benchmarking is used not only to compare performance but also to inform commissioning decisions, service redesign and the reallocation of resources towards interventions demonstrating the greatest impact and value. This approach provides assurance that BCF investment remains proportionate, delivers measurable benefits for residents, and reflects best practice across health and care systems.

Benchmarking capability continues to mature through the development of whole-system intelligence and shared performance dashboards, supporting a shift from periodic review towards more continuous and real-time assessment of value, outcomes and productivity. This approach provides assurance that BCF investment remains proportionate, delivers measurable benefits for residents, and reflects best practice across health and care systems.

The following range of established governance, performance management and benchmarking arrangements provide regular challenge, comparative insight and evidence-based decision making.

- *System oversight and assurance:*
  Value for Money (VFM) is monitored through the System Flow Board, which reviews key performance areas (e.g. discharge delay days) and associated programmes to ensure resources are delivering impact. In 25/26 this compared Brent to the other 7 Boroughs in NWL ICB. In 26/27 that will widen to the W&NL ICB footprint.
- *Benchmarking and comparative insight:*
  Development of whole-system dashboards (e.g. WSIC / HIU dashboards) enables comparison across boroughs, trusts and PCNs, helping identify variation and target improvement
- *Formal scrutiny:*
  Quarterly borough reports are signed off by the ICB Executive Management Team, providing structured challenge, benchmarking and financial oversight.
- *Benchmarking Adult Social Care Outcomes Framework (ASCOF) data related to 65+ long term care home admission benchmarks across all 33 London Boroughs allowing in year and year on year trend analysis and comparison*

Evidence of active value optimisation

- *Scheme review and rationalisation:*
  A line-by-line review of schemes has already been completed to assess whether schemes remain effective and represent value for money, with changes made where they do not.
- *Flexible use of funding:*
  Funding (e.g. pathway resources) is being repurposed flexibly to address local gaps, rather than being rigidly tied to specific service types.
- *Standardisation and productivity focus:*
  The system is moving towards a "common core offer" across core health schemes and key schemes within the LA such as bridging, using benchmarking to reduce variation and optimise use of existing resources across community services.

Wider system value narrative focus on outcomes (e.g. discharge performance) rather than just inputs

- *Alignment of system-wide programmes (e.g. bridging, homeless health) to shared priorities*
- *Continued development of data-driven decision making and comparative analytics*

Productivity improvements are a key focus for 2026–27, delivered through a combination of service optimisation and system integration. This includes prioritising high-impact schemes that support admission avoidance and rehabilitation, ensuring resources are focused where they deliver the greatest benefit.

Further improvements are being achieved through strengthened joint working between the Local Authority and ICB, including the continued delivery of agreed efficiencies from 2025–26 and addressing gaps in pathways or funding responsibility that can create delays or duplication. The development of integrated neighbourhood models will also support productivity by reducing fragmentation, improving coordination, and ensuring residents receive the right care in the right place at the right time.

The programme of ongoing service review and benchmarking supports continuous improvement and re-design. This includes evaluating existing schemes, identifying opportunities to streamline provision, and reallocating resources where needed. For example, changes to centrally commissioned schemes and the introduction of the Homeless Health model demonstrate a shift towards targeted, high-impact interventions that better meet local need while improving system flow and moving towards a more consistent common core offer.

Governance arrangements within the Council have been strengthened through the establishment of a BCF Board, which provides oversight of financial performance, delivery, and outcomes. This forum supports joint accountability across partners, drives consistency in operational standards, and enables data-driven decision-making to improve service effectiveness and efficiency.

Overall, this approach ensures that BCF funding is used effectively to deliver maximum public value, supporting improved outcomes for residents while making best use of limited resources across the health and social care system.

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:

The Better Care Fund (BCF) in Brent is governed through robust, jointly agreed arrangements between Brent Council and the West & North London Integrated Care Board (ICB), ensuring strong accountability, effective financial oversight, and a consistent approach to monitoring impact and value for money. As 2026–27 represents the first year of the newly formed ICB, governance arrangements will be aligned across legacy organisations to provide a coherent and streamlined framework for decision-making and assurance.

Statutory oversight is provided by the Brent Health and Wellbeing Board, which is responsible for approving the BCF plan and ensuring alignment with local strategic priorities. This is supported by borough-level partnership forums, which provide assurance on local delivery, monitor performance, and ensure that schemes are responsive to local need. Strategic leadership is jointly held by senior Local Authority and ICB leaders, including the Brent Council Chief Executive, Corporate Director for Service Reform and Strategy, Director of Adult Social Services, and ICB executive leads. This group provides overall accountability for delivery of BCF priorities, ensuring that resource allocation, performance, and outcomes are aligned with wider system objectives.

At an operational level, a joint BCF management group brings together ICB leads, Local Authority officers, and finance representatives to oversee delivery of the programme. This group monitors performance against BCF metrics, including non-elective admissions, delayed discharges, and reablement outcomes, alongside financial performance and activity data. Regular reporting and operational reviews enable early identification of risks, pressures, or underperformance.

Financial governance is supported through joint oversight by Local Authority and ICB finance teams, ensuring that expenditure remains within the agreed funding envelope and is aligned to Section 75

agreements. All proposed changes to schemes are subject to formal review and approval processes, with a clear focus on ensuring that funding is directed towards high-impact, cost-effective interventions.

A continuous improvement approach underpins governance arrangements, with schemes subject to regular review to assess their impact, productivity, and value for money. This includes evaluating outcomes, identifying opportunities to improve efficiency or reduce duplication, and making changes where required to optimise delivery. Learning from performance data, service evaluation, and operational insight is used to inform ongoing service development and resource allocation.

The establishment of a dedicated BCF Board within Brent Council has further strengthened governance by providing a focused forum for oversight of delivery, performance, and financial management. This supports greater coordination across all teams, enhances transparency, and ensures that decisions are informed by robust data and shared system priorities.

Wider local organisational governance processes provide further financial scrutiny, ensuring that funding and investment decisions are robust, demonstrate value and clearly align with the responsibilities of budget holders, including adherence to the scheme of delegation and relevant financial standing orders.

Overall, these arrangements provide a comprehensive and integrated governance framework, ensuring that BCF funding is effectively managed, delivers measurable impact, and supports continuous improvement in outcomes for residents.